

## THE BRITISH ARMY DIVISIONAL MEDICAL ORGANIZATION<sup>1</sup>

BY

Major General R. D. CAMERON<sup>2</sup>

*Royal Army Medical Corps*

THE medical organization within the division consists of (a) the Assistant Director of Medical Services (A.D.M.S.)<sup>3</sup> and his staff; (b) Field Ambulances,<sup>4</sup> three in an infantry or airborne division and two in an armoured division; (c) one field dressing station (F.D.S.) per armoured or infantry division, also allocated to an airborne division in a ground role; and (d) regimental medical establishments.

### ASSISTANT DIRECTOR OF MEDICAL SERVICES

The A.D.M.S., a colonel, is the adviser to the divisional commander on all matters which affect the health of the troops, and this includes advice on health discipline and the prevention of disease. He commands the medical units in the division and is responsible for formulating the medical plan for the collection and disposal of casualties. He is attached to the Adjutant-General's branch of the staff and is located at main divisional headquarters. He has 2 medical officers on his staff: A Deputy Assistant Director of Medical Services (D.A.D.M.S.) and a Deputy Assistant Director of Army Health (D.A.D.A.H.). In addition there are 15 noncommissioned officers of the medical corps: 6 clerks, 1 orderly, and 8 sanitary assistants.

### THE FIELD AMBULANCE

All Field Ambulances are standard and are similar in personnel. Field Ambulances with airborne divisions, in view of their special employment, have different types and scales of equipment and a minor difference in transport. A Field Ambulance consists of an H.Q., and H.Q. section, and one company,

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<sup>2</sup>Inspector of Training of the British Army Medical Services at the time of writing this article and now Director of Medical Services (Theatre Surgeon), The British Army on the Rhine.

<sup>3</sup>Corresponds to our division surgeon.

<sup>4</sup>Corresponds to our old collecting company or a combination of the collecting section of a regimental medical company and a section of an ambulance company under our new T/O.

which is divisible into a small company H.Q. and three equal sections similar in every way to the H.Q. section. The sections form casualty clearing posts (C.C.P.)<sup>1</sup> for the evacuation of regimental aid posts (R.A.P.)<sup>2</sup> and are administered by the company H.Q. The H.Q. of the Field Ambulance holds the bulk of the equipment and forms the advanced dressing station (A.D.S.)<sup>3</sup>. The Headquarters section assists the A.D.S. or is used for leapfrogging, augmenting, or relieving the company as required. The organization of the unit permits great flexibility.

The primary role of the Field Ambulance is the rapid collection of sick and wounded, the rendering of first aid to casualties, their preparation and classification for further disposal, and the completion of necessary documentation. It is a mobile unit and is not equipped to provide other than the simplest accommodation and essential treatment. When not engaged in active operations the Field Ambulance may hold patients with minor illnesses. This is a secondary role and cannot be undertaken in combat when casualties must be evacuated as soon as they are fit to travel. The Field Ambulances of airborne formations are specially trained and equipped for their special duties. When taking part in an airborne operation each Field Ambulance has two field surgical teams attached to enable the unit to operate independently when it is out of contact with ground forces. As soon as a link-up with the ground forces is made, the normal casualty evacuation procedure is reverted to.

Field Ambulances are divisional troops, and as such their disposition is controlled by the A.D.M.S. acting under authority of the divisional commander. One Field Ambulance is usually allotted in support of each infantry brigade<sup>4</sup> and then becomes an element of the brigade group, in which case it conforms to the movements of the brigade, and collects the casualties occurring on the brigade front. The siting, opening, and closing of the A.D.S.s is controlled by the A.D.M.S., except in the initial stages of a planned battle when he frequently delegates his authority to the Field Ambulance Commander, in which case the latter will inform the A.D.M.S. in advance of any intention to move and at once report the location to the A.D.M.S. In certain operations the Field Ambulance is placed under the brigade commander, e.g. when the brigade is acting independently or in the early stages of an airborne operation. In this event the Field Ambulance Commander, with the concurrence of the Brigade Commander, will locate and open the A.D.S. He should, if possible, intimate his intention to the A.D.M.S. and invariably report its location. An A.D.S. may be opened for each brigade in action, or the A.D.M.S. may decide to open one, or possibly two, for the divisional front.

The Field Ambulance Commander attends brigade operation conferences

<sup>1</sup>Corresponds to our collecting post or point.

<sup>2</sup>Corresponds to our battalion aid stations.

<sup>3</sup>An intermediate unit corresponding to a combination of part of our collecting and clearing stations.

<sup>4</sup>Corresponds to our regimental combat team.

and maintains contact with brigade headquarters throughout operations in order to obtain up-to-date information which will enable him to arrange for the speedy evacuation of casualties. The Field Ambulance Commander is the senior medical officer of the brigade, and as such is the adviser to the brigade commander in medical matters. He should frequently visit all units in the brigade area.

The guiding principles in the evacuation of casualties within the division are: (a) the maximum speed consistent with efficiency, limiting treatment to controlling shock and hæmorrhage, relieving pain, and rendering the patient fit for evacuation; and (b) minimal handling of the patient such as transfers between ambulances and change of dressings.

*Field Ambulance Section.*—The role of a Field Ambulance section is to collect casualties from R.A.P.s and evacuate them without delay to the A.D.S. It can perform this function either by: (a) direct transportation of casualties from R.A.P. to A.D.S., (b) establishing an ambulance post at an intermediate point, or (c) establishing a casualty collecting post (C.C.P.). It is often convenient to use two or more sections together thus forming a combined C.C.P. Prior to an engagement it is usual to attach one or more stretcher-bearer squads from the section to the R.A.P. If the ground permits, one jeep or ambulance is also attached. Treatment in a C.C.P. should be confined to such first-aid measures as the regimental medical officer (R.M.O.) may have been unable to carry out, and first aid for cases which have not passed through an R.A.P. It is primarily a check point, and it is only necessary to ensure that hæmorrhage is under control and that fractures and large flesh wounds are immobilized. Dressings and splints should not be removed unless such a procedure is essential before further evacuation. Hot sweet tea should be available. When there is an extended line of evacuation there may be occasions when it is necessary to assign to the C.C.P. its additional role of a treatment centre. These occasions should be rare. The main object is to transport casualties to the A.D.S. as quickly as possible.

*Field Ambulance Company Headquarters.*—The role of the company headquarters is to control, administer, and maintain the three company sections. In addition, the company commander controls and co-ordinates forward evacuation from R.A.P.s and locates C.C.P.s under the Field Ambulance commander's direction. The company commander frequently visits R.M.O.s and maintains contact with the brigade headquarters staff. The company headquarters is located where it can best control evacuation from the brigade group. This is normally at the junction of the lines of evacuation from which all sections are operating. It is not intended to form a medical post but a small amount of medical equipment is carried for the treatment of local casualties and sick.

*Field Ambulance Headquarters.*—The H.Q. of a Field Ambulance forms the A.D.S. It generally operates under the control of the A.D.M.S. division, but may occasionally be placed under the control of the brigade commander. In the former case, it will usually be possible for the A.D.M.S. to select the site

of the A.D.S. only at the commencement of an engagement, particularly in mobile warfare. It will usually be the task of the Field Ambulance commander to select any subsequent site and report this to the A.D.M.S. and the brigade commander or commanders concerned. When the A.D.S. serves more than one brigade, the A.D.M.S. controls its movements and issues orders to the Field Ambulance commander accordingly giving the approximate area in which to open, and the time for opening. When the unit is under the control of a brigade commander, the Field Ambulance commander normally selects the site of the A.D.S. in conjunction with the brigade staff.

*Advanced Dressing Station.*—The role of the A.D.S. is to receive casualties from one or more brigade fronts, through the C.C.P.s, or directly, and to provide essential treatment in order to render the casualties fit for evacuation as soon as possible. Speed in passing wounded through the A.D.S. is essential. The A.D.S. is the main medical centre in the brigade or divisional area and is formed by the H.Q. of a Field Ambulance. It is equipped to provide only such surgical treatment as is essential to render casualties fit to travel to the casualty clearing station (C.C.S.)<sup>1</sup> where major surgical facilities are available. The A.D.S. is equipped with shelters and tents for the accommodation of casualties. It can accommodate 150 patients. It may be wholly under canvas, but the use of buildings when suitable and available is a great advantage.

An A.D.S. would be located on, or adjacent to, good roads and requires :

- (a) An adequate in- and out-circuit for ambulances.
- (b) Accommodation (preferably in buildings) for casualties divided into reception, treatment, and evacuation zones. (For the purpose of evacuation to a C.C.S., walking patients are classified as "sitting." Certain casualties, initially sitting or walking wounded, become litter patients before they can be evacuated. When possible, separate accommodation should be allotted to litter and sitting patients.)
- (c) Facilities for treatment and documentation.
- (d) Water supply, cookhouse for patients and personnel, latrines, and mortuary (gas protection may have to be provided).
- (e) Pack stores for equipment and arms.
- (f) Reserve of splints, dressings, blankets, and stretchers.
- (g) Accommodation for personnel.
- (h) Natural protection against shelling and bombing. When time permits and particularly in position warfare, an A.D.S. should be able to withstand direct hits from small projectiles, and slit-trench protection should be provided. The location of the A.D.S. and all medical posts must be clearly shown by day and night signs. All road junctions in the neighbourhood in all directions must be adequately signposted. All signposts must be removed on change of location. Specifically detailed N.C.O.s will carry out signposting as a drill. The staff of an established A.D.S. should be divided into teams so that rest periods can be arranged and additional staff are easily available to augment the A.D.S.

<sup>1</sup>Corresponds to the patient-holding element of our clearing company.

when required. The personnel of H.Q. section, when with the A.D.S., should be incorporated in the teams.

Special care must be taken of the personal effects of casualties immediately on admission. This is the duty of the N.C.O. in charge of the pack store, who will collect, list, pack, label, and seal these articles. Particular attention must be given to money, valuables, rings, watches, and any articles of sentimental value. Similar care must be taken of the personal effects of the dead. These effects are specially labelled and sent to the second echelon.

The detailed tasks of the A.D.S. are :

(a) Treatment of the casualty : Wet and soiled clothing is removed and the patients are clad in pyjamas. They are made as comfortable as possible and kept warm and dry. Hot sweet tea and a hot meal are given to all, except when medical reasons prohibit this. All previous treatment is checked and any omissions rectified. Tourniquets if previously applied are removed. If hæmorrhage persists, other methods are adopted for its control, viz. ligation of the artery or the application of pressure forceps, failing which, the tourniquet is reapplied. Sucking chest wounds are closed by temporary means. If a limb is so shattered that it can be severed by a pair of scissors, it is removed to avoid continuance of shock. Pain is controlled by injection of morphine; sedation of exhausted patients is undertaken. Shock is combated by the aforementioned methods and the use of plasma. As a rule it is better to avoid transfusion with whole blood at the A.D.S. If, however, the chances of survival are doubtful without blood transfusion it should be begun and continued as a drip in the ambulance on the journey to the C.C.S. The time and place for a blood transfusion is normally at the C.C.S. prior to an operation. Every casualty to whom morphine has been administered is marked on the forehead with the letter " M " in grease pencil. Similarly the letter " T " is used when a tourniquet is employed.

(b) Documentation of the casualty : An accurate regimental and clinical record of casualties is a definite responsibility of all medical units through which casualties pass. This record consists of the number, rank, name, unit, and diagnosis of the casualty. It is required so that the next-of-kin can be informed of the casualty as soon as possible. General headquarters, personnel, second echelon, are charged with this duty, and to carry it out they depend on the nominal rolls of casualties received from medical units. These rolls are an extract from the admission and discharge book kept by all medical units and are forwarded daily to G.H.Q., second echelon, by every medical unit in the force. A record of the clinical condition and treatment of casualties in their progress through medical units is necessary so that each succeeding medical unit can adopt the optimum treatment. The first place in the line of evacuation where a permanent record of the casualty can be undertaken is the A.D.S. formed by the headquarters of the Field Ambulance. Documentation must not delay treatment or evacuation of the casualty.

(c) Classification of the casualty : The wounded are placed in one of three priorities according to their clinical condition. Priority 1 includes patients

requiring resuscitation and/or urgent operations ; e.g. penetrating abdominal wounds, open chest wounds, compound fractures of the femur, extensive lacerated muscle wounds, and severe shock. Priority 2 includes patients requiring early operation and possibly resuscitation ; e.g. severe and multiple wounds, compound fractures, and head injuries. Priority 3 includes all other wounded. In general these will be sitting patients. Priority 1 and 2 casualties amount to 15 or 20 per cent of the total.

(d) Evacuation of the casualty : Priority 1 and 2 casualties are evacuated to the C.C.S. (or to the advanced surgical centre if formed). Priority 3 casualties are also evacuated to the C.C.S. except those whose injuries are so trivial that they will be fit to return to duty in a few days. They are sent to the divisional F.D.S. Patients with severe illness arriving at the A.D.S. are evacuated to the C.C.S. and patients with minor illness including exhaustion are transferred to the divisional F.D.S. Patients transferred to the divisional F.D.S. are moved by ambulances of the Field Ambulance. All other patients are evacuated by ambulances and troop-carrying vehicles of the motor ambulance company under arrangements made by the Deputy Director of Medical Service, Corps.<sup>1</sup>

#### FIELD DRESSING STATION

An F.D.S. consists of a small administrative headquarters and two equal sections which can operate away from the unit H.Q. but are maintained by the H.Q. The sections may operate together, separately, or be used for leap-frogging. An F.D.S. is designed to hold 100 patients, 40 on beds and the remainder on stretchers. The primary role of the divisional F.D.S. is to maintain the fighting strength of the division within the division by holding all minor sick, injured, and mildly exhausted patients. Normally only patients who are expected to be fit for return to duty in seven days are held. This period may be altered according to the local or general situation. In special circumstances the F.D.S. may be employed in the divisional evacuation plan. The F.D.S. is sited by the A.D.M.S. in consultation with the divisional staff and is normally in the rear divisional area and away from gun positions. The F.D.S. possesses shelters and tents, but should be in buildings if suitable and available. Adequate bathing, reading, and other amenities should be provided whenever possible. Evacuation from the F.D.S. to the C.C.S. is by ambulances of the motor ambulance company, and is the responsibility of the Deputy Director of Medical Service Corps.

Intercommunication between R.M.O.s, sections, and Field Ambulance H.Q. is normally by dispatch rider or returning ambulance. Between A.D.M.S. and medical units it is by dispatch rider, telephone, or radio. Brigade headquarters may also arrange to link up the affiliated Field Ambulance by radio.

#### REGIMENTAL MEDICAL ESTABLISHMENTS

In war, each battalion and similar units have a medical establishment consisting of one medical officer and one to six N.C.O.s, according to the unit.

<sup>1</sup>Corresponds to our Corps Surgeon.

One N.C.O. is provided by the unit as the regimental medical officer's orderly. Regimental personnel are detailed as regimental stretcher bearers and are placed under the orders of the R.M.O. They are distinguished by a stretcher bearer's armband lettered "S.B." worn on the left arm. In addition, personnel of the unit are specially trained in water and sanitary duties. A number of smaller units do not carry a medical officer on their establishment but on active service have personnel trained in water and sanitary duties and first aid. In such cases, a medical officer of a near-by unit is appointed as officer in medical charge, in addition to his other duties.

*Regimental Medical Officer.*—The officer in medical charge of a unit is directly under the control of the administrative medical officer of his formation in professional matters but in other respects he is under the orders of the unit commander. The regimental aid post should normally be in close proximity to the centrally placed unit headquarters to permit access to and from all parts of the unit front. The R.A.P. should afford protection from rifle fire and machine-gun fire and mortar splinters. The exact site must depend on the tactical situation. If possible, the R.A.P. should be accessible to the ambulances of the Field Ambulance. Unit R.A.P.s should not be amalgamated.

In action, the R.M.O. should locate himself at his R.A.P. It is rarely possible and indeed it is inadvisable for him to proceed further forward, since when he is separated from his medical equipment, he can do little more than a trained stretcher bearer; meanwhile, casualties requiring his expert aid would be accumulating in the R.A.P. During the battle an R.M.O. can only carry out the essentials of first aid. This includes the control of hæmorrhage, the immobilization of fractures and gaping flesh wounds by splints, the commencement of prophylactic treatment with sulphonamides or antibiotics, the applications of dressings, and the administration of morphine. Close liaison between the R.M.O. and the Field Ambulance is essential. Although the R.M.O. should inform the supporting section of any change of location of the R.A.P., it is the responsibility of the Field Ambulance commander to maintain touch with the R.A.P. by means of his company and section commanders.

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