PARA MEDICAL AID

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Introduction:

The employment of airborne troops as a specialised striking force in war is comparitively new in modern warfare. Exploits of these forces at Crete, Arnhem, Sicily and the Rhine have added glorious chapters to the history of World War II. Medical units were formed, whose duty it was to accompany these forces into battles, thus maintaining the military medical principle that medical aid would be taken to the fighting soldier where ever he may be. This aid took the form of Parachute Field Ambulance, Surgical Teams and Field Hygiene Sections. It is befitting the high ideals of military medicine that the first volunteer and subsequently the first Indian parachutist was a doctor. Shortly after World War II, the Royal Air Force introduced a Parachute Medical Team for air land rescue work. In 1951, the first Parachute Medical Team was formed in the Indian Air Force.

Role of Para Medical Team:

The primary role is to render medical aid to the victims of aircraft crashes in inaccessible areas. These areas may be in the jungle, lower hill tracts of the Himalayas and North East Frontier in Assam, in the snow of Himalayas and desert of Rajputana. Its secondary role is to assist the civil authorities in natural calamities, like floods and earthquakes, where communications may be disrupted.

Organisation:

Personnel:—Each team consists of one medical officer and four medical assistants.

Equipment:—This comprises the equipment necessary for a parachutist, viz. a parachuting helmet to protect the head when landing, boots and puttees to stengthen the ankle joint, and a jumping smock which covers the webbing equipment worn over the uniform, thus allowing the parachute harness to fit smoothly over the body surface.

A scale of medical equipment has been authorised which allows the teams to be self sufficient for a few days. This includes drugs, dressings, instruments, blood transfusion equipment and splints. Nursing utensils and a Horrocks box for water analysis are also carried.

Other equipment: This includes towels, blankets, medical haver sacks, mess tins, airborne folding stretchers, primus stoves, kit bags for parachuting valises for stretchers and a quantity of tea, milk and sugar.

Packing and Carriage of Equipment:

Breakable items like syringes are wrapped in cotton wool and packed in mess

tins. Tablets and pills are kept in ashwood containers. The haversack itself is either strengthened by incorporating a panel of wood along the face of the haversacks or by bending a Cramer wire into the form of the letter 'U' and fixing it along the sides of the haversack. Compressed bandages, gauge and shell dressings surround the fully packed tins thus simulating a percussion head. Haversacks are placed in special airborne kitbags fitted with quick release pins. The kitbag is carried by the parachutist strapped to his right leg. On leaving the aircraft the kitbag is released from the leg and remains suspended to the waist band of the parachute harness by a 20 ft length of rope. The folding stretchers are wrapped in blankets and fitted into a special valise which is also carried and released in the same way.

Selection of Personnel:

All members of the teams are volunteers. This is in accordance with the war time principle that duties of a hazardous nature are best performed by individuals unfettered by the shackles of compulsion. A careful assessment of the physical and psychological fitness of the volunteer is made. Physically the individual must conform to the normal standards of fitness required of an airman but particular attention is paid to a sound lower limb medical history and also that the volunteer is within the prescribed height of 62" to 72" and weight of not more than 182 lbs.

Training:

This is done in two stages. During ground training, which lasts a week, the volunteer is taught the basic principles of handling a parachute, making exits, and the all important technique of landing. Most of this training is on synthetic apparatus which simulates actual parachuting. This training is followed by seven descents from a Dakota aircraft, one of the descents being made at night. In addition to para-training, medical officers are given practical training in surgery and also attend blood transfusion and resuscitation courses. Medical Assistants are given training in surgical nursing and also in the duties of resuscitation. Short courses in map reading, tent pitching and practical experience in survival are also arranged.

Operational Organisation:

Since para-medical aid is an emergency aid and brooks of no delay the main responsibilities of the Station where the team is located would be to maintain Dakotas fitted for parachuting, trained crews, trained drifters and despatchers and sufficient number of packed 'X' type parachutes. Units should also hold sufficient stocks of clothing, Ordnance and Supply stores for replenishment of the teams by airdrop. Another detail which is a vitally important one, is the provision of wireless communication between the team and the outside world. It would be an heroic adventure for the team to be 'cut off', but poor consolation to the injured if one could not replenish the stocks of medicines and food. During one of the operations, radio communications assisted us in bringing the pilot of the aircraft over our location when bad weather reduced air to ground visibility. Apart from purely materialistic considerations the appearance of an

aircraft, the pleasant anticipation of replenishing one's stock of food and medicines and the cheerful voices of the crew over the wireless boost a flagging morale.

For evacuation of the patient, air provides the only answer. It is sometimes possible to find a suitable piece of ground for constructing an airstrip at the site of the drop, as occurred in the first operation, or to walk till one is found, as was experienced during the second. The first operational drop by our team was carried out at Sagallie in Assam to render medical aid to the victims of a crashed Dakota and the second at Kodak in the Abor Hills of Assam to treat an officer of Field Survey Company who had been wounded by a tribal arrow. I shall narrate some of the experiences of the latter team to which I belonged.

Para Medical Operation :

In December 1952, a survey party comprising an Engineer officer of the Survey of India, with an escort party of the Assam Rifles together with an all important interpreter left the HQ of the Subansiri Area, North East Frontier Agency, with the task of surveying territory west of the Subansiri river. The early part of their trek was uneventful. Towards the end of December the party entered unadministered territory. To win the confidence of the tribals in these areas, the party took with them gifts of cloth and salt, the latter commodity is in very short supply in the area. Currency is of no use as barter system prevails in these areas. Towards the end of December, they reached the outskirts of a village, and with it opposition to their further progress. Gifts of salt and cloth were returned, not with proverbial thanks, but with the threat that any attempt to proceed further would be resisted with all the primitive means at their disposal, which included arrows tipped with metal, poisoned bamboo arrows and also by blocking the jungle tracks with poisonous staves. The officer offered to meet them unarmed. This was agreed to, and accompanied by the interpreter, he made a detour through the jungle to avoid the obstacles in the normal track, and on meeting them, succeeded in convincing the hostile tribals of the party's honourable intentions. They were then allowed to proceed, and the remainder of their journey was uneventful till, on the return journey in the middle of March, 1953, the officer was shot in the back with an arrow.

The motive behind this unprovoked attack was never discovered. This set a problem which seemed to defy solution. The party was at least 14 days' march from any form of medical aid, a seemingly hopeless situation. Fortunately before the grossly infected arrow had taken its toll of the officer's physical and mental strength, he gave orders to stage camp and to establish communication with HQ Assam Rifles and with the Political Officer of the Subansiri Area.

The Political Officer Subansiri Area asked the civilian doctor at one of his outposts to proceed to the area. The doctor contacted us on our return journey 17 days after he had started from his outpost. The Political Officer also asked his medical officer to wireless the suggested treatment to the party. As morse and Hippocratic codes

are not synonymous, it is natural that little treatment could be done. but it is creditable that the party spared no pains to make their officer comfortable and to give him moral support and comfort.

Four days after the incident, information trickled down to Barrackpore and my Para Medical Team was asked to stand-by. We were told that a Dakota was being flown from Agra with equipments and was due to land at 1900 hours the same night. It was not possible to take off that night. Our team which had been positioned at Barrackpore shortly before had not received all its medical and other equipment. A quick appreciation of the situation made it apparent that the priority of the moment was to get to the patient and treat him.

After bricfing at the air base in Assam the eventual decision as to whether we could drop was left to me as O. C. Team. We were told that we were inadequately clad and would require blankets. The air detachment was unable to provide us any.

On the first sortie heavy mist and clouds were encountered over the hills and so we turned back. Another attempt later that day also proved abortive. Next day we had perfect weather. We flew up the Subansiri river till we reached the spot where the party had camped. A cloud hovered motionless between 300 and 400 feet above the party's camp. The aircraft circled for nearly an hour, but the cloud refused to disperse. While we flew around, the survey party kept up a ceaseless conversation with the aircraft requesting immediate drop of the team. It was stated that the patient was desperately ill and had lost the will to live. It was obvious that the attendants were reaching the end of their tether too, and had little hope that the patient would survive. As it was impossible to drop, we decided to return. We had flown back a few miles when we were recalled, only to find that the cloud as immobile as ever and if anything a little more dense. It was pathetic to hear the repeated appeals from the survey party. A further attempt, the fourth, was made at 1200 hrs and this time we found the area clear. Seen from the air the camp was on the slope of a hill in a small clearing amidst dense jungle. The area appeared about the size of a sport field, but we could not appreciate the nature of the ground surface.

We first ejected a container load of supplies fitted to a parachute. As this appeared to be drifting close enough to the clearing we decided to drop. Having 'hooked up' and received an encouraging 'thumbs up' from the Captain of the aircraft the drifter jumped. As the pilot had to bank steeply after his run to avoid another hill, we could not see him land. One of the crew thought he saw him fall on to the clearing and this cheered me as I was next. When my chute developed and my kit bag had been released, I found myself hovering over the jungle. Pulling the lift webs in an attempt to avoid the jungle was of on avail. I finally crashed throught a thick bamboo jungle and to my horror found darkness all around me. A sturdy Assam Rifleman soon reached me by hacking his way through the jungle, and grasping his friendly hand I was steered through the darkness on to the clearing. This

was an uneven slope littered with tree stumps, ditches and boulders, an unsavoury dropping zone. The three medical assistants had landed on this clearing and miraculously escaped. The drifter had also gone into the jungle and he too was unscathed. Providence had smiled kindly on the team. Strangely enough we saw no tribals. We learnt that on seeing us descend they were convinced that we were gods and so they beat a hasty retreat lest retribution be meted out for their misdeeds.

The patient was found lying in an improvised bamboo hut and though relieved to see us after waiting anxiously for 8 days, looked very ill. The arrow had hit him between the 8th and 9th ribs posteriorly, pierced the lung and caused a haemo-pneumothorax. In addition a vicious cellulitis had set in. He was unable to move and complained of intolerable pain. Our thermometer had broken on the drop, but he was obviously running a fever. His pulse varied between 120 - 140 per minute. Owing to the extensive cellulitis it was difficult to make an accurate clinical assessment of the lung injury, but it was apparent that the urgent need was to relieve his pain, fight the infection and restore his general condition with sound nursing and food. The patient was uncooperative at first and it required a combination of patience, persuasion and firmness before he agreed even to drink milk. The medical assistants were wonderful and worked around the clock to make him well. The area in which we worked was teeming with flies and insects of a variety that would gladden any entomologist's heart. Rain also conspired to make an already bad position worse.

The survey party had a wireless set and at fixed hours messages were exchanged with the Base HQ. Bulletins on the patient's health were sent and demands for food and medicine placed as and when required. Improvised bamboo huts covered with leaves provided shelter, hill streams water, rations and urgent demands of drugs and dressings were met when the weather permitted.

The patient's condition waxed and waned for days and at times we thought our efforts were in vain. He was too ill to be moved and there was no area nearby suitable for improvising an airstrip for light aircraft. The alternative was to walk till we found one. Before I describe the trek it would be appropriate to refer to our tribal friends and their strange ways. They reappeared the morning after the drop apparently convinced of their own innocence. Their first appearance frightened us, but later we were amused. Clad only in a hat, with a bow and arrow slung from their shoulders, they looked like creatures from some other world. They smoked a bamboo pipe with some foul smelling tobacco and when they parted their lips to grimace or smile I could never tell which, they showed a set of dirty teeth with pyorrhoeic gums. Some were covered from head to foot with a fungus skin infection. Either through a form of modesty or for reasons never discovered the penis was brought up against the abdominal wall and covered with a bamboo, which remained in situ by a string tied around the waist. All else was exposed to the elements.

They descended on us in hordes. After the arrow incident I thought it diplomatic to smile at them all the time. It met with their approval and we developed this human

emotion as a safeguard against further incidents. They interfered with everything they saw and created the most terrific din when they talked. I had asked the interpreter to request their silence, particularly in the vicinity of the patient, but they paid little heed. Having failed to get their co-operation by request, it was incumbant to use other methods.

One very effective method was to clap the carphones of the wireless set on their ears. We had learned a few tribal words like 'aldo' meaning good and 'alma' meaning bad. By transmitting 'alma, alma, alma' we achieved the desired result. This was because they looked on the set, 'linching' as they called it, as a god, and having aroused his displeasure, they were quick to act to regain his patronage. This was conferred by transmitting 'aldo, aldo, aldo', the reception of which brought them instant relief.

Evacuation.

The para drop had tried our nerves, living amongst the tribals with the possibility of further attack was even worse, but by far the most trying experience was the trek out. The interpreter had arranged through Gaon Burras, the village headman, to supply us with porters to carry our equipment and food. They were prepared to accept a handful of salt for the day's march. Those carrying the patient demanded a blanket each.

The interpreter managed to achieve some order after hours of cajoling and we left our temporary home 10 days after we had dropped. The patient was carried on a cloth stretcher, as airborne stretcher was too broad for the narrow jungle tracks. We trekked continuously till the evening and when in sight of our first proposed camp, the tribals for some unaccountable reason, discarded their loads and disappeared swiftly and silently into the jungle. Only those carryiug the patient and 20 other stalwarts carried on. We now had the problem of retrieving these loads and this meant further arrangements with the people of the next village. They fortunately obliged and by midnight all loads were in. When superficially checked they appeared intact, but when a few were opened it was discovered that many items had been stolen.

The trek was through hills covered with dense jungle. So thick that even the sky was not visible. Over narrow tracks covered with moss; tracks which sometimes disappeared completely and were replaced by slippery rocks, to negotiate them required the agility of a mountain goat. Leeches were in abundance and even penetrated the eyelets of our boots. It was providential that we saw no wild animals as our tired limbs and flagging morale could have offered neither fight nor flight for self preservation. The patient travelled reasonably well, though he required constant encouragement, apart from nursing, to maintain his will to carry on. After fourteen days trek we reached an area where a landing strip for light aircraft could be built. By this time our porterage problems had considerably improved as the local inhabitants were more disciplined and co-operative.

The patient had regained his strength by now. He was an afebrile, free from pain and his morale had considerably improved. The air strip was constructed by our party with the help of local tribals. The patient and the Para Medical Team were evacuated, 29 days after we had been dropped. Patient was admitted for further treatment in a military hospital from where he was discharged after a few days having fully recovered.

Conclusion:

The development, role, organisation and equipment of a Parachute Medical Team has been discused.

Para medical operation in the forbidding hills and jungles of Assam is narrated. A life was saved and the Para Medical Team of the Indian Air Force proved its usefulness for the second time.

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