

Training Opportunities For Airborne Battalion Medical Platoons

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The three C-130s are on final approach to the drop zone, following the heavy-drop platforms by ten minutes. The troop doors are open, and paratroopers are standing by awaiting the jumpmaster's final command of "GO." In a couple of seconds, the sky fills with parachutes. Paratroopers land, recover their equipment, and rapidly move to their assembly areas. One soldier twists his ankle and word is relayed to the battalion medical platoon element to dispatch the drop zone coverage ambulance to check him out. Fortunately, it is nothing more than a mild sprain. In a few minutes the medical team NCO reports no more injuries. The ground troops quickly move out from the droop zone on their tactical training mission. The ambulance and the medical team return to the motor pool, park their vehicle, and are released.

Sound familiar? If this happens often—or even occasionally—in an airborne unit with organic medics, medical training opportunities are being wasted. Airborne medics need to be thoroughly tested in the tasks of getting equipment and supplies ready to drop, recovering this equipment efficiently, putting it into operation, and treating a wide range of casualty situations on the drop zone.

I commanded an airborne forward support company (FSC) in Italy that had an internal medical platoon supporting an infantry brigade in country. We tried various ways of increasing training opportunities for the platoon and learned many lessons that will be useful to others.

Individual Equipment

Medics who jump with aid bags and limited Class VIII supplies in their indi-

vidual rucksacks render first aid and perform lifesaving measures to seriously injured patients. The weight and size of the medical gear medics must carry, in addition to their own individual equipment, limit the number and the scope of injuries they can treat. But even with these limitations, it is still possible to conduct meaningful medical training.

The supported unit should designate soldiers to jump with moulage kits (to simulate wounds) and apply them immediately on landing on the DZ. The medics land, find the casualties, begin treatment, and evacuate patients.

Door Bundles

The weight and size of the medical gear that can be inserted by door bundles dramatically increase the capabilities for medical DZ training. A mass

casualty (MASCAL) situation, for example, is extremely difficult to address with only the medical gear jumped in individual aid bags and rucksacks. With the additional equipment and supplies, a MASCAL is within a unit's training capability. Our FSC procured a small generator that was dropped with the door bundle to power selected medical equipment.

Other training opportunities with door bundles are to rig and drop blood products, establish a limited Class VIII supply point, set up the advance treatment point for the brigade aid station (BAS), conduct MASCAL, and operate powered equipment.

Vehicles

Since four-litter M997 armored ambulances exceed the height restrictions for dropping from C-130 aircraft, their flexibility in deployment is limited. M996 HMMWV two-litter armored ambulances are considered fragile when airdropped. Cracks in welds and siding and dents can result in long, costly repairs. For these reasons, a unit may choose not to include the ambulances in the airdrop plans. This can adversely affect training opportunities for a medical platoon that is not equipped with M1035 softshell ambulances.

Our FSC was equipped with four-litter ambulances. The medical platoon in the company fitted a two-litter ambulance kit composed of 42 pieces (found in TM 9-2320-280-24P-1) to a platoon M998 HMMWV. This vehicle, which was airdropped twice during my tenure, gave the medical platoon a vehicle to evacuate patients to the BAS, transportation to reach training lanes immediately adjacent to the DZ, and a ready platform for vehicle secondary loads.

The training opportunities included vehicle rigging, planning secondary loads, tactical derigging, and access to training off the DZ.

Vehicle Secondary Loads

Vehicle secondary loads can take two forms—a load planned on an organic medical vehicle and a medical-specific package planned on a vehicle that is not organic to the medical platoon.

The FSC habitually uses an M998 HMMWV fitted with a two-litter kit. The standard load plan for this vehicle—configured for supporting a BAS—typically includes one or two modular tents, four to six Class VIII medical chests, and specialized x-ray and laboratory equipment.

Medical planners should request heavy-drop platforms to insert vehicles capable of supporting the medical plan and enhancing medical training. For airborne combat battalions that use M998s for an advanced trauma life support vehicle, the training potential increases if the vehicle has a two-litter configuration. With the two-litter kit,

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the vehicle can easily carry four or five trauma chests and Class VIII supply containers for airdrop.

If the mission plan cannot support a heavy-dropped medical vehicle, space should be requested as secondary loads on the drop plan. The key to this method is using every bit of available space on airdropped vehicles.

The medics can train on medical load planning, vehicle rigging and derigging, and BAS set-up.

Mass Delivery Systems

Medical equipment delivered by the containerized delivery system (CDS) and mass supply platforms offers another dramatic increase in the size and scope of medical support training. CDS bundles can be programmed into the sustainment phase of forces on the DZ. One mass supply platform, if properly loaded, can deliver the equipment and Class VIII supplies necessary to set up and sustain a functional BAS, including small and medium generators to provide electrical power.

Training opportunities include BAS drills, MASCAL, tactical derigging, Class VIII supply point, specialized rigging for medical equipment (x-ray and laboratory), and events requiring multiple pieces of powered equipment.

Training for Low-Density MOSs

The FSC's medical platoon includes soldiers in the following specialties:

- 91S (Preventive Medicine Specialist).
- 91K (Medical Laboratory Specialist).
- 91P (Radiology Specialist, commonly referred to as x-ray technician).
- 91A (Medical Equipment Repairer).
- 71G (Patient Administration Specialist).

While most airborne combat battalion medical platoons are almost exclusively 91B (Medical NCO), every effort should be made to integrate and include the low-density MOS soldiers in productive DZ training.

Preventive Medicine. Tasks for the 91S soldiers includes conducting an entomological survey of the DZ or adjacent operations area and drawing and testing water samples. Insect and rodent traps can be inserted in door bundle loads or on vehicle secondary loads and then emplaced as part of a training task. Limited water sampling gear can be jumped in the 91S's individual rucksack. Heavier and more fragile testing gear requires a door bundle or a vehicle secondary load.

Laboratory. Laboratory tests can be programmed with fluids extracted from soldiers on the DZ, using a light microscope with 10-power, 30-power, and 100-power magnification, jumped in a well-padded rucksack. Blood can be drawn under controlled circumstances, as can urine samples. Dipstick urinalysis, white blood cell count, and blood glucose are included in this spectrum of training. Additional chemicals and test materials can be dropped by door bundle or in vehicle secondary loads. Our FSC laboratory specialist was working on executing malarial smears and microscopic urinalysis tests.

Radiology. Conducting x-rays on a DZ within minutes of a parachute drop is a challenging task, but one that, performed under certain conditions, can greatly help the attending surgeon with

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treatment and evacuation decisions. The x-ray apparatus requires electrical power, and hence a generator. But once past these planning considerations, the x-rays can be done.

Administration. It is difficult to develop training for MOS 71G on the DZ. But if a MASCAL is planned after an airborne operation, useful training is available. The individual 71G can jump limited forms in his rucksack with more in the door bundles, and a field desk can be loaded onto a mass supply platform.

Medical Maintenance. Training for the medical equipment repairer after a parachute drop is the most challenging to develop. Equipment damaged in the drop, if any, could be assessed and an expedient repair performed. One solution might be to have the medical equipment repairer perform organizational services on a piece of equipment inserted on the DZ. Another solution is to have him assist in the calibration of specialized medical equipment such as x-ray apparatus.

Lessons Learned

The following are some of the lessons we learned from this training:

Plan and execute specific training for all medical MOSs available to the training medical unit. Having the soldiers in low-density MOSs jump and "lend a hand" in the derigging and set-up of an activity is proper and appropriate in most cases, but this should not become the primary focus of their training.

Protect fragile medical items from damage. Items damaged by impact are of little use to an injured soldier, and extreme care must be taken in configuring them for aerial delivery. Hard plastic cases with foam and bubble-wrap cushioning work best for loads jumped in individual rucksacks. For door bundle insertion, FSC medics use a braced plywood box that fits inside an A-21 cargo bag to supplement protection of the contents. The outer shell of the box provides extra protection on impact and prevents most load shifts during descent.

Integrate training with casualties from the supported unit. A comprehensive medical plan allows for treat-

ment by combat lifesaver personnel before evacuation through small-unit channels to the supporting aid station. This offers training for patient records specialists and exercises evacuation channels and casualty tracking. Every echelon of medical treatment benefits from this integration.

Use moulage kits to add realism. Casualties can be designated beforehand to jump with the moulage kits issued to them in their individual gear. An exercise observer-controller can issue a kit to an assessed casualty. MILES casualty cards are helpful for initial diagnosis, but a detailed casualty card is needed to instruct the casualty on how to act to provide the greatest training for the attending 91B.

Involve medical leaders in planning and sequencing. Medical leaders benefit from being involved in the planning and sequencing of loads carrying medical supplies and equipment. Particularly helpful are wargaming events that cause bundles or heavy loads to abort. Medical items should be cross-leveled to keep aborted loads from compromising effective medical support and training.

Rehearse assembly plans and contingencies for vehicle secondary loads not dropped on organic medical vehicles. Medics parachuting on the mission must know which vehicles they will help derig and take charge of medical equipment onboard. In addition, the vehicle crews must thoroughly understand what to do with the medical equipment loaded on their vehicles if airborne medics do not arrive on the DZ to take charge of it. A drop off point should be designated, understood, and rehearsed.

Develop skills in preparing refrigerated supplies. Procuring and configuring blood products for aerial delivery is a special challenge. It is extremely difficult to secure blood items for a peacetime airdrop because they present a medical hazard if opened or ruptured on impact. To sidestep these problems, our FSC medics used standard IV bags with the contents tinted by food coloring to simulate blood.

Keeping the contents within the required temperature range for blood is

vital (approximately 1-6 degrees C or 33-43 degrees F). Our FSC medics attempted to drop blood products, but aircraft movement regulations prevented the use of dry ice. The medics countered by using regular ice inside an insulated container in a door bundle. Water was pre-frozen inside plastic drinking bottles before being placed in the blood container.

Door bundles rigged immediately before aircraft take-off seem to be the best method of inserting readily available blood or blood products. Dispersion on the DZ is limited and the blood products can be maintained within the proper temperature range, but this would be a challenge with a vehicle rigged for airdrop and standing by for several hours.

Consider power generation as part of load planning. Generators in the 5-kilowatt range are too large to rig in door bundles, and they take up a lot of space in mass supply loads. Our FSC locally purchased a small generator to fit inside the outer door bundle box to provide power for the X-ray equipment.

Plan and rehearse ground assembly. During an operation where wounded soldiers are likely, medical personnel should jump, land, and move directly to their assigned door bundles or vehicles to begin derigging. Of course, primary and alternate load assignments should be rehearsed.

Consider ground tactical plans. If the medical equipment will be inserted into the operational area by door bundle or mass supply methods, the distance it will have to be moved to the designated aid station should be carefully considered. A great distance will lengthen the time required for assembly and set-up. The same is true for loads dropped with vehicles. In case the vehicle is damaged on impact, an alternate site for the aid station should be selected, rehearsed, and briefed.

Familiarize 91B personnel with vehicle rigging. Regardless of whether M998s, M996s, or M1035s are to be airdropped, 91B personnel should be familiar with the rigging procedures for them. Rigging these vehicles for airdrop twice a year is probably the minimum necessary to teach and sustain this

important skill. Even if the drop plan does not support heavy-dropped ambulances, the vehicle can still be rigged and notionally placed on the DZ.

Airborne combat units that take their airborne medical personnel through a graduated series of training events with gear jumped on the soldier, inserted in door bundles, or dropped with vehicle

secondary loads will have better trained, more highly motivated, and more confident soldiers to treat casualties. This competent, energetic, and confident care can be attained only through challenging medical training. This process is not easy, but it will save lives on the next peacetime or combat parachute assault.

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