

OPERATION MUSKETEER - THE SUEZ CRISIS 1956

PJ Parker¹, N Kirby²

¹Senior Lecturer, Academic Department of Military Surgery and Trauma, 16 Close Support Medical Regiment, Merville Barracks, Colchester, CO2 7SW; ²Major General (Ret'd) L/RAMC, formerly Consultant Surgeon RAMC

Introduction

Captain, (later Major-General) Norman Kirby joined the Territorial Army as a Medical Student in 1948. He was already developing what was to become a lifelong interest in the speciality then termed Accident Surgery. There being no specialized trauma units at that time, he was advised to join the Regular Army – a decision that he never regretted. Fifty-two years ago, on November 5th 1956, he took part in Operation Musketeer – the assault on El-Gamil airfield in Suez. Whilst he has lectured modestly on his experiences, he has never published them.

However, the problems that he encountered and the cases that his team treated still have genuine relevance today. This paper, based on personal interview, notes and diaries, recounts the planning, preparation and the reality of the actual medical support to the airborne assault. It also details the many constructive lessons learnt and then subsequently forgotten.

Historical Background

In 1956 Britain still regarded the Suez Canal as being vital for the defence of our interests in the Far East, specifically oil. The canal was owned by Britain and France, the controlling shares in the Suez Canal Company having been purchased for Queen Victoria by Baron Lionel de Rothschild in 1875 for £4,000,000. The canal was however, built on Egyptian land and in the 1950s Egypt was undergoing a major nationalist resurgence. Egypt's leader, Colonel Gamal Abdel Nasser was a public hero having fought in (but lost) the Palestinian war of 1948. He was a committed anti-Israeli. On July 19 1956, Nasser was stunned to be told that the US, concerned about his alleged communist leanings and his recognition of "Red China", was withdrawing its loan offer to fund the Aswan Dam, a strategic project to provide water and electricity for the Nile valley and Egypt's industry. A separate World Bank contribution was conditional on this US (and UK) contribution; this also lapsed. On 26th July 1956, during a speech in Alexandria, Nasser was moved to state *"Egypt will run the canal; the Suez Canal belongs to us...the Canal will be run by Egyptians...it will be taken over as a nationalized industry"*. Nasser's use of the word *"de Lesseps"* (the French engineer who had designed the canal) within this speech was the coded signal for special Egyptian military teams to assault and take control of the canal office buildings. Nasser planned to use the monies made from ship tolls and the frozen canal assets fund the dam himself.

British papers at the time compared this nationalization to Nazi Germany's annexation of the Rhineland and compared Nasser to Hitler. Eden and Mollet (the French Prime Minister) worried about being compared to Chamberlain and his policy of appeasement and ordered invasion plans to be made. In response

Egypt mobilized for war. Russia sent pilots and MiG fighters to assist in training the Egyptian Air-Force. Egyptian students in London lost their scholarships, the French evacuated their personnel. General Sir Charles Keatley was sent to Cyprus to plan the operation. Coming so shortly after WWII, the UK military was suffering from chronic under funding. There were Canberra bombers but no long-range fighters. The aircraft and carriers of the Mediterranean fleet were out-of-date when compared to the Russian jets. The RAF air-transport fleet was too small to move the Army and our best infantry units were fighting EOKA in Cyprus.

The mandate for invasion was sketchy at best. The Guardian newspaper pointed out that the canal was operating normally under Egyptian control (although not letting any Israeli ships through). A political pretext was therefore deemed necessary. On October 24, at Sèvres, outside Paris, Israel's Prime Minister, David Ben-Gurion, met with Selwyn Lloyd and Christian Pineau, the British and French foreign ministers. After three days, the parties signed a joint protocol. Israel was to attack Egypt, then Britain and France were to land at Port Said and other points along the canal on the pretext of separating Israeli and Egyptian forces and whilst there - 'protect the waterway'. Several plans were considered. These included an assault at Alexandria, a rapid advance overland to Cairo, and then a move east to the canal, but this terrain was difficult and the chance of significant guerrilla activity was high. The chosen plan was to assault Port Said – a small port with limited dock facilities and a narrow and vulnerable route out over salt marshes and lakes. Carrier support would be required for this joint seaborne assault which called for up to 45,000 UK and 34,000 French troops, 300 UK and 200 French aircraft, 100 Royal Navy and 30 French Naval ships. There would be a series of lightning air-strikes to destroy the Egyptian air-force on the ground as well as seaborne landings and an airborne assault.

On the 28th October 1956, as the triumvirate had planned, Israel attacked Egypt (Operation Kadesh). They parachuted into the Mitla pass, stormed over the Sinai desert, took Sharm el Sheik and the Gulf of Aqaba and had gained all their planned objectives by the 4th of November – just 6 days. The Anglo-French ultimatum to withdraw followed. In Parliament, Selwyn Lloyd and Anthony Eden were asked, as many had suspected, if there had been any collusion between France, Great Britain and Israel. This, of course, they strenuously denied and Eden ordered all copies of the agreement destroyed. On the 29th October, the main UK carrier battle group left Malta. The BBC broadcast that *"the operation to retake the canal may be on or off"* – perhaps not good news for the planned surprise attack. On the 4th November – the Allied Tank Force set sail from Cyprus. 3 Para Bn Gp and the French Foreign Legion Parachute Battalions (1er REP and 2ème RCP) prepared for action. The 24 hours they spent alone and unsupported awaiting seaborne support landings, facing the tanks and armoured vehicles of a modern army, was glossed over. Arnhem, only 12 years before, was conveniently forgotten. World opinion, led by the US, turned rapidly against the planned invasion.

Corresponding Author: Lt Col Paul Parker, Orthopaedic Department, MDHU(N), Friarage Hospital, Northhallerton, DL6 1JG

Tel: +44 1609 764901 Fax: +44 1609 764638

Email: paul.parker@stees.nhs.uk

Airborne Medical Plan

A 14 man section with an MO from 23 Parachute Field Ambulance along with a 6 man FST was selected to jump with 3 Para: This comprised one surgeon, one anaesthetist, a Cpl OTT, two nursing orderlies and a blood-transfusion orderly. The RAP of 3 Para was augmented with five RAMC orderlies and these assisted in the formation of Company Aid Posts. The surgical plan was to perform life saving priority one surgery and hold all casualties until evacuation was possible. Individual training for the drop began at the Cambridge Military Hospital in Aldershot. As the operational tempo increased, training continued at the British Military Hospital (BMH) in Nicosia, Cyprus. The input of Colonel John Watts RAMC, a parachute trained surgeon who had taken part in both the D-Day and the Rhine crossings was deemed invaluable at this stage. A WWII scaled FST (still wrapped in 1944 newspapers) was tactically broken down into three parts and repacked: The retained institutional medical memories of Operations Market Garden and Varsity were thus still intact.

Indispensable kit was carried on the person, for the surgeon, this was their own selection of surgical instruments; pre-sterilized excision packs containing Bard-Parker knives and blades of different sizes, curved and straight scissors, toothed and non-toothed forceps, Spencer-Wells forceps and light retractors (heavy retractors and instruments were carried in the CLE containers). All FST members carried amongst themselves: Plaster of Paris, transfusion fluids, large packs of pre-sterilized gauze swabs, many shell dressings and a sterilizer heated by a primus stove. The six man-packs of the FST enabled three cases to be started before the other elements arrived. The other vital parts of the FST were packed into the heavy drop CLE (Central Landing Establishment, WWII Pattern) containers. These contained the Sugar (Surgical) and Don (Medical) packs comprising the remainder of the FST. An AB stretcher on trestles was to be used as the operating table. Finally, packs were prepared as resupply to go with the seaborne forces.

The parachute scale surgeon's packs were trialled at the BMH until they contained the absolute minimum required to perform adequate field surgery. They were also used in support of three large scale anti-terrorist operations against EOKA on Cyprus. This field use gave invaluable experience in the packing, rapid movement and setting up of the FST. All members of the FST became familiar with the surgical complex, their own packs and field living. The anaesthetists prepared similarly. The regular unit anaesthetist was, strangely, posted to the UK two weeks before the operation and Captain Elliot, a section MO thus volunteered to undertake the two weeks refresher training at the BMH to become the 'anaesthetist'. On the last day of training, he was told by the RAF that he could not carry ether onto the plane. A wartime ESO chloroform apparatus was found and some very rapid re-training ensued.

For blood, a case of the old-fashioned glass transfusion bottles was supplied – the standard army pattern from the 'last' war: A box of the more modern American polyethylene transfusion bags had been sent to the UK for trial, but the Brigadier (to whom they were sent) did not know what they were for and so there they remained. Of the twelve bottles that were parachuted in – nine shattered. Dextran and glucose/saline was therefore used for much of the resuscitations.

Airborne Assault

Synthetic parachute training started on Monday 29th October after returning from an anti-terrorist operation. Parachutes were drawn and fitted (Figure 1). From the experience gained from the invaluable field and BMH training, all equipment was re-checked and re-packed. More swabs and more operation packs were needed, these were rapidly added. Field currency was issued.



Figure 1. Drawing and fitting parachutes (N Kirby 2nd from left).

Saturday November 3rd – Six CLE containers were initially drawn, painted, tactically loaded and delivered to 3 Para for loading onto the aircraft. Naturally, at the last moment the container numbers were reduced from six to four. Frantic re-packing ensued. Then at almost the last minute, the container numbers were increased to eight; five in the first lift and three in the second. This final effort was accomplished in 35 minutes flat. The FST then moved into the sealed camp and after a full Battalion brief was given, they were able to liaise with both the RAP and Advanced Dressing Station (ADS). This brief was the first opportunity for the FST to see air photographs of the buildings that they had provisionally been allocated to work in – likely to be garages at the back of the control tower complex on the airfield (Figure 2).



Figure 2. The Objective: El-Gamil Airfield. Port Said is to the South (Bottom of Picture).

Sunday November 4th – The Parachute assault was brought forward to be twenty-four hours before the sea landings and with no early ground support. As all the aircraft were now bombed up and filled with containers which could not be touched, more packing was necessary. All personal weapons containers were packed to the brim, all pockets crammed with drugs, shell dressings, food, water and ammunition. The lost equipment problems of Arnhem and the Rhine Crossings were only twelve years in the past and thus even more shell dressings, plaster of Paris, Dextran, chloroform and penicillin were requisitioned from the 23PFA QM and Brigade. A late night visit to BMH Nicosia with a patient allowed the FST to rifle theatres there for additional atropine, pentothal and penicillin and to sterilize a few more dressing packs. The operating theatre nursing staff gave invaluable help in this frantic task.

Monday November 5th – Breakfast was early - 0200 hrs. Parachutes had already been drawn and fitted. Take-off was at 0415 GMT and the planes were over the canal at 0615 GMT. A perfect run-in and drop took place. The tactically loaded

planes approached from the west. 'A' Company with sappers were in the first stick, tasked to secure the west end of the airfield to blow the bridge on its west side. Next came the centre troops, battalion HQ and company, medical staff and finally 'B' Company to capture the east end of the airfield. Rifle fire as the troops exited the plane indicated that they were somewhat unwelcome. Perfect parachuting weather gave most a comfortable landing (Figure 3).



Figure 3. The combat jump, 5 November 1956.

The FST headed straight to the control tower whilst the RAMC section treated casualties before going to the RV. A mortar bomb landed and bounced nearby, the FST threw themselves down expecting the worst but fortunately it was a dud. Many bombs did not explode – they had possibly been fused in haste. Smoke from burning huts rose from behind the control tower and numerous bangs created a Guy Fawkes atmosphere. The RMO – Sandy Cavenagh was already busy with casualties. He had a hugely bruised black eye having been hit in the air by a piece of wadding. He continued to treat casualties until he was incapable of carrying on.

The first casualties were mostly from heavy Egyptian mortar fire. A salvo of shells bracketed the ADS but these were not repeated. The garage that the FST found themselves in was quite suitable – the large covered bay made an ideal reception and gave some overhead cover from indirect fire (Figure 4).



Figure 4. The Advanced Dressing Station reception area behind the control tower, 0800 Hrs 5 November 1956.

A repair shop leading off from this made a very adequate resuscitation and intensive care ward. The adjoining office block became the operating theatre. The previous occupants had left in a hurry – pitta bread and coffee still covered the tables. Private Neal, who had jumped with the field sterilizer, was still missing at this stage – he appeared just under an hour later having landed in the sewage farm that was the front-line in the east between both sides. He had crawled most of the way, dragging all of his equipment, and it seemed most of the sewage farm with him. For his troubles, he was shot at by both sides.

One of the early casualties was a chef who had parachuted in with his Dixie pan and a job-lot of tea, sugar and condensed milk. His wounds were treated, his Dixie was first used to boil the second set of instruments on the FST's Primus stove and second to make hot sweet tea (with milk!) for the resuscitation of both casualties and staff. The surgeon and anaesthetist assisted in triage, treatment and resuscitation whilst the orderlies prepared the theatre. The single anaesthetist was quickly hard-pressed with three priority cases. Three orderlies had to be bled to provide fresh blood for transfusion – using the few unbroken citrate bottles.

The first operative case of the campaign was an open chest wound. The skin wound was excised, the damaged lobe was debrided and sutured. Intercostal vessel bleeding was controlled and the chest closed. Post-operatively an underwater drainage apparatus was constructed using a self-retaining catheter and a spare transfusion bottle. Two mortar casualties had sustained heavy loss of blood from buttock wounds which were explored, debrided and haemostasis secured; thus ended the first list (Figure 5). Minor casualties had also been treated now by the RAMC staff. The fighting remained fierce with many fresh casualties. One case of multiple fragment wounds to the head died. After two more limb debridements Captain Kirby met the Brigadier, MAH Butler doing a tactical walkabout outside the control tower. He blithely asked. "Sir, if the Royal Navy is standing off today and may possibly join in tomorrow, could they possibly send a helicopter today?"



Figure 5. The first post-operative Ward Round.

This amused the Brigadier but he did send an urgent signal and the Royal Navy sent the first helicopter at P+4 hours. A French Dakota, which had been used as an aerial command post, flown by one Colonel de Fouquieres landed at the same time on the cleared runway and was loaded with nine casualties for BMH Nicosia in Cyprus. Sandy Cavenagh was sent back as reluctant medical escort with the chest drain and transfusion case and for an urgent ophthalmologic opinion on his damaged eye. Luckily, the globe had not been damaged and he made a full recovery after two weeks of pain, treatment and rest. Thereafter the helicopters ran a continuous evacuation to the British Aircraft carriers; Bulwark, Albion and Eagle (Figure 6). On board, naval surgical



Figure 6. Helicopter loading before casevac to the carriers.

teams were rapidly mobilised to receive these casualties. An RAF casevac team with their surgeon, Flt Lt Ken Mills was on board the helicopter carrier HMS Ocean making it a truly tri-service operation. On the return flight, these helicopters brought extra water, stretchers and penicillin, as well as beer and cigarettes. Captain Kirby was asked if he was going to close his patients' wounds. He replied "*Read the Field Surgery Pocket Book*".

Meanwhile, the French Foreign Legion (1er Régiment Étranger Parachutiste) had landed at Port Fouad and the Raswan Bridge on the east side of the canal. They were already taking casualties and their heavy-drop surgical equipment had dropped into the water: One whole British stick landed in the Sweet Water Canal – famed for its bilharzias. They were hosed down to get the obnoxious snails off them. No-one developed haematuria in later life.

By P + 7hrs, combined force helicopters were ferrying French wounded from their positions on the east side of the canal to the UK FST. Functioning as an Advanced Dressing Station, the wounded were triaged, resuscitated and carried by helicopters to the carriers offshore. At 1400 hrs, a second stick of 58 soldiers of 'D' Company and a formal resupply of equipment and medical supplies were dropped by parachute. 1530 hours brought last light. Several wounded Egyptian soldiers underwent wound excision during this quiet period. Their already primed hand-grenades were defused prior to surgery using WWII home guard skills. A brief cease-fire was declared whilst a surrender was negotiated by Brigadier Butler, but this came to nothing. The Russian Ambassador hinted that Soviet Troop reinforcements were on their way and that Egypt would receive a more direct military assistance.

By now, the French Foreign Legion had captured the essential bridges outside Port Said and 3 Para were in a strong position short of the town. No-one wanted to get too close to the town for three reasons; it was night, there was considerable guerrilla activity and a 'softening-up' naval airstrike was planned for early the next morning – as a prelude to the sea landing. The night was thus relatively quiet. There were three British wounded left. They underwent primary wound excision using Tilley lamps as lighting. The Primus stoves started playing up with the sand and instrument sterilization became a temporary problem. At midnight, all the work was done and the team lay down in the theatre and slept.

Tuesday November 6th – Reveille came early - an Egyptian MiG fighter strafed the DZ at 0430hrs. Morale was heightened by the sight of the invasion fleet sailing into Port Said and the sound of 3 Para knocking out further enemy strong points. Helicopter flights soon resumed. A Naval Gannet aircraft landed with 1200 cans of beer. An extraordinarily rapid supply line to the French and UK Battalions ensured one can per man dropped on D-day.

Major-General Kirby later edited the 1981 edition of this book – just in time for Operation Corporate

40 and 42 Commando landed at Casino pier at 0615 hrs. They were rapidly followed by C Squadron 6 Royal Tank Regiment. By 1200 hrs, the tanks had reached the Raswa Bridge captured by the French the previous day. The only exit from Port Said was now secure. 45 Commando logistically surpassed themselves. Using helicopters from the aircraft carriers, the whole Commando was ashore and in battle within 90 minutes in the world's first major helicopter operation. By 0700 the Royal Navy were clearing the harbour so that ships could be berthed by the Casino Palace Hotel.

Fighting continued in Port Said. By 1600hrs 2nd Battalion, The Parachute Regiment was ashore and advancing through the town. They reached the Raswa Bridge at 1900hrs and met up with the tanks of 6RTR ready for the 'big push' down the canal. Major Tony Farrar-Hockley had mobilized all sorts of vehicles; Coca-Cola vans, lorries, taxis and captured jeeps in readiness for a high pace move. Just as they were about to move down the canal, a UN brokered ultimatum and cease-fire came into effect and instead of breaking out of the narrow isthmus at El Cap, they simply had to dig in 2 miles beyond it where Egyptian resistance continued to fire on them.

In the later morning, the Battalion HQ moved forward and took the RAP with them. Captain Fernley moved with them as RMO. Casualties were few and had occurred mainly at the end of the political cease-fire. Captain Elliot, who had been working as the FST's anaesthetist, went forward to look in the deserted Egyptian ophthalmic hospital for anaesthetic equipment. He found instead a fighting patrol with four casualties, still under fire. He took his jeep straight in, retrieved them, rapidly dressed their wounds and returned to the FST. Local hierarchy initially accused him of 'swanning around' in his jeep, but when his gallantry was fully recognized, he was awarded the Military Cross.

The first helicopter of the day brought in Lt Don Agar RN, a naval anaesthetist. He brought in extra dressings and drugs. He had previous anaesthetic experience and was quickly at work helping to remove a British bullet from an Egyptian neck. Surgery continued throughout the day; control of haemorrhage, wound excision, dressing and limb splintage. At 1400 hrs, three RAF Valetta aircraft landed bringing further supplies and an RAF contingent to run the airfield. Lt Glyn Bennet, an RAMC surgeon arrived with some badly needed blood for transfusion. Despite not being parachute trained, he had been ready to parachute in to replace, it was rumoured, the 'wounded' Captain Kirby. At last light, Sgt Lofty Read was brought in. He was in poor shape. He had been severely wounded after giving covering fire to Capt Elliot and had been left for dead in an isolated house, cut off by enemy fire. After two hours, he was fortunately able to crawl the 300yds to the British lines by himself. Four bottles of blood and control of the bleeding from his saphenous vein in a large groin wound markedly improved his condition. Casevac control flew in a Valetta just before midnight. This included the first woman to land – a PMRAFNS flight nursing sister. She took charge of Sgt Read and escorted him back to Nicosia.

The Seaborne Surgical Team from 23 PFA now worked with surgeons from 2 Casualty Clearing Station in the Casino Palace Hotel operating on some British but mainly Egyptian wounded. The Marines had a rather nasty battle with many casualties – 9 killed and 60 wounded during the whole operation. Most of these were evacuated to the carriers. 2CCS had a rough time with equipment. Their first lot had been loaded straight from the Army Medical Equipment Depot in the UK onto ships bound for the canal and all sight of it was lost. A second load was sent from the AMED in Cyprus. Both ships arrived at the same time and unloaded side-by-side. None of the cases were marked, none had packing lists. The first 20 unloaded contained only cotton wool and dressings. It took five hours to find the much-needed surgical packs. 23 PFA were able to help the CCS by donating their spare seaborne scales.

Wednesday 7th November – A Valetta departed with casualties at 0230 giving the FST a few hours sleep before stand-to. Battalion HQ moved forward again with the ADS leaving the RAF to run the airfield casevac system. The FST moved to a school opposite the new Bn HQ. Mid-morning a Brigadier (L/RAMC) arrived by helicopter for a visit and complained mostly of his back-ache after the ride and was pleased that we were having a quiet time. Spasmodic firing continued in the shanty town. In the late afternoon a reconnaissance party from the FST, mobile in a captured Egyptian jeep, located the main dressing station of the Parachute Field Ambulance which was setting up in a fruit market on the outskirts of town. The only enemy here was a senior staff officer who tried to loot the FSTs jeep – he was firmly rebuffed. Further elements of an RAF Casualty Evacuation unit arrived to arrange movements of the remaining casualties. By this time only one casualty remained – so he had the choice of three aircraft. As the crews argued as to who should take him, an RN Whirlwind helicopter landed, the casualty was loaded, and away he went. Link up was not yet possible with the Marines – as firing was still continuing in the shanty town. The main Egyptian hospital was there.

Thus ended the parachute phase of Operation Musketeer. Parachute Battalion casualties were 4 killed and 36 wounded – 6% of the force. This was the equivalent of 24 hours fighting in NW Europe. The first patient with the chest injury died in BMH Nicosia 48 hours later – possibly of what we now know as adult respiratory distress syndrome. The FST stood down and loaded all its spare equipment, dressings, drugs, transfusion fluids, POP and the like onto their jeep and drove into Port Said to the main Egyptian Hospital. Rows of Egyptian wounded were still waiting to be treated. The nurses were quite formal and polite. They said the FST could not meet the medical staff as they were still at lunch. Captain Kirby asked if they should wait but the nurses indicated that the doctors would also need to rest after lunch. The FST dumped their 1/2 ton of supplies and made themselves scarce. 23 PFA went on to man a Red Crescent train under command of the 2i/c Major Peter Knight. They took 200 wounded Egyptian soldiers to El Cap where they handed them over to the International Committee of the Red Cross Relief Team.

Sunday 11th November - A decision was made to move the Parachute Brigade out. They embarked on the HM Transport Ship 'New Australia' on the 12th November and set sail for the UK. Halfway across the Mediterranean, the ship was turned around and returned to Cyprus because of continuing doubts about the take over of the Canal Zone by UN forces. It was not until the 3rd December that the Anglo-French withdrawal was formally announced and the main body of the troops were withdrawn from Port Said. This was completed on 23rd December. Nasser named this day – "Victory Day". The canal clearance operation by the joint salvage fleet was ended on 24th January 1957. On April 19th 1957, the first British ship passed through the canal. As noted by Captain Kirby at the time, this was *'The end of an Empire and a sad disarray when compared to the victories of 1944 and 1945'*.

There were some general lessons learnt by the government from the crisis. A stated need for a permanent staff organization to support close inter-service liaison led to the formation of the Ministry of Defence. Moves away from the more set piece battles of WW2 led to a realization that the Parachute Brigade and Commando Forces would need to be better supported than in the past, and that they were best suited to this expeditionary warfare. However, by the Falklands and Gulf, there was little reserve left once the fighting men had been deployed. Suez had been badly planned and organized but it had been well fought: A political disaster but a military success.

Medical Lessons Leant in 1956

It was clear that permanent FSTs had to be available at all times and that these must be able to train with their own equipment. French experience reasserted the need for parachute surgical teams to jump with their (robust) vital equipment on them. Similarly it was apparent that a permanent Field Hospital was required to be fully trained, staffed, equipped and ready to move at short notice.

Training in the principles of War Surgery, with practical experience, was clearly essential for all surgical team members. In addition, a Consultant Surgeon needed to be responsible for all surgical policy in the force. This lesson was first learnt in WW1 and then forgotten. It was re-learned during the North African Campaign in WW2 and remembered until the end of that war. It was forgotten by the Second Gulf War, and the same mistakes were made. It was also obvious that field training was needed for all ranks to enable them to live under active service conditions and that advanced first aid training was essential for Infantry soldiers.

In view of the fact that evacuation of casualties from the bridgehead during assault landing was on an ad hoc basis, it was decreed that in future helicopter evacuation should always be available and that a hospital ship with Helicopter Landing Platform should always be in the Task Force. In addition, it was concluded that there should be enough flexibility in the medical plan to allow optimum use of resources. A French Dakota landed on the airfield as soon as fighting had stopped in order to evacuate casualties. This was typical of the Parachute Battalions of the French Foreign Legion. Overall, they were far more experienced in the principles of airborne war and were thus able to take advantage of unforeseen opportunity. This short campaign also highlighted the importance of early blood administration in the management of the trauma victim.

Acknowledgements

The authors would like to thank Capt(Retd) Peter Starling RAMC, director of the RAMC Historical Museum for his invaluable assistance with the photographs in this article.