Outline of organisation of "War Surgery" 1914-1945

Many types of wounds and injuries occur, though in more recent conflicts the effects of bombs and burns (due to petrol driven vehicles) have featured in casualty lists because of their higher mortality.

Penetrating wounds by sharp weapons and bullets are easily infected via dirt and debris brought into the wound, and dead tissue. Death, if not instantaneous, may result from haemorrhage and shock, and later by infection. Loss of function by delayed healing, poor positioning or prolonged disuse may require extensive rehabilitation. Efforts are therefore concentrated not only in stopping any bleeding, counteracting shock or preventing infection, but also ensuring any damage is minimised.

Much depends on where the fighting is (the country, the climate, the season), the type of fighting, the distance from base and facilities available, but in general we can consider the following:

First Aid
Comprises pain relief and field dressing to prevent contamination. Haemorrhage must be stopped, fractures splinted and possibly Plasma given.

Field Surgery
Cases are assessed as to severity and priority:

- Those needing pre-op resuscitation and cleaning of wounds eg. abdominal injury, severe haemorrhage, severe limb injury, severe chest injury, face & neck injury and severe burns.

- Those needing urgent operation, but can wait a while.
- Those needing operation but can safely travel further back to the rear.
- Those, that if possible need a specialist centre for their priority operation eg. neck, eye, face & jaw.

Teams in specialist hospitals may comprise of Chest, Orthopaedic, Plastic and Neurological surgeons.
Evacuation may be determined by the military situation rather than the patient's condition, as well as the distances involved. An air evacuation may allow cases to be transported to a fully equipped hospital after initial resuscitation and before their priority operation.

Hospitals may be divided into advanced hospital, base hospital, and hospital in the home country, but this of course depends on where the action is taking place. Ideally hospitalisation should be provided within 24 hours of the fighting. Mechanisation and speed have altered the ways in which casualty care is organised.

Nowadays, fully equipped hospitals can be set up at bases with prefabricated units. Helicopters may be involved in evacuating the wounded.

Whereas the military had its own specialist hospitals and units, these have been disbanded and amalgamated into units such as the Queen Elizabeth Hospital, Birmingham. While the RAMC deals with the immediate care, there should then be a system of aftercare and rehabilitation, as well as any psychiatric support that might be needed for PTSD (Post Traumatic Stress Disorder).

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