Role of the Squadron Medical Officer
An Appraisal by the Air Staff

By Air Vice Marshal S Jena, AVSM, VM*

THE role of the Medical Officer in the aviation environment, and particularly, what is expected of the Squadron Medical Officer has already been highlighted. I would like to cover, from the Air Staff point of view, what we feel is lacking today in the functioning of the Squadron Medical Officer, and make some suggestions for your consideration.

Aircrew to-day are required to fly their machines from almost ground level to heights of 15 km or more, at speeds almost twice the speed of sound, and over terrain varying from stark featureless desert areas to jungle covered mountains and valleys. For many of them, flying the aircraft is only part of the job. In Military Aviation, what counts is weapon delivery; the aircraft is only the platform that carries the weapon. During this process the aircrew are subjected to stresses which call for a great deal of physical and psychological adjustments. When aircrew get airborne they carry with them their physical and mental well being or otherwise.

The Medical Officer by basic training has acquired a level of skill in treating ailments that are essentially manifest. In the flying unit he is dealing with people who are basically fit. His task is to recognize any departure from the normal standard required for execution of the task by the crew, and then to take remedial action. Some of these aberrations are all too apparent but others cannot be easily recognised without co-operation from the concerned individuals.

To my mind the three essentials for the Squadron Medical Officer are :–

—Know the machine and the role of the Squadron. This will give him an insight into the aero-medical problems that the aircrew have to contend with.

—Have a deep knowledge of human psychology and relate his experience or learning to the particular group of people he is to look after so that his analysis and therapeutics are on the right lines.

—Establish himself as a confessional father figure.

Acquiring knowledge about the aircraft and its role is a fairly easy proposition and I need not dwell on it. I feel there is a need to increase the scope and coverage of human psychology in the various courses that are run at the IAM for the AF Medical Officers. Only then will we be equipping our Medical Officers with the tools so essential for their task.

Coming to the third aspect, what we want is much greater rapport between the aircrew and the M.O. And this is a task which falls fairly and squarely on the shoulders of the doctor. It is his initiative and interest that will make it possible for him to achieve a degree of rapport whereby aircrew will come to him to discuss their problems. From the administration side, we have to ensure that the MO stays on with the squadron for a length of time. The average tenure of the Squadron MO is probably 2 years in the Unit. This is not long enough. There is no continuity. Every time there is a change, the MO has to get to know new people, new aircraft, new environment. We must allow him to establish himself as a permanent figure in the Squadron to the maximum extent possible. Secondly, if we are not particularly short of doctors in the Air Force, can we not arrange for the Squadron MO to look after the health of all Squadron personnel and their families? This way he will know of medical problems in the family which may have an effect on the aircrew. Today, a large number of accidents occur because of human failure

* Assistant Chief of Air Staff (FS & T) Air HQ, New Delhi - 110 011.

on the part of our technicians. All of them are not due to negligence. They sometimes have worries regarding the health of their families and this is a distraction which may lead to their skipping an important step in assembling a sub-unit or while checking the function of a particular component. If the technician knew that his squadron MO is looking after his family, it will certainly make for some reduction in tension. Continued sickness in the family of aircrew will certainly affect their performance in the air; they carry their worries with them. The MO, knowing that a particular officer has these problems can certainly counsel him and his Squadron Commander, and if need be, arrange for a spell of leave which the officer, especially if he is in a position of responsibility, feels will be unfair to the unit if he were to take it at that time.

The main reason for lack of communication between the MO and the aircrew to-day is that there is a lurking fear in their minds that the doctor may discover in them some abnormality which may lead to being kept off flying. Such an apprehension may not be wholly justified, but adverse attitudes are rarely based on full facts and some reasoning. It is the duty of the MO to instill confidence in the aircrew about his sincerity of purpose and that whatever he eventually does is for the good of the individual. It is a known fact that lot of aircrew to-day go in for self medication or consult non-specialists who prescribe drugs which are dangerous for flying. This will stop only when aircrew have the assurance that they are obtaining the highest level of professional care from their Medical Officers. I would add to professional care, special care. There is a need for us to-day to go out to give special care to the aircrew. Please remember that in air operations, they are the people who deliver the goods, they are the ones who fight the battles or keep our forward posts supplied. This special care must be given a tangible form in the manner in which their illness or other problems are followed up and all efforts made to put things right. If they are treated like run-of-the mill patients then you are asking for a communication gap.

In our fighter squadrons, we have a lot of young pilots, as bachelors, living in the Mess. Such community living has its advantages, but it also deprives them of some of the pleasures of a home life. In certain individuals it creates emotional conflicts which show up as a tendency to become insular or go to the other extreme. I would like to see the Squadron MO visit the boys in the Mess and their rooms, talk to them and generally establish the level of a confidant. Not all of what he hears must reach the ears of the Squadron Commander, it is not necessary. But these sessions will give him an insight into the character and up-bringing of the young man, an insight into the pulls and pressures which are part of his life. We are now paving the way towards a relationship of mutual confidence which will be long lasting.

Today, the functioning of the Squadron Medical Officer is rather impersonal. We have to get away from this by positive action so that he becomes an effective member of a fighting unit, who lives with the men and for them, who looks after them and their families in their hour of need, who shares their joys and aspirations, who commands respect and confidence.