Commentary on
The Falklands War - Army Field Surgical Experence

Ann R Coll Surg Engl 1983; 65: 281-5

Professor JM Ryan

Reviewing this paper, published nearly a quarter of century ago, the writer is immediately struck by how much has changed. Although those deploying did not realise, the war was to be a watershed, at least in medical terms. The Army (land based) surgical support elements were lightly equipped, lean and austere and would have been easily recognised by an earlier generation of surgeons deployed in support of troops fighting in the Boer War and World War 1. Even the field clothing worn by the surgical teams were a throw back to an earlier century – Long sleeved vests and KF pattern shirts worn with aprons. Never again would field surgical teams deploy in such manner.

It was of course not meant to be this way. Carl Von Clausewitz's observation that 'the plan would not survive the first contact with the enemy' proved prophetic. The initial plan envisioned that surgical support for the wounded would be afloat on the hospital ship SS Uganda and the liner SS Canberra. Field Surgical teams (FSTs) were to be held in reserve and few thought they would be needed. The Argentine air force put paid to that plan, necessitating the early deployment of Royal Navy, Royal Marine and Army personel ashore and into a disused refrigeration plant at Ajax Bay.

Turning now to the paper – it is immediately obvious that only part of the story is told here. The paper relates the experience of the Army FSTS only and barely a mention is given to the considerable experience of the Royal Navy teams both ashore and alongside the Army FSTs, and those deployed on the hospital ship SS Uganda and on ships and liners throughout the fleet. Memories fade with time and it is difficult to recall why this was so. There was certainly no malice or jealousy, more likely a desire to be first in the race to publish. What a pity, as a paper describing the total experience would have left a more complete and better record. How invaluable the retrospectoscope!

Jackson et al's paper gives a vivid and raw account of surgery ashore under the most primitive and sometimes dangerous conditions. It will shock many reading it for the first time in the light of early 21st century advances. So many features are striking. The majority of the surgeons and anaesthetists were trainees with only one consultant surgeon and one consultant anaesthetist. Towards the end of the campaign a lone trainee surgeon was deployed forward to work single handed in Teal Inlet – something unthinkable in the modern climate of clinical governance. Yet there were no fatalities at Teal Inlet. The equipment scales were basic and limited. This was the age before field ventilators and oxygen generators. Paper towels were used due to the absence of any linen. Surgeons and their assistants worked in shirt sleeve order and with the bare minimum of instruments. Table lighting was appalling, sometimes with bare light bulbs in use. There was no imaging and laboratory support was confined to blood group typing. Another striking aspect of the campaign was the scarcity of helicopters for both evacuation of the wounded to the FSTs at Ajax and for evacuation to the Hospital Ship and other receiving ships. Most of the helicopters earmarked for casualty evacuation went down with SS Atlantic Conveyor destroyed by an Exocet missile early in the campaign. Another example of Von Clausewitz's dictum on planning. Further difficulty was caused by Argentine air attacks over San Carlos Water. Such was the danger that the Hospital Ship could only anchor close to Ajax at night and then only for short periods. This further altered planning as the original intention was for the FSTs ashore to confine their operations to life and limb salvage. Evacuation delays now dictated that as much surgery as possible was to be performed to avoid potentially lethal wound infection in the majority of wounds.

The paper provides an analysis of wounding agents and injuries by region. The preponderance of limb wounds is striking but not surprising. Lengthy delays in evacuation occurred due fighting at night and the lack of helicopters. Jackson et al report in the paper that some of the most seriously injured died before evacuation was possible which paradoxically lowered hospital mortality. It is sad to recall a note of bitterness here and it concerns the numbers operated upon by Army FSTs. Following the publication of the paper some senior Royal Navy colleagues questioned the numbers cited and felt that the Royal Navy teams had not been given credit for their contribution. Such disagreements are all too common, even in reports from civilian hospitals. Fortunately this has caused no lasting ill feeling.

The war was to provide a sharp reminder of the danger of providing close in surgical support. The redeployment forward of two FSTs with a role 2 dressing station in support of 5 Brigade's daring assault at Fitzroy/Bluff Cove put surgical and medical teams at hazard in a most unexpected way. The FSTs and role 2 elements were boarded on the troop ship Sir Galahad alongside the Welsh Guards and other support personnel. With just elements of the dressing station and one FST ashore the ship was bombed with considerable loss of life. The author was aboard with his FST and saw at first hand the effects of the bombing and the chaos that followed. It is fair to say that for a considerable time few expected to get off the ship alive and uninjured.

In the months and early years following the war individuals and some national organisations, notably the British Limbless Ex-servicemen's Association (BLESMA), began to question the decision to send such junior surgeons to work under such adverse conditions. BLESMA questioned the apparently high amputation rate and the surgical techniques used. In fact the teams were better trained that might appear. All had been exposed to the surgery of war in Oman or Northern Ireland and all trainees were older and vastly more experienced than their counterparts today. A careful analysis of the available data supports early decisions to amputate and to carry that out at the lowest possible level to allow a 'site of election' amputation later. Further analysis of those who died of wounds (only three) suggests the injuries sustained were non-survivable even under

optimal conditions.

In conclusion this writer hopes that the current generation of military surgeons might find some valuable lessons in the paper under commentary. It might also cause them to reflect on the advances that have occurred in the last 25 years. What a joy it would have been to have had the field surgical facilities of today transported back through time to Ajax. One final comment – at least in Ajax Bay at the end of a long operating session the unit Commander – Surgeon Captain Rick Jolly produced copious quantities of best Navy rum before bed time.