moved immediately, but there is no way to move him. You decide on utterly sound logic that he needs to be flown out, but the helicopters are not flying. You may decide that the patient needs only to get to the battalion aid station, but a helicopter picks him up along with a man more seriously wounded, and drops both of them at a hospital far in the rear. But your decisions have not been wasted; you have used them in planning the evacuation process.

If you are a medical platoon aidman, you should always know where the aid post of the senior company aidman is; and whether you are a platoon aidman or company aidman you should know where the nearest aid station is—your own battalion aid station, or the station of a battalion you are working with. You can take care of some "evacuation problems" by directing walking wounded to these points.

You will have helicopter ambulance support available on call, but more likely you will depend on litter bearer teams and surface ambulance support in contact, or both. The people back at the battalion aid station are responsible for designating and arranging surface evacuation support. The evacuation teams are supposed to maintain contact with you, but that does not mean you ought to sit back and let them wander around looking for you. Before an operation, get back to the aid station if you can and tell them what is going to happen, and how you think it is going to work. When you move, pass the word to them on where you are going. Every time they come up



to pick up one of your patients, fill them in on what is happening, and what you figure will happen next.

When you need a helicopter, get the word to the commander or his radio man. Your commander needs to know four things from you in order to place the request:

- How many patients are to be moved?
- How many can be moved sitting and how many require litters?
- What type of wounds do the patients have?
- Are they urgent? Priority? Routine?

Learn how to use the radio. You should be able to place an evacuation request yourself. If you are placing the request, you need to know several more things which the radio man normally knows already, and which you should know also:

- Where are you (coordinates to six digits, plus the two letter designation of grid zone)?
- Who are you (radio call sign and frequency on which you can be contacted)? Remember, the radio frequency where the patients are and *not* a relay radio.

*Note.* The encoded location, call sign, and encoded radio frequency should always be transmitted first. This information enables the Army air ambulance to begin the mission and precludes unnecessary delay, should the other information not be immediately available, both in helicopter reaction time and in cases of communication breakdown.

- What is the category of patient precedence?

(1) *Urgent:* Emergency cases which must be evacuated immediately to save life or limb. This precedence will be used when it is anticipated that the patient's condition is such that evacuation



is required within 2 hours. Psychiatric cases are not considered in this category.

(2) *Priority:* Patients requiring prompt medical care should be considered as priority patients. Use this precedence only when it is anticipated that the patient must be evacuated within 4 hours or his medical condition will deteriorate to the degree that he will become an urgent case. Psychiatric patients are not considered in this category.

(3) *Routine:* Patients who require evacuation but whose condition is not expected to deteriorate significantly during the first several hours or longer can wait for routine pickup (about 12 hours). Psychiatric cases are considered in this category.

- How many patients do you have and type (litter or ambulatory)?
- What is the security of the pickup site? (Significant information on enemy location and/or weaponry, if available, should be noted here.) Also, air ambulance should be used only when the landing area is reasonably secure from hostile fire. This may be defined in practical terms as being sufficiently secure so that members of the unit requesting patient pickup can stand up in the landing area, guide the approach of the air ambulance, and load patients. The air ambulance unit *must be notified* if this degree of security does not exist so they can take action as they deem necessary.
- What type injury, wound, or illness? (For example—penetrating gunshot wound (GSW) of abdomen, first and second degree burns over 30



percent of body, sucking chest wound—left side, or traumatic amputation of left leg.)
- How will the pickup site be marked? The site can be marked by using smoke grenades, flares, flashlights, or panels. Make sure the panels are fastened securely to the ground so they will not fly up into the rotor blades. The minimum site requirement for a single utility helicopter is generally an area 100 feet in diameter and clear of obstruction.
- Will the DustOff need emergency medical supplies or special equipment (for example, hoist, respirator, penetrator, or semirigid litter)?
- What is the weather at the pickup site? Cloudy, windy, rainy, or sunny and clear?
- What is the nationality of the patient? US military, civilian, or third country national?
- Whatever else that DustOff needs to know.

And, of course, you need to know the radio frequency to use to call for a medical helicopter. If you don't know, then just call in on the the frequency you are on and ask someone to relay for you.

Remember, every time you use the radio, there's a good chance the enemy is listening in. So, make your messages brief and to the point. Don't hang on the radio and shoot the breeze. The more you talk, the more the enemy can learn about you and the unit you're with, and the better his chances will be of fixing your position by direction-finding.

A typical call for helicopter evacuation might go like this:

YOU: DANGER DUSTOFF, this is UGLY REVIEW, over.

THEM: UGLY REVIEW, this is DANGER DUSTOFF Control, over.

YOU: DANGER DUSTOFF, I have urgent Medevac request, over. (Use code word when appropriate.)

THEM: UGLY REVIEW, Roger, over.

YOU: DANGER DUSTOFF, coordinates YANKEE DELTA FOUR EIGHT FIVE ONE THREE SIX. Call sign UGLY REVIEW TANGO. Frequency THREE FIVE POINT FIVE. (Use code word when appropriate.) I have two urgent and one priority, all litter with multiple frag wounds. All US. Area will be marked with smoke. Area is secure. Weather clear. No special equipment required. Over.

THEM: UGLY REVIEW, this is DANGER DUSTOFF. Roger, ETA 10 to 15 minutes. Over.

YOU: DANGER DUSTOFF, this is UGLY REVIEW. Roger, out.

Let's look at that patient-precedence business again. It's important that you get it right. A patient is *urgent* when it appears to you that he may not live unless he immediately gets some sort of medical treatment which is beyond your capability. A good example is a man with a wound of the chest or belly. It may turn out that the bullet or fragment did not punch a hole in anything important, but you do not know that. You do know that he needs a surgeon, and an operating room, and he needs them fast. "Urgent" to the medevac crew



means that they have to take some risk, if necessary, and put off some other mission, if necessary, in order to pick up your patient within 2 hours.

A patient is *priority* when you know that he needs definitive medical care, but you do not think there is any real danger of his dying if he has to wait a while to get it. A simple wound or fracture of the arm or leg should be classified as priority, not urgent, and so is even a mangled foot from a mine explosion if you have been able to control the bleeding. "Priority" to the medevac crew means that they have to pick up the patient within 4 hours, but this does not mean they are going to fool around for 4 hours before deciding to come and get your patient. It means only that they take care of urgent pickups first.

A patient is *routine* when you know that he needs to be examined and treated by someone with more experience and equipment than you have, but the apparent illness or injury is not a real emergency.

Don't overclassify your patients. Don't cry "Wolf" and mark all your patients "urgent." If the case is urgent, say so. But don't overdo it. If the patient is in pretty good shape, and can wait for a while, then mark him "priority" even though the disease or wound he has is pretty bad in itself. You will seldom make a serious mistake this way. And you will earn the gratitude of medevac people. If word gets around among the pilots that when you call in "urgent," it *is* urgent, then when you ask for help, you get it fast.

One more thing you do: you keep some medical



records. This is not listed as a separate Army Medical Department mission, but it is an integral part of the whole process of keeping the Army healthy, and treating the sick and wounded.

Never let the paperwork interfere with the care of the patient. The patient comes first; paperwork second. Get to your patient, protect him from further harm, examine him, treat him, and evacuate him. But whenever time permits (before you evacuate him) make out a Field Medical Card: who he is (name and SSN); what he has (what hit him, and where); what you did for him if it affects his further treatment (tourniquet, morphine); and when and how he is to be evacuated. It is very important that you try to identify the patient properly. If he is unconscious, don't forget his dog tags. He won't be able to give you his name, and a well-meaning buddy may have covered him with a field jacket or other garment with another name on it. Remember, most misidentification of people starts on the battlefield. If the patient dies on his way to the hospital, the Army could easily end up with a report that someone is KIA when actually he is alive. Tie the original card onto the patient. Keep the carbon a reasonable period of time before you throw it away. Then when the First Sergeant comes around after the operation and asks, "What happened to Willie?", you can thumb through your carbons and answer, "He got shot through the chest. I got to him right after that at 1415. DustOff picked him up at 1440." That is enough for a clue for Old Sarge to find out where Willie is and how he is doing.



### OK, so how do I go about this?

The first thing to do is to get accepted as a real team member of the outfit you serve. You do not do this by applying for membership, and getting voted in. You do it by acting like a member of the team, working with the men you serve, and working for them and serving them well.

It may be that you first join the unit as a replacement aidman when it is already committed to battle. If so, you will make or break your reputation real fast. Most often, your opportunity to gain acceptance comes in a relatively quiet or noncombat situation.

Be interested in your men. Be dedicated to your work. And be a good listener. Hear the patient out. Don't make a snap diagnosis even if the patient has already given you enough clues to make a diagnosis on. Your diagnosis may be correct, but it still may not be "right." A lot of times patients come in to see a doctor with complaint of a headache, or a sore back, or loose bowels when that is not the real problem they want to talk about. Get a feel for what the whole problem really is, and then treat the headache, sore back, or loose bowels as only one part of it.

Don't make a big thing of the fact that you are assigned to another unit—medical detachment or platoon—and are just working with this company, battery, or troop. In fact, play it down. Be proud of being a medic, even if some combat type describes it as "just a medic"; in the crunch he will learn what it means to be "just" a medic. But be proud too of being a member of the Screaming

Eagles, Geronimo, No Slack, First Team, or Black Horse.

Besides gaining the acceptance of the men you serve by becoming "one of them," make a special point of earning the trust and confidence of the unit commander. In a way you are one of his staff members. You are *his* "Doc," his advisor on all medical matters. Sometimes you are going to have to advise him that he is doing something wrong, or at least suggest to him that there is a better way to do it—when he is not enforcing basic sanitary standards in bivouac, when he is not providing enough break time on a forced march, when he is pushing a man well past the limits of "Big Doc's" "profile" limitation. You can get away with this if he knows you always level with him; if he knows you are sincerely interested in your patients, who are his men too; if he knows you are for him, and not against him; if he knows that any job he gives you will be done quickly, and well.

Learn what kind of man your CO is, and if you can, get a feel for what kind of man *his* CO is. You might understand better why some of the decisions are made.

Learn what your outfit is doing. The whole outfit. You don't have to master the MOS of rifleman, gunner, tanker, or engineer, but you need to understand what kind of work your patients do. You need to understand their language. And you need to know how their jobs fit together. If you know how the whole platoon or company works you are more likely to make the right judgments and decisions when action is hot and heavy and



there is nobody around to tell you exactly what to do.

Get interested in cross-training. If you know how to clear a jammed M–60, you might save your own life as well as that of your patient. If you know how to drive an APC you might be able to save some men who would otherwise be lost. If you know how boobytraps are set, you might be able to avoid the one next to the one that got poor Joe.

Cross training works the other way too. Keep your men brushed up on their first aid. Show them more about how to carry or drag the wounded. Demonstrate how to improvise litters, or to use standard litters in nonmedical vehicles. Caution them on the dangers involved in loading patients into helicopters. Brief the long range patrol on foot care, water purification, malaria discipline. Explain how to use the jungle penetrator in hoisting out patients.

Learn more about your own job—a lot more. Your men think you know a lot more medicine than you really do. Be humble and don't bluff; they will still respect you if you admit your limitations. But they will respect you even more if they know you are finding new answers and learning more all the time.

No "Doc" ever learned it all. Talk to "Big Doc" about patients you have sent him, and about the ones you have treated yourself. Read up on drugs, and instruments, and anatomy, and surgery, and psychiatry whenever you can get hold of the material to read. When you think you have learned



to handle something new, then talk to your medical boss and maybe he will give you the stuff you need to put into your black bag.

And speaking of that "black bag" again, you really ought to have several bags. How big each bag is, and what goes in it, depends first on the mission, and second on your skill and experience.

Say the mission is this: "We are going to stroll down to that village and have a look and see what is left in it if anything. I don't expect to find anything in there. Two squads ought to be enough. We will be back in a couple of hours." A light aid kit is what you want—bandages, instruments, maybe a jug or a bag of saline.

But when the mission is like this, you have a different problem: "We are going to slip through these woods, see, and blow this bridge. When we blow the bridge, we will be covered with gun ships and picked up by choppers. The total distance is 40 miles. It will take us 3 days, marching only at night. We will not be resupplied or reinforced unless we run into trouble on the way." This time you will need a big kit, with drugs as well as bandages and instruments, some saline, and maybe a semirigid litter.

In any case, take what you need, but only what you can handle. And what you can "handle" means what you can carry, as well as what you can put to good use. Every bag or jug of saline you carry costs you over 2 pounds in weight. That is dead weight if you don't need it, or don't know how to use it. It is lifesaving if you need it, and know how to put it to use.



By the way, if you want to know more about Army Medical Service, get copies of FM 8–15, which covers the division, and FM 8–10, which covers the whole theater. You'll find out how the system works and where you fit into it.

That's it, friend. Now you know how to be a good aidman. Good luck. A lot of people are depending on you.

## REFERENCES

| | |
|---|---|
| AR 40–5 | Preventive Medicine. |
| AR 40–554 | Prevention and Control of Communicable Diseases of Man—Venereal Diseases. |
| FM 8–10 | Medical Support—Theater of Operations. |
| FM 8–15 | Medical Support in Divisions, Separate Brigades, and the Armored Cavalry Regiment. |
| FM 8–35 | Transportation of the Sick and Wounded. |
| FM 8–36 | The Aidman's Medical Guide (to be published). |
| FM 8–40 | Management of Skin Diseases by Company Aidmen in the Tropics. |
| FM 21–10 | Field Hygiene and Sanitation. |
| FM 21–11 | First Aid for Soldiers. |
| FM 21–40 | Chemical, Biological, Radiological and Nuclear Defense. |
| FM 21–41 | Soldier's Handbook for Chemical and Biological Operations and Nuclear Defense. |
| FM 27–10 | The Law of Land Warfare. |
| TM 3–215 | Military Chemistry and Chemical Agents. |



| | |
|---|---|
| TM 8–215 | Nuclear Handbook for Medical Service Personnel. |
| TM 8–230 | Army Medical Department Handbook of Basic Nursing. |
| TM 8–285 | Treatment of Chemical Agent Casualties. |
| DA Pam 27–1 | Treaties Governing Land Warfare. |

By Order of the Secretary of the Army:

W. C. WESTMORELAND,
*General, United States Army,*
*Chief of Staff.*

Official:

VERNE L. BOWERS,
*Major General, United States Army,*
*The Adjutant General.*

Distribution:

To be distributed in accordance with DA Form 12–11 requirements for Medical Service—Theater of Operations.



N–O–T–E–S



N–O–T–E–S