CHAPTER 18

LESSONS FROM CAMPAIGNS

THOSE experiences of the medical services in the Middle East from which lessons might be derived have been already described, but it may be of value to refer to these briefly in a consolidated form.

SELECTION OF RECRUITS FOR OVERSEA SERVICE

Several types of recruits for the A.I.F. proved unsatisfactory. These were drawn chiefly from the following classes. (1) The potentially or actually unfit who should have been excluded by adequate examination, (2) those who proved unable to stand sustained strain, physical or more frequently psychological, and (3) the over-age. In addition to these of course the usual attrition of war through illness or injury necessitated further reinforcements. All unfit cannot be excluded by any examination, but a high proportion can be detected, provided that experienced and instructed examiners are used, that they are given adequate accommodation and time for the carrying out of the work including the taking of a history, and that consultant opinion can be obtained concerning special senses and mental make-up.

The disabilities of age either in the too young or too old gave no surprises, but were often not taken into consideration as much as they should. In Libya and Greece the best age period seemed to be over twenty-one and below thirty-five. Colonel Disher A.D.M.S. of the 6th Division found the best officers to be under forty, prefarably much less, and those "who had not been handicapped by experience in the last war". The ability to react quickly and to think forwards and not backwards was a mental gift of high value. Even headquarters in rearward or base areas are not immune from enemy attack, and here too age is often a disadvantage.

ACCOMMODATION

No major problems occurred with accommodation either for well or sick or wounded soldiers, except when it was not in the place where it was most wanted. Dispersal impressed itself as an uncomfortable necessity, associted with certain drawbacks, such as the lowered efficiency of the men, who had longer distances to go everywhere. It made official staff establishments inefficient to some extent when units became very busy, for example the 2/3rd C.C.S. in Greece. On the whole troop accommodation was good; in the desert, cover, except that supplied by niggardly nature and that necessary for air defence could only be provided to a limited extent. Camouflage found some soldiers wanting: it was an example of the need for adaptation to the changing conditions of the natural world. The lure of buildings for medical units was often costly. In Greece buildings attracted air attack, even though the red cross was respected. Even in safe areas buildings were often unsuitable for hospital

purposes, and in addition were frequently very dirty. In fixed locations the comfort of huts built after a suitable pattern and economically arranged was a great help to good work.

WORK OF MEDICAL UNITS

The work of the field medical units was naturally of the highest importance, the first link in the chain. As has been pointed out in previous chapters, fears lest the sub-division of companies of field ambulances should lower efficiency proved groundless. Small sections often carried out important work, and secured that necessary mobility which gave medical service to dispersed or rapidly moving units. The experiences of the 6th Division were summarised by the A.D.M.S. as follows:

Mobile sections were budded off from companies and became as required quite independent units even at times bivouacking separately from the parent company: cf. light sections of light field ambulances which did likewise.

Mobile sections consisted of 1-2 officers and 14-20 O.Rs. or more, as required, with two vehicles plus one or more motor ambulances. These sections proved invaluable and gave good training to the captain in charge, who became very proud of his command.

These sections can act as—

(1) Super R.A.Ps. clearing portion of a wide front,
(2) Advanced A.D.S.,
(3) A.D.S.

or as (4) Staging post between R.A.P. and A.D.S., A.D.S. and M.D.S., M.D.S. and C.C.S. where distances are long.

One mobile section can clear a whole brigade front or battalion front as circumstances demand.

On one occasion a mobile section was even divided into half in a rapid advance, one portion being left stationary forming a relay post on the way back to the parent company which was bogged during the rains.

The advantage of the section is that it is highly mobile and flexible and does not add to congestion of traffic. It can always be supplemented as required even to the full strength of the company if necessary.

In mobile warfare as experienced in Libya and Greece the casualties trickled in, rather than came in a rush, and so the smaller section was able to cope with them adequately. They thus saved unnecessarily opening up larger stations and so becoming less mobile. Further they permitted one to an extra reserve up one's sleeve.

Brigades were at first suspicious of them but later asked for them in preference to companies.

The remainder of the company was capable of forming an A.D.S. in the normal manner, usually becoming a rear A.D.S. if such was needed.

A.D.M.S. 9th Division reported that mobile sections proved to be the answer to the medical problems during their withdrawal in Libya.

A.D.M.S. 7th Division used light sections in the early stages in Syria and later some use of light sections of a light field ambulance was made. The Syrian campaign was in general more orthodox in type.

Some wise aphorisms from the same source are reproduced in the appendix.

Siting of advanced dressing stations or collection posts called for elasticity of mind in some situations; indeed the conventional arrangements were often successfully disregarded in favour of others which fitted local circumstances best. Advanced dressing stations were discarded altogether

with advantage under some conditions. Posts for collection of walking wounded were sometimes of little use, and roving transport proved more useful. Some anxiety was felt about casualties in combatant units with high degrees of dispersal. It must be admitted that some of the problems of the first Western Desert campaign would have been more troublesome had the enemy been more persistent and aggressive. Notable among these problems was that of holding men operated on in a forward main dressing station. The principle adopted by the A.D.M.S. should be noted, for it was bound to be exploited in other campaigns, that of combining and permitting attachments of field ambulances without regard for complete individual identity. The idea of a mobile but self-contained field operating unit naturally came prominently to the minds of the experienced workers in the desert, but the campaigns which followed in the Middle East gave no opportunity for trying how this device would work. The static arrangements of Tobruk, the rapid crystallisations of parts of units and the short distances of Syria, the dynamic sweep of Greece and the set piece of Alamein all presented different patterns. Nevertheless it was evident that when the M.D.S. was used as a holding unit even for brief periods the parent field ambulance was immobilised. The C.C.S. with its mass of equipment could not move with ease or speed except under favourable conditions and with borrowed transport, and its light section, though most valuable for certain tasks, proved at Alamein that it could not well be independent without increases in establishment. The good working of the surgical arrangements was partly due to the resource and skill of the surgeons.

A point sometimes lost sight of was the great value of convalescent depots and rest camps. Colonel Johnston emphasised this both in Greece and Syria. Even in Greece steps were taken early to secure convalescence in simply equipped camps for men who did not need hospital treatment. In Syria the forward units would have appreciated the relief that the 2/13th Field Ambulance gave when it arrived and formed a rest camp had this been possible earlier.

When the Middle East period closed, a definite impression had been left on the administrators' minds that the growing elasticity and versatility of the field ambulances made these units the pivot of medical services in the field. Though casualty clearing stations were useful they did their best work when peacefully stationary, and seemed to possess no advantage that could not be found in small field hospitals. There was, however, no opportunity to try these. General hospitals on numbers of occasions moved and opened or closed with remarkable speed, but even the spur of necessity could not overcome the immobility of an extensive and weighty equipment. The psychological effect of an apparently fixed unit has been somewhat ignored. Its members acquire something of the policy of the unit itself, as is evidenced by the amount of the professional and personal belongings which they accumulate and take with them. On occasion medical officers and nurses lost equipment which should have been drastically reduced at the outset.

TRANSPORT

In the actions of the Middle East the most troublesome problem was that of transport. Australia, with small resources in this respect, in the years 1940-1942 was dependent on others for motor vehicles, and the enhanced needs of the peculiar types of country over which battles were fought made shortages even more striking. It will be remembered that one field ambulance was virtually immobilised in the first Western Desert campaign for lack of vehicles. This question of transport affected the whole medical problem of action, not merely in the matter of evacuation of the sick and wounded to rearward units, but in their conveyance to a forward surgical post. We must hasten to admit that the stretcher bearer was as necessary as ever. In the desert the work of bearers was sometimes as hazardous as it has ever been, and in parts of Greece and Syria the fortitude of both bearers and patients was fully tested. The need for medical orderlies in ambulance cars was sometimes felt. When journeys are perforce long by time, even if not by distance, there are occasions when orderlies with some medical training could render useful aid to patients *en route*. Staging posts sited suitably for inspection and, if necessary, resuscitation, provided a partial answer. A transfusion begun at an aid post can be continued in transit if facilities exist, and may save life.

Early in the Libyan actions it was evident that conditions of evacuation introduced other factors in treatment. As has been pointed out, adequate immobilisation of fractures was a necessity if wounded men were to reach the next stage in reasonable condition. Air evacuation was only occasionally possible in the Middle East, for aircraft could not be spared at that time, but the advantages were obvious and outstanding. The great assistance of light aid detachments in the maintenance of vehicles used for medical evacuation deserves notice, an unseen but important factor in a successful system. The wear and tear of long hard travelling increased the need for more vehicles; indeed the medical services were forced like other services to think in terms of wheels.

Ambulance cars were derived from army sources, and from the British and Australian Red Cross Societies; both American and British vehicles were used, and in future plannings for defence from the medical point of view supplies of motor vehicles must be an important item. Ventilation was difficult to secure in ambulance cars. Some, like the British type, were closed in by doors at the rear, and even with rotary ventilators in the roof were close and stuffy. On the other hand vehicles closed by some type of curtain were extremely dusty. The comfort of the ambulances varied considerably; springing designed with regard to the roads to be traversed helped patients to arrive in better condition. In some vehicles racks for stretchers were fragile and fitted poorly: the importance of standard fittings, made accurately and robustly is obvious. Some arrangement whereby a man may be carried propped up was found desirable in certain cases, and facilities for continuing intravenous therapy or duodenal suction drainage were also needed at times. Passive air defence sometimes

demanded that rear windows on cars should be covered to avoid reflections: the same applied to windscreens also; their removal facilitated night driving in difficult country.

EQUIPMENT

Though it cannot be denied that difficulties were encountered with equipment in the Middle East there can be no doubt of the value and magnitude of the Australian effort in providing medical equipment, and supplies, including drugs. Many items were produced for the first time in Australia, and in great quantity, sometimes sufficient to allow export of surplus to other countries. Yet it would be idle to assume that there were not defects and deficiencies, especially in the early years. Those in Australia, no doubt with justice, felt that the A.I.F. was impatient and that the unavoidable delays were not always appreciated. Even after goods were procured they had to be paid for, a process which was often irritatingly slow in passing through its various official stages, and shipping space had to be found before the goods could begin their final or even semi-final journeys. On the other hand, the A.I.F. could envisage the possibilities of losses, and realised clearly that shortages did exist and that the position could become precarious without reserves. Australian independence too was aroused by the need for further imposition of burdens on the little parent country with a dangerous enemy across the narrow Channel. Several lessons may be derived from these experiences. Personal contacts of people actually working in this technical field can alone resolve difficulties and misunderstandings. The necessity for rigid economy was clearly seen in the Middle East, and this was all the more difficult when a truly high standard of technical performance was demanded and maintained. Lastly, the practical problem of packing needed closer study. Here again personal conduction of valuable material was found desirable and all the details arising from the transport overseas of precious and often fragile equipment called for a firm and standardised practice. It was important to realise that medical equipment was bound to become more extensive to meet modern requirements.

It is only right to comment that the capacity to extemporise was well in evidence in the Middle East campaigns. Perhaps the hygiene service should be given special praise for their work in this regard, and their efforts to bring home to each soldier his personal responsibility. The collective hygienic conscience of a unit is after all only the sum of each individual conscience, kept active by teaching and discipline.

Communications

Faulty communications made medical work difficult in most campaigns. The solution of this problem is no doubt in part a technical problem, but all administrations in the field emphasised the necessity for personal contact between a person with some authority and knowledge of the situation and the units doing the actual work. The A.Ds.M.S. of every division of the A.I.F. found that personal liaison with their field units far surpassed

in value the writing of operational orders. One caution emerged from the desert fighting; an ambulance commander had to keep in close touch with the medical personnel depending on him, but it was also necessary that his whereabouts should be known and that some responsible person should always be obtainable at his headquarters in case of movement or other important event.

The value of a liaison medical officer in joint campaigns was well illustrated in Greece, where this officer certainly was much better informed concerning the medical situation, and in some respects the general situation too, than those whose duties tied them to a general headquarters.

NURSING SERVICES

Unfortunately nurses were often compelled to remain idle during time of stress because the military situation did not permit them to work in forward areas. Different opinions were expressed on this question, for example in Tobruk and in Greece. Only those on the spot can give the correct answer, but among them there was not always unanimity. There can be no doubt whatever of the immense value of the work of nurses, and without detracting from the splendid work done by medical orderlies in many places they cannot be expected to replace fully highly trained and experienced women, who bring their own special personal touch to their technical performance. After the Grecian campaign it was apparent that it would have been wise to withhold nurses from Greece till the stability of the position was more assured. It was evident too that had the question of returning nurses to a base area been decided earlier much anxiety would have been saved, and their movement would have been simple and much less perilous. This leads to the need for training of orderlies, which was taken very seriously in 1941 in the Middle East. A high priority should be given to this work, and all concerned, surgeons, physicians and sisters, should be impressed with the duty which rests with them of helping to train these men to assume responsibility as well as carry out routine work. Moreover, though some time must be taken to fit orderlies approximately at least, into the military picture, this should not lessen the time spent in technical training.

TECHNICAL FEATURES OF MEDICAL WORK

New techniques and their modification or extension usually call for some administrative changes. For example, facio-maxillary and plastic surgery, orthopaedics, and other specialties often need either special departments, or special facilities and accommodation for their work. This is reflected in the establishments of hospitals, which may need some additions, as nurses and orderlies are diverted from general to special work. Dermatological wards, for example, were most efficiently run when nurses with special experience supervised and carried out the often frequent and exacting treatment. This in turn brought problems of rostering the nursing staff as a whole, for night duty in particular. These are domestic problems, but they arise, and can only be solved by placing all-

round efficiency first without allowing standards to suffer, or enthusiastic specialists to escape their proper share of economy and improvisation.

In the same way a nice balance has to be preserved between the sending of patients to special departments perhaps housed in some distant hospital, and their retention in other hospitals whose staff feel capable of rendering similar service. In this regard it was not always found possible to to carry out the letter of administrative instructions, but compromise was always possible. It must be remembered too, that changes in the military strategic position may negate the value of medical plans and thus subject them to unwarranted criticism. There were several instances of this during the Middle East period.

The advisers in special subjects appointed by the D.M.S. were perhaps not so fully functional as they might have been because of the general shortage of medical officers, which forced them to combine their unit duties with those of advisers. They were therefore of greater value to the D.M.S. in the framing of policy than they were to individual units and medical officers. However, the need could be seen for consultants who could move about amongst the medical officers and give instruction by the most useful method, that of showing how the problems of the moment could be solved. The value of the A.I.F. consultants in medicine and surgery to the medical services and to the force needs no further emphasis. The value of having a psychiatrist was seen in the late stages of the El Alamein battle. It might have been valuable had a study of self-inflicted wounds been made throughout the 1940-1942 period; this and other psychological problems of the army demand first hand research by those with special knowledge.

A growing recognition of the necessity for medical technical advice was discernible through the Middle East experience. Even in 1942 there was still evident some of the obsolescent tendency of some combatant officers to brush away medical scientific advice, probably because it is about the only technical subject on which most people have personal views. But this resistance was yielding to the pressure of experience: for example, the official attitude to malaria prevention was different during the later stages of the Syrian adventure than in the earlier weeks of the campaign. It was clear too that advice based on medical grounds was of value in proportion as it bore on the military situation.

Finally one general observation may be made concerning one aspect of morale. Medical units are in no way different from others in the sensitiveness of their staffs to their psychological environment. They may be disturbed because of idleness, or overwork, or insufficient staff, or shortage of supplies and may even think that they are the victims of neglect. These feelings are usually dissipated by personal contact with an A.D.M.S. or higher official, but there can be no question that the most valuable method of sustaining morale assailed in these ways is for responsible officers to be taken into the confidence of their leaders. Units or formations and even headquarters sometimes persistently complained when their grievances would have been quickly stilled had they known

the reasons for them. This casts no reflection on the excellent liaison maintained between England, Australia and the Middle East, and between the various medical headquarters and the elements of their commands. Nor should it be implied that medical units were lacking in that finer spirit that surmounts reverses, their history disposes of that. Yet it is better to walk in light than in darkness if the cause of safety permits.

APPENDIX

Australian Military Forces
Director of Medical Services A.I.F.
Administrative Instruction No. 5

D O N'T S

1. DON'T suture wounds except to stop haemorrhage—all break down.
2. DON'T remove edges of wounds.
3. DON'T unnecessarily cut tunics, e.g. to give morphia—there are other places to give it than the upper arm.
4. DON'T remove boots from cases of fracture of the lower limbs. They are better for traction than skin. Pins of Thomas splints require boots.
5. DON'T tear up paybooks if they have been removed from kits of evacuated casualties.
6. DON'T forget to remove ammunition and loaded revolvers from casualties. Search pockets for hand grenades.
7. DON'T use loaded rifles as splints.
8. DON'T redress cases unless they are bleeding—leave well alone.
9. DON'T forget that motor ambulances if attached from field ambulances to you are not yours, but are only under your orders as regards to move to places of safety and for evacuation of casualties from R.A.P. to field ambulance.
10. DON'T take NO from your unit as an answer to requests for water for the R.A.P. Your unit is entitled for an extra supply for the purpose. See that you get it.
11. DON'T hoard stretchers, the field ambulances are very short of them and there is barely sufficient reserve.
12. DON'T forget to use plenty of directing signs.
13. DON'T allow spectators. Kick them out.
14. DON'T leave all supplies in R.A.P. truck. Divide and place some in slit trenches. Also spread supplies over several or all field ambulance vehicles—not all eggs in one basket.
15. DON'T forget to help the man in front.
16. C.Os. must not be away too long from M.D.S. Notify itinerary. 2 i/c must know whereabouts and conditions. If you state you will be back by a certain time make every effort to be punctual.
17. DON'T talk about what you have not got. See what you can do with the things you have got.

The above DON'TS are promulgated for guidance as a result of practical experience in Sidi Barrani and Bardia battles, as well as experience gained in previous wars.

These rules were issued by A.D.M.S. 6 Aust. Div., on Jan 13 1941, and are forwarded for instruction of all M.Os.

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