Troops and of most of the Militia." McGrigor engaged such civil practitioners as were available. Everything that could be thought of was done. But still the numbers of typhus cases continued to increase. Haslar Hospital took nearly 4,000 cases. Floating hospitals were taken over by the Army for the worst cases. Two Deputy Inspectors of Hospitals were sent to Portsmouth under McGrigor's orders. But, in spite of all this accession of medical strength, the typhus continued. A very serious complication, a mixture of typhus and pneumonia became prevalent. Mr. Knight himself finally came down to take charge himself and was met by McGrigor who had daily parties of officers to meet him—but he only remained a few days and returned to London "to make his report to the Duke of York and to express his satisfaction to His Royal Highness with what had been done." It only remains to tell one funny story about Haslar Hospital. There was a very correct and almost prim old retired Naval Officer in charge. The old gentleman told the Sergeant of the Guard that he was entitled to "a march by Beat of Drum" as well as by the Guard turning out. The Sergeant applied to the officer on duty, a young Irishman with a sense of humour. "Certainly," said he, "play him the Rogue's March," which was actually done, all persons being satisfied!

Here ends the manuscript as left by Colonel Lyle Cummins.

Correspondence

DEAR SIR,

An unquenchable hope of starting a lively correspondence in the Journal exposes me to the risk of being thought contumacious and self-opinionated, so I persuaded Lt.-Col. P. L. E. Wood, whose views largely coincide with mine, to write a criticism of the views of the Southern Command Medical Study Week (Journal, February 1949). As he is a busy physician his letter never got beyond a rough draft. General Dowse's very interesting article (Journal, October 1949), however, renews the need for discussion of some points concerning the deployment of Field Ambulances about which I know the views of my fellow divisional A.Ds.M.S. (Cols. T. F. M. Wood of 2 Div. and J. B. Macfarlane of 40 Div.) differ from those expressed in the two articles.

To the Hartgill Committee recommendations we owe our invaluable F.D.S., and indirectly our modern Field Ambulance; but has it given us anything else except new names for the old A.D.S. and M.D.S.?

In 1937 in a letter to this Journal I advocated the excision of one link from our chain of evacuation, using the Field Ambulance in the role of collection by means of a network of posts like our present Sections, and evacuation to a Dressing Station which I visualized not as a heavy rearward element of the highly mobile Field Ambulance, but as a light element thrust forward by the

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C.C.S. I was therefore not hostile to the concepts of the Hartgill system as described by General Dowse, but I do not think that it worked in European warfare.

I hope that my fellow "diehard and very conservative medical administrators" will forgive me if I quote them. T. F. M. W. "The C.C.P. (old A.D.S. really)." J. B. M. "for continental warfare . . . an affair of large armies and generally narrow divisional fronts . . . the old A.D.S.–M.D.S. combination caters admirably and should not be altered . . . 'a rose by another name'." P. L. E. W. (who also used the A.D.S.–M.D.S. set up in Italy, retaining those names) "I only know one A.D.M.S. who tried the Hartgill system, and he quickly won himself a 600 bed General Hospital."

Of course one's battle experience colours one's views. One section C.C.P.s served me as well in the desert as I believe they did in the jungle; but experience in Normandy—the really horrible experience of seeing them swamped by a rush of casualties, and I had seen something not unlike it at Keren, cured me in one morning of regarding them as the normal.

The normal deployment I consider is: (*a*) One C.C.P. per Brigade, at Main Bde. H.Q. level, on or near the centre line, its location, etc., controlled by O.C. Fd. Amb. and/or his Coy. Commander, and consisting of at least two Sections; (*b*) One A.D.S. per Division at Main Div. H.Q. level, on the main administrative axis, controlled by the A.D.M.S.

There will certainly be special occasions—some have occurred in our recent exercises, and many will probably occur in the early phases of future wars when wide dispersion may be essential—when one section C.C.P.s will be necessary, and we will then be thankful for the flexibility of the Field Ambulance which General Dowse stresses. It is unnecessary to give examples of such occasions, but some of us incline to the view that when one section C.C.P.s are necessary it may often be best (despite the risk of losing two M.O.s by one shell) to have R.A.P. and C.C.P together to avoid dispersal of force, and because a two-doctor post is so much more efficient.

I can see no reason for again changing the names of our medical posts, and risking a rise in the incidence of neurosis amongst Staff College candidates. So long as the combatants see well-signed, easily found medical posts in suitable places they don't care what we call them. "Casualty Collecting Post" exactly describes the function of such posts—places where casualties are collected into economic ambulance loads. The more of them we open the less economical is our use of ambulances likely to be. General Dowse's use of the words "the open Field Ambulance" implies a single A.D.S. open for the whole Division, which is the normal plan. For this the term "Brigade Dressing Station" is misleading. He sites the A.D.S. "in the Brigade area"; R.A.M.C. Training Pamphlet No. 2, 1943, puts it in the vicinity of Brigade H.Q.: but there are three Brigades in the Division, and to site the single A.D.S. in the area of one might be inconvenient to the others. The general area of Main Divisional H.Q. is likely to be convenient to all, and is suitable for other reasons, amongst them the difficulty of squeezing Field Ambulance H.Q. into the march tables

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of an advancing division far enough up the column to enable it to get to the neighbourhood of Brigade H.Q. in time to open before battle is joined. Here, however, I must admit that if the Air O.P. Flight is likely to be well in advance of Main Divisional H.Q. then the A.D.S. might have to be near that level if we eventually get aircraft for evacuation from the A.D.S., since the Divisional R.E. can hardly be expected to make special air strips for our exclusive use.

The location of the F.D.S. depends less on tactical needs than on suitable accommodation, and O.C., F.D.S., should make arrangements at the Reception Department of the open A.D.S., or of the C.C.S., whichever is the nearer, for filtering off the divisional sick and cases of exhaustion.

These suggestions for our normal deployment may be too rigid and too geographical, for in this connexion one must think less in terms of miles from the F.D.S.s, or of areas in the Division, Corps or Army, than of Travelling Time to the Surgeon. In his journey to the surgical team at or near the C.C.S. the casualty passed through two Field Ambulance posts where adjustments or additions to the R.A.P. treatment, which was sometimes unavoidably sketchy, could be made; and in practice it usually worked out that if these posts were sited as indicated above the journey was smoothly staged. Modern surgery may possibly extend the maximum time within which the casualty must reach the surgeon, and this together with air evacuation may affect the location of the forward surgical teams, and the divisional medical units will have to shape their deployment accordingly.

Many alternative methods of employing Field Ambulances can of course be elaborated, especially with the aid of diagrams in which the deployment of the Division itself is sketchily represented by such airy generalities as "Troops in the Line"—(Is Training Pamphlet No. 2 still catering for the Thin Red Line?).

One can theorize, as I did in 1937, about doing without one link in the chain, and I have seen one or two major battles in which the A.D.S. could have been dispensed with at least in the early stages, but I believe that something on the lines suggested above was common practice in 21 Army Group and 8th Army; and when one remembers the many engagements in which we must all have seen what was really a pre-Hartgill set-up at work, with the C.C.P., the A.D.S., and the C.C.S. all hard at it, all clearly doing necessary jobs and doing them well, and all apparently just where they were tactically required, one hesitates to lay even a diagrammatic finger upon any of the old and well tried links in the chain.

If the Bible of the True Faith is Training Pamphlet No. 2, with the Gospel according to S. Command, and the Epistle of General Dowse to the Collegians, then this is heresy—but I think it will be found that the heretics are many, and securely entrenched even in episcopal appointments.

I entirely agree with the measure of responsibility which General Dowse gives, despite a note of caution on p. 178, to Field Ambulance Commanders. Most battles are fought as Brigade battles and O.C. Field Ambulance is the best man to control evacuation from his Brigade, within the framework laid

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down by the A.D.M.S. As an O.C. Field Ambulance I found it best to live at Main Brigade H.Q. during battle, but perhaps the new Company H.Q. organization will make this less essential.

General Dowse puts certain problems for our consideration.

The question of the replacement of Regimental stretcher bearers and the drivers of medical vehicles by R.A.M.C. men has twice been referred to divisional A.Ds.M.S., in 1946 and 1949. On both occasions I found that the weight of opinion amongst combatant officers and medical officers with much divisional experience in the last war was against these proposals.

Although there may be no technical objection to continuing as far as Field Ambulance Company Headquarters and the R.A.P.s the wireless frequency allotted to the medical services, the problem will be the provision of trained men with a high sense of signals security to operate the additional sets.

For a short time as an A.D.M.S. I had a Rover set but the bother of operating it inclined me rather to use the nearest set at a Field Ambulance or Brigade H.Q. Whatever sets we have must, I think, be manned by Signals operators. We cannot add this highly specialized trade to our R.A.M.C. training commitments, and, quite apart from the fact that the enemy gets his most valuable information from intercepts of administrative nets, an indifferently operated net is worse than useless.

Like General Dowse I am surprised that the location of the A.D.M.S. and his staff at Main Divisional H.Q. is not yet officially prescribed despite the statement in the Report of the A.M.D. Committee on Post-war Field Medical Organization that at Rear H.Q. "no A.D.M.S. can function efficiently during active operations." Of the many arguments in support of this the one which often appeals to logically minded staff officers is as follows. R.A.S.C. and R.A.O.C. collect material from the rear and deliver to the forward area. R.A.M.C. and R.E.M.E. collect casualties from the forward area and convey them to the rear. Experience has proved that this R.A.M.C. work can be properly controlled only from Main Divisional H.Q., whereas C.R.A.S.C., C.R.A.O.C. and C.R.E.M.E. all prefer their H.Q.s to be at Rear H.Q. The problem of the C.R.E.M.E. resembles our own, L.A.D.s correspond to R.A.P.s, but he has no C.C.P.s and his Brigade Workshops are normally set further back than our A.D.S. Were we to have our own H.Q. like theirs (C.R.A.M.C., etc.) our position at Main Divisional H.Q., which is now accepted in all enlightened Divisions, might be imperilled. Even the addition of an A.D.D.S. as suggested in the Southern Command article might be dangerous, and I for one do not support this. Excellent results were given by using the senior mobile dental team officer in an advisory capacity.

The D.A.D.A.H. can well be at Rear Divisional H.Q. provided his need of an office is catered for by a 15-cwt. truck with penthouse, or by the prescriptive right to a share of the office of the D.A.A.G. or D.A.A.G. (Health Discipline).

With this exception an A.D.M.S. is justified in saying to the Divisional Commander "If your A.D.M.S. and staff are to be at Rear Divisional H.Q.

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Sir, he will NOT be ME." ("ME" sounds so much better than "I," and when moved by profound emotion one is seldom pedantically grammatical.)

Comments on General Dowse's last problem can best be made by those with jungle warfare experience.

"Sand in your shoes" was the 1944 taunt when anyone spoke of the desert, and in 1945 those whose war experience was confined to Europe would dismiss as Bush whackers men whose knowledge of Air evacuation and of the intricacies of Air Supply must put the Bocage Bores in the beginners' Class.

If we do get our own ambulance planes it must be remembered that we may still have to use returning empty transport planes, just as in emergency we may use returning empty supply vehicles, and, in forcing the passage of land or water obstacles, returning A.P.C.s, L.Vs.T., and D.U.K.W.s. In the design of new A or B vehicles and planes the possibility of their occasional use for stretcher carrying should always be kept in mind.

I mentioned this point in a letter to the Journal (January 1949, p. 49) which did not start the correspondence which I hope that this one will; for these points need to be discussed if our training is to be on sound and more or less generally agreed lines.

I am, Sir,

Yours, etc.,

F. M. RICHARDSON, *Colonel.*

January 27, 1950.

[Further correspondence is invited. Letters should be short—preferably from 500 to 100 words.—ED.]

DEAR SIR,

When recently perusing original reports in connexion with the Medical History of the War, I came across a note by the D.D.M.S., Brigadier D. T. M. Large, on the subject of hill-stretchers (i.e. stretchers for evacuation in hilly country).

He mentions the "Thomson-Hill" stretcher and comments that it was too heavy and cumbersome.

This hill-stretcher, which should have been noted as the "Thomson hill-stretcher" (i.e. for use on hills and mountains), was designed at Razmak on the Indian Frontier for the very work of evacuation from such country as that encountered in the Campaign in Greece. It was, therefore, made light, handy and almost flimsy looking but did its job in several short campaigns on the Frontier with success. The original models weighed 9 lb., were deliberately made with a two-piece socketing single pole and were so easily carried on the back over normal equipment that the S.B. had both hands completely free for rock climbing; while two stout S.B.s could bring the casualty downhill.

This could hardly be called "too heavy and cumbersome."

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It was in the hands of "Ordnance" that the stretcher was *"improved"?* and "modified" so that it attained a weight of 18 lb. and finally, I believe, 24 lb. Perfectly ridiculous etceteras were added, such as large "turks heads," to prevent the loops slipping, whereas all that was wanted was a single rope knot, and a large metal pin to hold the jointed ends together, whereas *no pin* was ever required because it would be a physical impossibility for the socket to come undone once the patient was in the sling-stretcher.

It was the Ordnance pattern with unnecessary *improvements* (?) which made the Thomson hill-stretcher too heavy and cumbersome.

I suggest that for future use something approaching the original production and pattern should be used.

Yours faithfully,
TREFFREY O. THOMPSON,
Lieutenant-General.

February 6, 1950.

In a letter to the Editor Brigadier D. T. M. Large comments:

. . . He agrees that, as modified by Ordnance, it is, as I commented, heavy and cumbersome. . . . It is much too heavy to be of any value at all and I agree with him that something much lighter and flimsier is required. The present modification, as sent to us in Greece in 1941, is fit only for the rubbish heap.

By the way, I saw some very interesting stretcher work in Austria recently, both in actual casualties among skiers—which were frequent this year—and in connexion with the training of the Chasseurs Alpins, who were occupying that part of Austria. This ski-stretcher is just a long flat wicker-work basket, on which the casualty lies, and is fitted with several steel bands underneath to act as runners. One bearer skis in front, braking all the time on his skis, and one behind, braking hard, while the stretcher itself just skids on the snow.

I have seen these things go down very fast in charge of trained guides over places where I would hardly dare to ski. They were in daily use and seldom a day passes without one seeing two or three broken legs brought in on them. The patients are comfortable enough, which is as well, as there is no other possible means of evacuating them from the higher snow slopes.

[*Brigadier Large does not tell us how this contrivance is secured to the skiers—presumably there is some material connexion.*—ED.]

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