Another area in which cooperation with the Base Medical Facility is important is in planning the activities of the group surgeon. We have always felt that there is ample work in the Rescue group to keep a group surgeon busy. However, in view of the desire of some group surgeons to maintain their proficiency in specialties other than aviation medicine, we have always said that the group surgeon should be permitted to engage in such hospital activities as he wishes to, as long as they do not interfere with his Rescue duties. We know that he cannot adhere to a regular schedule of hospital activities because of his flying responsibilities and the requirement that he make frequent staff visits to the squadrons of his group. In at least three of the groups presently possessing surgeons we have recently had misunderstandings with the local hospital commanders. These commanders, being used to having control over all surgeons on the base, have attempted to increase the amount of work the Rescue surgeon does in the base facility. In addition they have indicated a desire to have him accept a regularly scheduled responsibility, usually for holding sick call. Our attitude has been to support the group to the hilt in preventing compromise of the effectiveness of the surgeon to the group. However, this attitude is not shared by other major commands, and they are supported to some extent by the Surgeon General. Basically it boils down to this. If more hospital commanders indicate dissatisfaction with the amount of work they obtain from our group surgeons, and if this dissatisfaction is conveyed through major commanders to the Surgeon General, it is likely that Rescue will lose all its surgeons. They will be reassigned to the base and the base will be given the responsibility of providing aeromedical assistance to Rescue. It goes without saying that Rescue would suffer if we had to obtain such assistance from Flight Surgeons who lacked familiarity and interest in Rescue, and who were able to devote only a fraction of their time to us. Therefore, I see no alternative but to request that you try to come to a complete understanding with the hospital commander on the base where your group headquarters is located. Try to help the hospital commander understand the scope of the aeromedical job in Rescue. Inform him of the frequency of staff visits required of your surgeon. Let him see that your surgeon has a full time job. But in addition, to clinch the cooperation, let your surgeon assist in the sick call duties, particularly for Rescue personnel and their dependents. If it is necessary to have your surgeon participate in the general sick call and pull Medical Officer of the Day occasionally, then it looks as if we will have to let him do that. However, be most careful that the hospital commander realizes that Rescue duties do come first, that those duties arise at unpredictable times, and that although he retains the responsibility for what our surgeon does in his hospital, we must retain the responsibility for when he does it. The group surgeon himself is probably the best person to discuss this with and to determine if any more concessions need be made in the interests of good will. However, these concessions will probably benefit the Air Force as a whole, and should help cement good relations with the base if they are made sincerely and generously.

c. Maintain a suspense file (preferably in the operations section as they have the prime interest) on all groundings and try to have paperwork accomplished in time to reach the action headquarters prior to ninety days after the suspension was imposed. If the deadline is approaching, use airmail and request Aeronautical Orders number, paragraph, and date, by TWX, although this is normally done by ARS Headquarters. An "Expedite" slip attached to the correspondence will catch the eye of the Adjutant at any echelon and will often reduce administrative delay.

d. Use ARSR 160-1 and MR 36-1 as guides to the composition of requests for removal of suspensions. This should reduce the number of times correspondence has to be returned for corrections and additions.

e. Be certain that suspensions of ARS personnel are not confirmed by other commands. When this happens a delay is caused because only USAF or the other command can remove that suspension. This is particularly important when ARS personnel are grounded while on TDY, at schools, on extended operations or projects, or at RON points.

There are two additional steps that we have planned to assist in the prompt removal of suspensions. The first is to compile a pamphlet for the individual flyer to assist him in monitoring his suspensions. It will contain much of the information discussed above and will list all pertinent regulations, manuals, and policies. The second thing we wish to do is to obtain permission from MATS to have certain remote groups and squadrons come under the operational control commander as far as returns to flying are concerned. This will limit mail lag and will insure uniformity of review in that theater by a headquarters more familiar with the operational characteristics and the mission load of the squadrons.

Coordination With Base Medical Facilities

It is not too generally known that the Base Flight Surgeon has the prime responsibility for the vigorous prosecution of the Aircrew Effectiveness Program for all flying units on his base including active participation in the medical training of Air Rescue crews and teams. In units where there is not an active or otherwise satisfactory medical training program for the crews and rescue teams, it will often help if the Base Flight Surgeon is consulted. In discussing the problem the fact that AFR 160-69, Aircrew Effectiveness Program, lists these responsibilities can be brought out. At the same time an effective, practical medical training program can be discussed. The use of base and civilian hospital facilities for the practical training of Pararescue personnel is discussed in the new ARSM 50-1.

PARARESCUE

Physical Qualifications for Parachute Status

Most of our Pararescue teams are located at non-MATS bases where the base medical facility has no way of being familiar with MR 160-3, Physical Qualifications for Parachute Duty. It often happens that when an airman presents himself for physical examination prior to requesting parachute status, the Base Flight Surgeon proceeds to give him a Flying Class III examination. He does not realize that paragraph 135 of AFM 160-1 lists a specific physical examination for parachute duty. He does not realize that MR 160-3 directs that waiver authority for parachutists assigned to Rescue units be retained at Hq ARS. Because of this, and since the local flight surgeon is the waiver authority for airmen taking the Flying Class III examination, some of our jumpers have been qualified as physically fit for parachute duty and in some instances have been given waivers in violation of the above cited directives. It is most important that we check all physical examinations for parachute duty to see that they are conducted in accordance with the proper paragraph of AFM 160-1. Further, we must check all waivers for jumpers to insure that they are granted by Hq ARS.

New V-Slot Parachute

The latest word is that the new parachute should reach the using end of the supply pipeline by the first of the year. At that time we will attempt to convert completely to the new parachute. Since packing and using precautions are quite critical with this parachute, it is most important that they not be jumped until the jumpers are completely checked out. Since each of the ZI squadrons has received five of the handmade versions of this parachute, we have numerous jumpers in the ZI checked out already. We will assign official out-checkers to squadrons as they start to get the new parachute. We want to use instructors who have received their own instruction directly from this headquarters or from WADC, and we request that you not assign this instruction duty to a Pararescue man just because he has recently shipped in from the ZI and has had some jumps on the new parachute. We do know where the suitable instructors are, and will see that you get the services of someone who will insure safe and effective use and packing of this new parachute.

The new parachute definitely is safer to use by virtue of its decreased opening shock, its slower rate of descent, and its much slower rate of oscillation. Therefore from the jump safety point of view, it is desirable to use the new parachute exclusively as soon as enough are on hand. Two recent accidents would probably never have happened if the

new parachute had been used instead of the old E-1, and yet in both organizations in which these accidents occurred, the new parachute was available but the E-1 was being used. This was due to the natural reluctance of the parachutist to convert to the unfamiliar item after learning to depend on the other to save his life. We must combat this tendency and restrict the use of the old E-1 parachute to those instances where the new parachute is not available. In this way we can anticipate a reduced accident rate and an increased Pararescue potential.

Deletion of Aeromedics

I would like to direct your attention to the new ARSM 50-1 with respect to use of Pararescue personnel as crewmembers. Specifically this relates to participation in normal aircrew training. The new Training Manual lists the training requirements necessary to insure proficiency in performing aircrew member duties. It will be necessary for the Pararescue man to participate in aircrew training to an extent that insures proficiency in hoist operation, delivery of MA-1 Sea Rescue Kits, and the other prescribed duties. However, since he has a heavy alert schedule and extensive quarterly training requirements for ground training, Pararescue training, and field training, it will be manifestly impossible for him to participate in all aircrew training. He should participate to the extent necessary to demonstrate proficiency in his aircrew duties, but should not be required to shoot twenty successive water landings or to fly extended night navigation check rides.

Basically there will be little or no change in his job. He has always been available and frequently used for all sorts of missions in any type of aircraft. This continues except that now he is the only one available and he will get paid for it. On every rescue effort it will be necessary to depend on him to establish that final link to the survivors, whether it be by hoist, landing, raft, overland, or by parachute. His training must be so controlled that it encompasses all these varied activities, and it must not concentrate on one aspect at the neglect of another. In short, the mission can be summarized as searching for the survivors, delivering the Pararescue man to them by the most expeditious means, and then supporting and assisting him in their care and recovery.