BACKGROUND PAPER

ON

PARARESCUE: DYNAMICS AND EVENTS OF CHANGE

The USAF pararescue specialty (AFSC 1T2X1) dates back to World War II.[1] In 1943 aircrew casualties began to climb and the Army Air Forces became increasingly concerned with the need for rescue.[2] Rescue squadrons activated and dispatched to all parts of the globe. Placed under the operational control of theater commanders, units adapted themselves to particular local conditions. Distances, geographic conditions, and the frequency and type of incidents dictated the equipment and methods used.[3] One rule applied, "Rescue forces must presume survivors in each crash until proved otherwise." Thus, a unique element of aerial rescue, pararescue, perfects techniques and equipment to provide on-site medical and survival expertise.[4]

Progress of operations:

- 1922: Air evacuation system proposed; Col. Albert E. Truby (MC); predicted that "airplane ambulances" would be used in the future for purposes that included taking medical officers to the site of crashes and bringing casualties from the crash back to hospitals.[5]

  - Emergency surface vehicles and ground teams could not cover the remote and uninhabited terrain over which the plane could fly.[6]

  - It was not until W.W.II when aviation reached full combat stature that aerial rescue techniques began to be developed in earnest.[7] In addition to reflecting the concern for humanitarian values, this reflects also a hard-headed concern for a highly skilled combat team which cost much in time and effort to produce.[8]

- 1940: First para-doctor trained, Dr. Leo P. Martin, by U.S. Forest Service Parachute Training Center, Seeley Lake, Montana. Captain Leo P. Martin, USAAF, MC, was Chief Flight Surgeon at Walla Walla Army Air Base during W.W.II., and killed 25 October 1942 in a military plane crash.[9] Forest Service conducted for the following twenty-four year period rescue jumper training to physicians, medics, and other specialist of the U.S. Coast Guard and military services.[10]

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These rescue jumpers provided on-site medical care to injured smoke jumpers, survivors of crashed aircraft, and other distressed and isolated people.[11] The highly successful operations accomplished by these pioneer rescue jumpers contributed to the development of USAF pararescue teams in 1947.

- July 12, 1940, U.S. Forest Service: "Smoke jumpers" Earl Cooley and Rufus Robinson jumped then state of the art steerable parachutes and protective equipment to the site of a forest fire. Demonstrated precision parachuting techniques and methods can put fire fighters safely into roadless wilderness areas to suppress forest fires.[12]

- Smoke jumper techniques, methods, and equipment totally different from techniques, methods, and equipment used by Army airborne jumpers. Emphasized ability: to select drop zones from the air; to drop spotter chutes to help compute and correct for existing wind conditions; and to use steerable parachutes and protective equipment to hit a selected spot on the ground under any conditions.

- Clobbered Turkey Operation. This rescue operation demonstrated the importance of proper equipment, methods, and techniques. On 24 December 1947 a senior officer directed Lt Albert C. Kinney, USAAF (MC), First Sergeant Santhell O. London, and T/5 Leon J. Casey to jump to a B-29 crash site, eight crewmembers onboard, near Fairbanks Alaska. They were ill-prepared for what they encountered. The hostile environment, temperatures, -40°F to -50°F, soon claimed the lives of the three jumpers. Contributing causes for this tragedy included: lack of adequate training on how to survive in the hostile environment; survival equipment was not carried or available; flight surgeon had no jump or field experience; they jumped unaware the surface winds exceeded 30 mph; dragged by their parachutes, for miles, over the tundra. Rescue jumper equipment, procedures, and techniques would have prevented this useless loss of life. Surface rescue teams eventually rescued six survivors of the crashed B-29 and recovered Sgt London's body found 500 yards from the wreckage. The bodies of T/5 Casey, the B-29 pilot, and navigator (both crewmembers survived the crash and decided to walk out of the wilderness to get help) were later found near the wreckage. The flight surgeon's body

was found, six months later, by natives seven miles from the crash site.[13]

- 1941-45, World War II: Rescue capabilities provided by a hodgepodge of specialties assigned to various military operations.[14] i.e., surgical technicians, flight surgeons, operating surgeons, anesthetists, surgical nurses, intelligence officers, personal equipment officers, etc. The battlefield was not the primary concern. Open water and remote and isolated land areas dominated search and rescue activities. Aircrews downed behind enemy lines were virtually certain of capture or death. Some Army Air Corps and Navy aircrews used to conduct long-range rescue-escort missions incorporated with long-range bombing raids.[15] Amphibious and conventional aircraft were landed in both land and water areas to recover downed aircrews. Rescue teams parachuted into incident sites where landings could not be made.[16]

  - European Theater of Operations. The primary mission was combat and an important aspect of medical care was the care of flying personnel and combat casualties. Senior medical officers recognized need for more tactical training for medical personnel. Medical Department put enlisted men on a rigid training schedule in the care and evacuation of combat casualties. Particular attention given to the administration of plasma and oxygen, splinting of fractures, treatment of shock, control of hemorrhage, the use of numerous medical appliances, and avoiding/countering new health hazards.[17] The extremely high rate of losses among crews forced down over water created another concern. An emergency rescue unit was activated which raised the number of 8th Air Force crews saved from 1.5 percent in early 1943 to 43 percent in 1944. This concept subsequently adopted throughout the Army Air Forces.[18]

  - China Burma India (CBI) Theater of Operations. A secondary theater having vast isolated areas and a long treacherous subsidiary range of the Himalayas known by flyers as the "Hump". Rescue forces conducted long range missions using parachute qualified teams to access remote incident sites.[19] The team shepherded or carried casualties to hospitals or to areas where landing could be made for evacuation. Rescue teams consisted of medical officers, surgical technicians, and air evacuation technicians. Also, rescue jumpers onboard cargo and bombardment aircraft used to support very

long range bomber raids. Search and rescue missions were undertaken in remote regions and areas unoccupied by the Japanese.[20]

- At Chabua, in eastern India, there gradually developed an aggressive search and rescue program intended to save the men who crashed or bailed out over mountains or jungle.[21] Under the leadership of Captain John L. ("Blackie") Porter and Lt Col Don Flickenger specialized search and rescue proved to be both ingenious and effective.[22] Teams—composed of medical and survival specialists—would be transported to the landing strip nearest the crash site, or parachute to a suitable clearing, would proceed overland into the jungle and recover downed airmen.[23] Likewise, aircraft were used to remove the teams and survivors after completion of the mission. After a very successful series of rescues, Porter was killed on 10 December 1943 when his B-25 and another rescue plane were lost to enemy action.

- Lt Col Don Flickinger, Wing Flight Surgeon, Sergeant Harold Passey, Combat Surgical Technician, and Corporal William MacKenzie, Combat Surgical Technician, parachute to the assistance of the crew and passengers (twenty men in all, including Eric Sevareid, CBS commentator) who had abandoned a disabled C-46 on 2 August 1943 over the much-feared Naga country in northern Burma.[24] Although pararescue teams were not officially authorized and trained until July 1947, U.S. Air Force pararescuemen consider this mission to be the birth of pararescue.[25]

- Pacific Theater of Operations. Primitive conditions and island warfare such that the Air Force assault mission was to establish airfields from which missions could be launched. For flying personnel, weather conditions (clouds, fog, ice) were more destructive than Japanese fighter aircraft. If forced to land or bail out, death from exposure was a very real danger. The Army Air Forces' recognized the need for self-sufficient rescue units early in the war and by August 1943 programmed for the creation of seven emergency (ER) squadrons.[26] One ER squadron saved 300 men from death or capture during the first six months of its operations.[27]

- Besides saving lives on the sea, the emergency rescue air squadrons and boat crews were often called upon for land search rescue. Friendly natives often hid Allied pilots and managed to convey word of their presence to the nearest AAF forces. Evacuation by air or boat was then arranged.[28]

- North Africa and Mediterranean Theater of Operations. Rescue operations and missions impromptu and improvised as required by the situation.

- Although activities in the combat theaters dominated global rescue operations, rescue needs in other isolated land areas received increasing attention as the war dragged on. Airlift and deploying combat aircraft flew north through Canada and Alaska, others flew through South America, across the Atlantic into Africa and then into CBI, Mediterranean, or European theaters of operation. By 1945 air rescue had improved to the point where chances of rescue were good, given adequate planning and advantageous positioning of the forces.[29]

- 29 May 1946: The Air Rescue Service (ARS) officially organized to achieve world-wide unification of the U.S. Army Air Force's aerial rescue operations and to develop and perfect rescue techniques and equipment.[30]

  - Global search and rescue concept oriented to saving the lives of Air Force crews who may be involved in: aircraft disasters, accidents, crash landings, ditching, or abandonment which occur away from an air base. In addition to these everyday missions of rescue and evacuation, units will be ready to deploy to any area of the world in support of air operations.[31]

  - Air base commanders maintained jurisdiction for local area crash-rescue and controlled all functions equipped for these purposes. Local Base Rescue (LBR) helicopter operations established at some locations. Limited by technology of the era to 135-mile travel radius with limited lift capabilities (about four people including pilot and copilot).[32]

  - Rescue jumper concept oriented to maintaining capabilities compatible with the mission of long-range transports and bombers; to rendering medical and survival expertise to

aircrews and other personnel on front lines and in territory behind the battle line; and to providing service for other agencies and activities when aerial rescue assistance is requested.[33] These parachutists formed the nucleus of instructor personnel in the Pararescue and Survival School conducted by the 5th Rescue Squadron, MacDill AFB, Florida, shortly after pararescue teams authorized in July 1947.[34]

- September 18, 1947: The U.S. Air Force became an independent service with a status coequal with the Army and Navy.[35]

  - 1 July 1947: Pararescue[36] teams authorized and established and first teams ready for field assignment in November 1947. Teams composed of a para-doctor and four pararescue technicians; cross-trained in medical, rescue and survival, and tactical procedures.[37] Medical Service Corps (MSC) officers replaced para-doctors, Medical Corps (MC) officers in short supply, as members of pararescue teams in 1949.[38] General Dubose issued a directive, 2 October 1952, removing Medical Corps officers from jump duties and prohibited MCs from participating in actual pararescue activities of any nature. Medical Service Corps officers deleted from pararescue teams in November 1952. MSC officers participated in pararescue activities with some teams until 1960.[39] Master Sergeants, experienced pararescuemen in all cases, attend Medical Service Supervisors Course at Gunter AFB (19 weeks) and assigned duties of pararescue team commanders as MSC officers are phased out of the teams in 1953.[40]

  - Pararescue military occupation specialty, MOS 3383, Rescue Survival Specialty, approved (1948). Changed to: AFSC 921X0, Rescue Survival Specialty (ca. 1957); AFSC 923X0, Para-Rescue/Recovery Specialty (1967); AFSC 115X0, Pararescue/Recovery Specialty (1975); and AFSC 1T2X1 Pararescue/Recovery Specialty (1993). Occupation established as part of the Aircrew Protection Specialty Codes on 31 October 1953 by AFR 35-492.[41] Pararescue AFSC and positions are not aligned under or utilized within the Air Force medical service.[42]

  - Pararescue teams assigned to each Air Rescue Service squadron to give global coverage. Teams equipped and trained to jump to the aid of crashed airman in areas inaccessible by other means.[43]

- The Air Rescue Service (ARS) assumed responsibility of continuing pararescue training in order to meet world wide Air Force requirements. Alignment of all Air Rescue Squadrons under ARS begins in June 1948 and ends on July 1, 1950. Does not include Local Base Rescue (LBR) units which remain under the jurisdiction of the air base commanders.[44]

- Formal rescue concept established: Wartime rescue operations will be dictated by the capabilities of equipment used for peacetime SAR, and will be conducted in accordance with JANAF [Joint Army, Navy, Air Force] and Standard Wartime SAR procedures.[45]

- 1950-52, Korean War: Battlefield was the primary concern and offered the first test for search and rescue organizational tactics developed after World War II. Rescue concept, for the first time as a standard procedure, included the rescue of stranded personnel from behind enemy lines. Air Rescue assigned mission of rescuing pilots and other UN personnel from behind the enemy lines and evacuating critically wounded men from front line first aid stations to mobile army surgical hospitals in the rear. Rescue aircraft made history landing in remote areas inside enemy territory to retrieve downed pilots. Air-rescue crews saved 170, or ten percent, of the USAF airmen who were lost in action over enemy territory. Air-rescue crews, in fulfillment of all missions: rescued 996 men from enemy territory; rescued 86 men from within friendly lines; and evacuated a total of 8,598 men, most of whom were front-line ground casualties.[46]

  - On the front and in enemy territory pararescuemen flew on air rescue aircraft to render emergency medical treatment to the injured. They were the preferred medical aircrew members for fixed- and rotary-wing aircraft undertaking rescue and front line air-evacuation of front-line casualties to mobile army surgical hospitals.[47]

  - Pararescuemen often required to make extended excursions from the helicopters in enemy territory to recover downed pilots. Excursions frequently required a surface stay of 24 to 48 hours with 2 to 3 miles of overland travel.[48]

    - Longest known, Lone Wolf, excursion lasted 72 hours in enemy territory.[49]

- Medical service personnel forbidden to get off the helicopters when survivor's location or condition precluded effective utilization of such aircraft. Only pararescue employed from the helicopter, as long as chance of reaching the survivor existed, to continue the mission and physically control the fate of the survivor.[50]

- Pararescue provided combat medical coverage for at least one airborne operation needed for combat operations at Suwon and Seoul. A three man pararescue element inserted as part of a reception party, 24 September 1950, on the Munsan-ni drop zone prior to the airdrop of 3,500 paratroopers, 187 Airborne Regimental Combat Team (RCT).[51]

- Dateline, Korea, 12 October 1950: While Communist slugs snapped past his head; a pararescueman, Captain John C. Shumate, USAF, MSC, exited a rescue helicopter; ran to a downed aircraft; lifted a critically injured pilot out of his plane; and carried him to the helicopter. As the helicopter took off, Shumate, went to work on the badly hurt pilot administering blood plasma and rendering life saving medical treatment. Thus, this was first known transfusion given during a helicopter evacuation.[52]

- 16 April 1954: Two pararescuemen, TSgt Elliott Holder and SSgt Robert Christiansen, jumped to the crash site of a Navy patrol bomber high on the Polar Ice Cap, far above the Arctic Circle. They landed in high winds and traveled more than a mile over treacherous ice ridges to the crash. A storm with temperatures below zero and winds, oftentimes exceeding 100 knots, howled around them for eleven days. On the 12th day, the storm abated and they and the bodies (all aboard the bomber died upon impact) were lifted from the crash site by helicopter.[53]

- Previously, no expert considered military operations in the Arctic practical or even possible on any significant scale because of the extreme cold, high winds, and difficult terrain. This and other ice-cap rescue jumps proved conclusively that with proper expertise, minimal equipment, and a few "guts," troops can survive and operate for significant periods of time under the worst of arctic conditions.[54]

- 1956: Although ARS was unable to maintain an accurate count of lives saved by its units, their estimate concludes that over 4,078 people had been found and rescued from certain death.[55] The mission of ARS is to provide a professional rescue force, specially trained and equipped to support global air operations. The ARS also will: maintain all squadrons in a state of readiness to deploy in support of USAF air operations; participate in joint SAR operations in accordance with AFM 1-1 and National SAR plan; and assist in retrieving and safeguarding hazardous cargoes (special weapons) in accordance with AFR 55-14.[56]

  - "Constituting an elite corps within the Air Rescue Service are the Paramedics.[57] They are a breed apart and certainly among the best trained men in the armed forces today. Precision parachutists, highly trained medics, expert on survival under any earthly conditions, these men will jump anywhere anytime a possibility exists that there is a life to be saved."[58]

  - "Tough and courageous, these men form an elite corps within Rescue and if a man is alive when they get him, he couldn't be in better hands. Doctors who have seen paramedics in action claim that, to do more than these men can do, you'd have to parachute in a whole hospital."[59]

  - Rescue activities in the Korean war and other missions proved pararescuemen to be the best qualified to establish that final link to the survivor, whether it be by hoist, landing, raft, overland, or by parachute. Pararescue personnel validated as aircrew members and jumpers on all ARS aircraft. Consequently the ARS commander removed Aero-medical personnel from aircrew status on rescue aircraft in 1956.[60]

- 1961-75, Southeast Asia: The fighting actually involved several wars, each interrelated conflict posed different problems in rescuing and recovering aircrews shot down in enemy territory. The leadership at Air Rescue Service was not convinced that it had a legitimate wartime rescue mission consequently planners had not planned for war. By late 1962 and early 1963 it was evident that combat rescues required more than a crew, a helicopter, and good intentions.[61] The air-rescue crews gave each mission all they had and successfully,

in Southeast Asia, saved 3,883 human beings from death, suffering, or captivity.[62]

- 1960: ARS had very few helicopters. Acquisition of local base rescue functions provided Air Rescue Service some additional helicopters, but these HH-43 "Huskies" were primarily used in fire-fighting and picking up pilots who had bailed out in close proximity to an air base.[63]

- 1961: The rescue vehicles in the Air Rescue Service inventory were ill-suited for extended search and rescue in jungles and mountains.[64]

- By late 1961: A local base rescue unit was stationed at every major AF installation in the world. The HH-43B was limited to a relatively small radius of action that varied between 125 to 140 nautical miles. Five man pararescue teams provided both firefighter and medical support at the Bien Hoa and Da Nang units. Other local Base Rescue activities utilized firefighter and medical technician personnel to perform local area recoveries from non hostile areas.[65] Air rescue helicopter capabilities did not significantly increase until 1967.[66]

- By 1964 the pararescueman was the most admired man on the rescue team for several reasons: The pararescueman was always the first friendly face seen by the flier downed in enemy territory; It was the pararescueman who was lowered by forest-penetrator to retrieve the survivor; It was the pararescueman who would parachute into the water if survivors were unable to reach or use the rescue kit airdropped to them; It was the pararescueman who rendered life saving medical treatment, if the survivor was injured; and on the occasions when not all could be transported, it was the pararescueman who stayed behind.[67]

- September 30, 1967: The HU-16 Albatross completed its last amphibious recovery and is replaced by the HH-3E helicopter, which was capable of landing on the water. In the five years of service, in SEA, Albatrosses picked up twenty-six (26) USAF and twenty-one (21) Navy aircrew members. These recoveries were some of the most dangerous rescue missions of the war.[68]

- A1C James E. Pleiman was the first pararescue KIA which occurred during a rescue mission in the Gulf of Tonkin, 14 March 1966. The HU-16 Pleiman was on had landed in the water to pick up two downed pilots and was hit by shore batteries. Pleiman was one of two crewmembers lost. His remains were repatriated, positively identified, and buried with full military honors in March 1989.[69]

- Improving combat skills: To increase effectiveness and chances for survival, pararescuemen: attend the U.S. Army Special Forces School at Nha Trang RVN for instruction on how to operate deep within the enemy's sphere of influence without detection; and enhanced their medical skills by performing duties in emergency and surgery departments at major in theater medical facilities.[70]

- Pararescue recognized as Air Force's primary asset rendering life saving emergency medical services for the Air Force in hostile, denied, or sensitive environments.[71] In addition, to the rescue and recovery of downed crewmembers, they were frequently tasked to assist the air evacuation of the critically wounded from outlying areas. An extremely hazardous aspect of this air evacuation responsibility was the hoist extraction of dead or wounded combat ground forces from a remote battle area.[72]

  - A1C William H. Pitsenbarger, a pararescueman, was awarded the Air Force Cross posthumously for his actions during an air evacuation mission. He was killed 11 April 1966 while aiding an encircled Army platoon. He was the first enlisted man to receive the Air Force's highest decoration since it was established in 1960.[73]

  - Pararescuemen earned ten (10) of the twenty (20) Air Force Crosses awarded to enlisted men during the SEA conflicts.[74]

- 1976: Tactical Enhancements; HQ Air Rescue and Recovery Service convenes a pararescue combat readiness conference to plot a future course action for pararescue. Strategic tasks and missions committed to combat rescue associated with contingency operations and war.[75]

- ARRS Commander approved recommendation to regenerate combat skills de-emphasized by pararescue role as an aircrew gunner-scanner acquired during operations in Southeast Asia.[76]

- ARRS Commander, approved recommendation for tactical enhancement of pararescue's ability to perform extended surface operations. "Proposed enhancement: the pararescue team will be employed by any clandestine means available, surface movement will be made to the designated area, the downed crewmember(s) located, and surface movement to a safe area for pickup."[77]

- 10 May 1983: HQ 23rd Air Force (MAC) activated. Consolidates Air Force's special operations and combat rescue forces to facilitate their efficient employment. Merger results in significant increase in fitness of capabilities provided to combatant commanders. Pararescue role defined to provide a capability to augment aerial SAR operations, to conduct surface SAR operations, to manage multiple-casualty situations, and to support time-sensitive crisis response operations.[78]

  - Pararescue received new vitality. Focus of capabilities realigned to emphasize combat medical skills and operations in adverse areas and conditions.[79] Allowed pararescue to operate either on the aircraft or get off the aircraft in an extended role to conduct ground search and recovery of isolated personnel, during war and operations other than war. Pararescue forces demonstrated during exercises and real world situations the ability to employ limited and extended surface tactics for the rescue and recovery of pilots downed in enemy territory.[80]

  - Pararescue described as the cutting edge of the rescue tool: Major Force Plan 11 provided badly needed facilities and increased O&M funding; acquisition of new technology and equipment supported; and development and improvement of training programs encouraged.[81]

- January 1984: Pararescue force integrated with Special Tactics Teams. Unique combination of Combat Control and Pararescue Forces (Det 4, 23AFCOS, Pope AFB NC) established a force with the attributes and operational capabilities relating directly

to an assigned task and mission that cannot be otherwise performed.

- Pararescue role expanded to support joint operations and military priorities in low-intensity conflict. Provides aerial SAR operations, conduct surface SAR operations, manage multiple casualty and mass triage situations, and coordinate aeromedical evacuation in support of special tactics activities. Emphasis toward operating for extended periods to provide "far forward" emergency medical services.[82]

- Begins evolutionary requirement for pararescue in all special tactics teams.

- 24 July 1987 to 31 October 1990: 1730 Pararescue Squadron (PRS), Activated.[83] The sole active-duty rescue function to provide full-time air and surface rescue capabilities to support U.S. Air Force operations during Just Cause and Desert Shield. HQ ARS deactivated unit while most of its forces were deployed in support of Southwest Asia combat operations. However, the former 1730 PRS pararescue teams remained in place and continued to render rescue and recovery services for the duration of the war.[84]

  - Availability and capability of dedicated Air Force CSAR aircraft limited. Situation required tasking pararescue capability separate from dedicated rescue-coded aircraft in order to accomplish air rescue objectives. Pararescue teams accomplish combat and humanitarian missions from any available DOD aircraft, i.e., Air Force C-141s, C-130s; Coast Guard and U.S. Marine C-130s and helicopters; and Army and Navy helicopters.[85]

  - Pararescue Unit Type Codes (UTCs) developed and approved. Facilitated tasking pararescue forces to perform rescue and recovery operations from any combat-coded aircraft capable of employing pararescue.[86]

  - The 1730th PRS merited the Air Force Outstanding Unit Award[87] on 15 November 1989. The accompanying citation[88] to the award identifies that this pararescue squadron and its nine separately located units distinguished itself by exceptionally meritorious service from 1 August 1987 to 31 July 1989.

- 1 August 1989: Air Rescue Service re-established. Air Rescue aircraft ill-suited for deep penetration into enemy airspace.[89] Rescue planning focused on helicopter recovery of the uninjured pilot. Planning ignored demands: to provide medical transportation of the sick and injured; to treat casualties in-flight and for prolonged periods; and the need for "someone" to extend beyond the confines of machinery to adapt themselves to the physical conditions of the incident area to provide on-site assistance.[90]

  - USAF Pararescue Force structure and mission split. One group of pararescuemen remain assigned to AFSOC to support special operations, the remaining pararescuemen assigned to air rescue squadrons.

  - AFSOC advocates pararescue role as combatant that renders emergency medical services on the battlefield. AFSOC primary provider for rescue and recovery of isolated personnel in far forward hostile, or denied territory. Pararescue continues to be the singular occupational specialty committed to rescuing human lives.[91]

  - Combat rescue advocates pararescue role of helicopter gunner-scanner providing: minimal medical services; limited individual combat skills; limited flexibility to support joint operations; and limited ability to gain access and remove the injured from the battlefield. Concept lacks redress for changes in the post Cold War mission of the military services.[92]

- January 1993: Air Rescue Service deactivated; Air Combat Command lead agency and proponent for Air Rescue doctrine, policy, tactics, procedures, and acquisitions. Service authority and air rescue squadrons assigned to several MAJCOMs.

  - Pararescue specialty now influenced by management and administrative decisions in several commands.

  - Combat air forces severely limit pararescue role and capabilities. Administrative and management infrastructure disruptive because senior officers lack knowledge of how pararescue capabilities support the combat mission.[93]

- 9 May 1993, Southwest Asia (SWA) area of operations: Draft Concept of Operations, Pararescue Fixed Wing Tactical Operations demonstrated and validated by a rescue mission accomplished by pararescuemen assigned to the 4404CW (P), 4411RQS (P).

  - Six pararescuemen did a night tactical jump at 800 feet AGL from a HC-130 aircraft. An ELT emission as the only ground reference, the team jumped using computed air release point procedures to an unmarked drop zone. Their objective is a Saudi single seat fighter (Tornado) and its pilot that crashed hours earlier. The team moved in tactical formation using a global positioning system (GPS) navigational aid to establish a search pattern. After searching for thirty minutes, they arrived at the crash site, located 200 meters from the drop zone. Unfortunately, the pilot died upon impact. Extraction executed by surface vehicles, vectored to the crash site by electronic means and visual signal.

- 3 October 1993 to 4 October 1993: United Nations Operations—Somalia, Joint Service CSAR specialty team. In connection with military operations against an opposing armed force in Mogadishu, Somalia, 24th Special Tactics Squadron pararescuemen were directed, to a situation where an assault helicopter had been downed in a congested urban area. After fast roping from a helicopter and assaulting through heavy enemy small arms fire from three directions, the pararescuemen established a casualty collection point and made their way to the wreckage to conduct an assessment, provide emergency medical treatment to the survivors, and to extract all on board. While freeing these survivors, a pararescueman was wounded and sent to the ground. Ignoring the traumatic effects of the gunshot wound, he treated his own wound, and moved back to the casualty collection point and continued to triage and treat the survivors of the crash. At this time a Ranger element 45 meters from their location was engaged and were suffering casualties in an intense fire fight. A pararescueman, on his own initiative, broke cover and ran through a thick barrage of small arms fire, shrapnel, and RPGs to reach the Ranger position. Once there, he pulled the wounded one by one into the safety of a covered position and began immediate medical treatment of the seriously wounded Rangers. For eighteen hours these pararescuemen rendered emergency medical services to the wounded and repeatedly took

up security positions and returned fire to suppress enemy forces.[94]

- Air Force Cross awarded to TSgt Timothy A. Wilkinson, Pararescue Technician, the first to be awarded to an enlisted man since the SEA conflict twenty years ago.

- Silver Star and Purple Heart awarded to MSgt Scott C. Fales, Pararescue Technician.

Progress of Training:

- 1941-45, World War II: Pararescue training obtained on-the-job. No formal training provided by any military service. Previous attempts to justify service school disapproved by the commanding officer, U.S. Army Air Forces School of Applied Tactics, Orlando, Florida.[95]

  - U.S. Forest Service Parachute Training Center, Seeley Lake Montana, provided advanced parachute training to meet the military services' requirement for rescue jumpers. Principal participants: U.S. Army Air Forces; U.S. Coast Guard; and Canadian Air Observer Schools.[96]

  - In unit training based upon trial and error and on-the-job experiences born of necessity.

  - Late 1943: On-going air combat experiences result in new training programs. Principal techniques taught: modes of entry into isolated locations; overland travel and navigation; administration of medical aid; and providing facilities for survival and eventual rescue of distressed personnel. Enlisted personnel required to have served in their military occupational specialty for six (6) months or more, and to meet the physical requirements of class three, WD, AGO Form 64.[97]

  - Air evacuation medical technicians (enlisted) recruited from medical installations to undergo a basic three-week course in the elements of field work, first aid, camouflage, and other subjects necessary to the medical soldier.[98]

  - Surgical technicians (enlisted) given their practical medical work for latter application in air evacuation. Instruction included: the elements of nursing care,

intravenous techniques, catherization, oxygen administration, and other emergency procedures. Surgical technician also given a didactic course in emergency medical treatment, conversion of a cargo plane into an ambulance plane, loading of patients, and use of equipment.[99]

- Medical technicians (enlisted) placed in training programs including medical subjects, field subjects and air evacuation subjects.[100]

- Rescue jumpers attended advanced parachute training provided by U.S. Forest Service Parachute Training Center, Seeley Lake, Montana.[101]

- Tactical combat and survival training proved unsatisfactory as no system was established whereby students could be moved to and from the different schools.[102] Preparation for rescue duties remained the responsibility of the line unit.

- 29 May 1946: The Air Rescue Service officially organized to achieve world-wide unification of aerial rescue operations. HQ ARS authorized and constituted pararescue teams during the opening months of 1947.[103]

  - Every enlisted pararescueman received formal training as technicians medical (409) and technicians surgical (861).[104] Each learned the form of communicating assessments by radio to a physician and for receiving a physician's recommended measures.[105]

  - All Pararescue team members trained in both survival and para-rescue techniques.[106] Advanced parachute training obtained from U.S. Forest Service. Smoke Jumpers provided training and facilities.[107]

  - The 2156th Air Rescue Unit, Technical Training Unit (TTU), MacDill AFB FL, organized and developed the Pararescue and Survival School. Recruited and trained "experienced" enlisted medics (combat surgical technicians, preferred) and Medical Service Corps officers from any and all military services. Lt Perry C. Emmons, an Office of Strategic Service (OSS) pilot during World War II who had, along with his six flying sergeants, flown prisoners of war out of Thailand and earned the nickname "Perry and the Pirates," assigned as the school's first Commandant. Upon his

graduation from Ft. Benning Airborne School, 1948, Lt. Emmons became one of only two USAF pilots who held a parachutist rating.[108]

- Para-doctors signify their intentions to separate from service.[109] Medical Service Corps Officers assume role of para-doctor on teams. Medical Service Corps officers given same training and qualifications as enlisted pararescue team members. The rescue medical hero of heroes in the Korean zone, Lt Col (Ret.) John C. Shumate, USAF, MSC, (a pharmacist) was among the first. In 1949 he [Shumate] became Commandant, Pararescue and Survival School.[110]

- Air Rescue Specialist Course developed and organized at the School of Aviation Medicine, Gunter AFB, Alabama. Provided pararescuemen the medical skills to determine the nature and extent of most serious and complex injuries and to administer the proper treatment. Instructors selected from Medical Corps officers having pararescue team experience, i.e., Dr. Pope B. Holliday, Dr. Rufus Hessberg, Dr. Hamilton Blackshear, Dr. Randal W. Briggs, and Dr. Burt Rowen.

- 1950/51: The pararescue and survival specialty training programs provided by the 2156th Air Rescue Squadron (TTU), MacDill AFB, Florida established as an approved Air Force school.[111]

  - Opened USAF pararescue specialty to recruits straight from basic military training. Prerequisites: Rescue and Survival Technician-Medical course, School of Aviation Medicine, Gunter AFB Alabama,[112] and Army Airborne qualification.[113]

  - Overall curriculum contained courses relevant to: land rescue; precision spot-parachuting techniques; evacuation of injured or distressed personnel; emergency medical procedures and administration of emergency medicine; survival (Arctic, desert, and jungle); special vehicle operation; land navigation; native psychology; mountain climbing; advanced swimming techniques; communications; aerial delivery of equipment and supplies.[114]

  - Medical procedures taught above and beyond those practiced by medical professions other than the licensed physician. Studies provided in emergency medicine, preventive medicine, dentistry, chemical and biological warfare, radiological

decontamination, and surgery: Each subjects of pre-hospital care provided by pararescuemen in the field.[115]

- Advanced parachute training provided by pararescue instructors on-site (TDY) at U.S. Forest Service smoke jumper training site.

- Design operation capability (DOC) statement included: producing operational pararescue and land rescue team members and personnel well trained in survival techniques, emergency medical procedures, and briefing procedures; performing research in survival and rescue equipment and procedures; and making recommendations pertaining to new survival and rescue techniques.[116]

- Strengthened USAF pararescue specialty link in aircrew protection career ladder versus medical services.

- 1961-75, Southeast Asia period: HQ ARRS discovered major deficiencies in pararescue medical knowledge and skills. Insufficient entry level medical training proved to be significant contributing factor. Increased tempo of mission activities in SEA hindered ability to upgrade apprentice pararescuemen to mission ready medical proficiency in unit.[117]

  - January 1965: HQ ARRS re-established a medical officer authorization on its staff to restore some of the degree of professional medical supervision for the medical training and mission of pararescue. HQ ARRS surgeon determined pararescue's medical parameters and implemented new programs to improve deficient war-fighting medical capabilities.[118]

    - Pararescue's preparedness to deal with life-threatening emergencies had deteriorated through neglect and lack of physician oversight during the past five years. Since 1960, rescue commanders consulted medical corps physicians at the local medical facilities and depended upon their interest to keep pararescue proficient in field and emergency medicine. Most USAF health care providers understood poorly the independent field and emergency medicine practiced by pararescue. Thus, as the volume of life-threatening emergencies increased dramatically in the SEA areas of operation, it revealed enormous deficiencies in pararescue training.[119]

- The extent and purpose of the independent field and emergency medicine provided by pararescue is unfamiliar to most health care professionals. The nature of pararescue operations in SEA dictated pararescuemen master a variety of complex medical skills that can be very hazardous if performed by persons poorly trained in their use. Therefore, administrative physician oversight established to ensure pararescuemen are the highest-trained pre hospital medical providers in the USAF.[120]

- March 1968: Air Force validated and approved The Office of the Staff Surgeon, ARRS. Provided the necessary supervisory direction for medical technician and pararescue personnel supporting both combat and non combat missions.[121] Validated authorizations include: position of Staff Surgeon, Lt Col, AFSC P93560; Pararescue Medical Training Branch, SMSgt; AFSC A92390; Chief, Aeromedical Branch, MSgt, AFSC A90170.[122]

  - Senior pararescue NCO position established and provided primary interface between line units and ARRS staff surgeon. Managed pararescue training programs ensuring directive compliance and proper mission accomplishment. Evaluated and advised staff surgeon of issues concerning field and emergency medicine and hazardous materials.[123]

- Enhanced emergency medical course established at the ARRS pararescue school. Curriculum emphasizing life sustaining emergency procedures and initial care of the severely injured. An anesthetist flight nurse, AFSC 9756, position is established at the school to provide on-site oversight for all medical training. An administrative assistant, AFSC 90650; and two pararescue (instructor) positions established to support medical training activities.[124]

- January 1968: The emergency medical treatment training animal laboratory became an operational reality. This laboratory serves to provide several levels of instruction and proficiency development. It provides the confidence and skill necessary to meet the medical treatment responsibilities inherent in any combat rescue and recovery mission.[125]

- School of Aviation Medicine, Rescue and Survival Technician-Medical, ALR 92170-1, enhanced, provided instruction in all areas of field medicine. Curriculum emphasized knowledge

and skills needed for independent field operations. Provided knowledge and skill levels needed to attend emergency medical course provided by the pararescue school.[126]

- Several civilian emergency medical services (EMS) systems adapted ARRS pararescue medical manuals and training programs for their use, i.e., California, Ohio, Alabama. Concurrently, they requested and obtained on several occasions the ARRS surgeon and pararescuemen to facilitate the development of their pre-hospital emergency care programs. These actions reflected creditably on the quality and standard of medicine rendered by pararescuemen.[127]

- September 1975: Pararescue Recovery Specialist Course-Medical, School of Health Care Sciences 3AZR92330 is discontinued. All medical instruction, qualification, and certification is provided by the Pararescue School, operated by the Military Airlift Command.

  - The Pararescue School officially sanctioned, December 1981, by the State of New Mexico as a certifying school for paramedics.[128]

- CY 1988: Pararescue School curriculum separated into six AFCAT 36-2223 courses: medical operations; advanced casualty care; aerial operations; field operations; team leader; and advanced tactics. Courses opened to DOD occupations needing the training provided at the pararescue school., i.e., Marine Recon, Navy Seals, and Army Rangers. Allowed experts from other military occupational specialties to be assigned as instructors.

- October 1989: HQ MAC established physician position, Director of Pararescue Medicine-AFSC 9356, at the pararescue school. Provided professional medical supervision for all USAF pararescue medical qualifications, procedures, and equipment. Reported direct to HQ MAC/SG concerning level of training, medical procedures, certification issues, and effective use of pararescue to render emergency medical care.[129]

  - Position location and responsibilities dictated by recent USAF forces alignments: Air Force Special Operations Command, established; HQ Air Rescue Service, without control of the pararescue school, reestablished; and HQ MAC (later

renamed HQ AMC) controlling and managing headquarters for the USAF pararescue program. HQ MAC also controlling and managing headquarters for the USAF pararescue school and training pipeline.[130]

- CY 1993: Major realignments of Air Force Structure; HQ Air Education Training Command gains responsibility for pararescue school, 542 TCHTS/TTJ, Kirtland AFB, New Mexico.

  - Conducts core training required for qualification in USAF Pararescue Specialty. Individuals awarded specialty are assigned to line units having a combat rescue or Special Operations mission.

  - Produces trained personnel well qualified to render emergency medical services in sensitive, denied, and hostile locations with the ability to conduct operations in any climate, terrain, or land and water environment, day and night.

  - Curriculum development continually revised. Goal is to train new, novice, and experienced pararescuemen to be globally deployable from an emergency medical and tactical combat skills standpoint. Emphasis is on capabilities needed to retrieve downed-airmen from the battlefield.

    - June 1989. Quads, motorcycles, and special vehicle operations added to advanced tactics course.

    - June 1989. Satellite Communications (SATCOM) added to team leader course.

    - June 1992. Emergency Medical Technician-Intermediate (EMT-I) certification, National Registry of Emergency Medical Technicians, established as a requirement needed to receive medical course completion documents.

    - June 1992. Advanced weapons course established. Focus is night optical devices and foreign weapons. Increased courses conducted at pararescue school to seven.

    - June 1993. Global Positioning System (GPS) uses and methods added to field operations course.

- January 1994. Emergency Medical Technician-Paramedic (EMT-P) certification, National Registry of Emergency Medical Technicians, established as a requirement needed to receive medical course completion documents.

- January 1994. Rigged Alternate Method Zodiac (RAMZ) added to aerial operations course (12 days). Students instructed in procedures and methods for air dropping motorized zodiac boats to perform rescue and recoveries at sea.

- Pararescue provides unique capabilities essential to battlefield rescue and front line evacuation. No other military profession trained to survive under any earthly conditions with the ability to render life saving pre-hospital medical care, anytime-anywhere. Capabilities critical to successful air rescue operations in times of peace or combat.[131]

Progress of Laws of armed conflict:[132]

- International laws of armed conflict is binding on all nations and their armed forces, it can usually be changed only by an international agreement.[133]

  - Most law of armed conflict applies only to conflicts between nations.[134]

  - Hostilities with terrorist groups are not governed by law of armed conflict, since these groups are not nations.[135]

  - Military operations other than war are not exempt from the requirement to comply with domestic and international law. In this regard the judge advocate should review all aspects of the operation. For example, the medical annex to an exercise plan may not address the legal issue of introducing narcotic medications into an allied country.[136]

- The 1949 Geneva Conventions: Experience in World War II demonstrated a need relevant to the status of medical personnel and aircraft attached to the armed forces. This international agreement establishes the special status of medical personnel and medical aircraft, if they are exclusively engaged in medical operations during an armed conflict.

- Medical aircraft are not permitted to fly over territory controlled by the enemy, without the enemy's prior agreement, medical aircraft must comply with requests to land for inspection, and must be clearly be marked with the red cross or other comparable, internationally recognized symbols.[137]

- Hospitals, medical personnel, ambulances, hospital ships, and other medical activities lose their special status under the Geneva Conventions if they commit, or are used to commit, acts harmful to the enemy outside their humanitarian functions.[138]

- Medical personnel are permitted to carry arms solely to protect themselves and their patients against unlawful attack.[139]

- The rescue of military airman downed on land is a <u>combatant activity</u> that is not protected under international law. Note, however, that care of the wounded on land, and the rescue of persons downed at sea or shipwrecked, are protected activities under international law.[140]

- Combatants: A person who engages in hostile acts in an armed conflict on behalf of a party of the conflict. A lawful combatant is one authorized by competent authority of a party to engage directly in armed conflict.[141]

- Unlawful Combatants: An individual who is not authorized to take direct part in hostilities but does. The term is frequently used to refer to otherwise privileged combatants who do not comply with requirements as to mode of dress, or noncombatants in the armed forces who improperly use their protected status to engage in hostilities. It is a term used to describe only their lack of standing to engage in hostilities, not whether a violation of the law of armed conflict occurred or criminal responsibility accrued.[142]

- Noncombatant Military: Members of the armed forces classified as noncombatants because of their status as medical personnel, chaplains, or personnel employed in specific medical functions. Specific protections and restrictions are prescribed for these individuals in the 1949 Geneva Conventions.[143]

- USAF permanent medical personnel include all personnel assigned to the USAF Medical Service.[144]

- 12 August 1949, Article 24, Geneva Conventions-WS: Defines categories and functions of personnel assigned to and exclusively engaged by the Medical Service of the armed forces considered to be medical personnel proper and noncombatant military. Two separate categories identified: The doctors, surgeons, dentists, chemists, orderlies, nurses, stretcher-bearers, etc., who give direct care to the wounded and sick; and the administrative staff who look after the administration of medical units and establishments, without being directly concerned in the treatment of the wounded and sick. They include office staff, ambulance drivers, cooks, cleaners, etc.[145]

  - The distinguishing feature of medical personnel properly so-called, i.e., permanent staff, is that they are employed exclusively on medical duties.[146]

  - Permanent medical personnel[147] cannot directly engage in hostilities themselves; if they do, they commit serious violations of the law of armed conflict.[148]

  - For effective protection personnel should wear an armlet bearing the red cross and carry a special identity card stamped by military authority.[149]

  - Permanent medical personnel, if captured, are retained. A status having different values and shades of meaning attached to it compared to other military personnel who, if captured, are prisoners of war (PW).[150]

- 12 August 1949, Article 25, Geneva Conventions-WS: Prescribes a special military category, <u>Auxiliary Medical Personnel of the Armed Forces</u>. Such auxiliary medical personnel must: be actual members of the armed forces and cannot belong to a Red Cross Society or other relief society; have received medical training and they are, when necessary, used by their officers to search for or look after the wounded; and, for the remainder of their time assigned to and utilized to perform other military duties.[151]

  - This category, which has not been very numerous in practice, generally refers to auxiliary: stretcher-bearers, hospital

orderlies and nurses, employed in the search for, or the collection, transport or treatment of the wounded. Doctors and administrative staff cannot assume their medical character temporarily.[152]

- For effective protection personnel should: use an armlet, which will however, only bear a red cross in miniature; carry identity documents specifying what special medical training they have received, the temporary character of their duties, and their authority for wearing the armlet.[153]

- A combatant detailed for auxiliary medical duties becomes part of the medical services and is considered to be privileged combatant. While rendering or performing medical services this individual is not authorized to take a direct part in hostilities and, if captured, is a prisoner of war (PW).[154]

Progress of rules of engagement:[155]

- The United States imposes rules of engagement for its own military forces. The United States government can, by its own action, change its rules of engagement.[156]

  - Rules of engagement usually reflect political and diplomatic as well as legal factors. The rules of engagement will, then, often restrict operations far beyond the requirements of the law of armed conflict.[157]

- 1941-45, World War II: No clear cut policy established on the combat role of the medical elements of the Army Air Forces. Through out the war there was to be a difference of opinion over whether medical officers should fly on combat missions.[158]

  - Medical officers initially permitted, but not encouraged, later in some theaters they were forbidden to do so.[159] Some commanders felt that no medical officer as such serves any good purpose on a combat mission and therefore risked a critical item—the medical officer—for a very questionable gain.[160] Others felt there was a need for "intimate personal contact between crew members and flight surgeons" necessary to keep flyers in the air.[161]

- 1950-52, Korean War: Rules of engagement did not forbid permanent medical service personnel from flying combat missions.

  - Most air rescue missions flown on the front lines to evacuate critically wounded men had enlisted men, aero-medics or pararescue, providing life saving medical services.

  - Most air rescue missions flown into enemy territory had pararescuemen providing life saving medical services.[162]

  - Medical service personnel forbidden to get off the helicopters. Only pararescue allowed to depart the aircraft to assist injured and wounded in their recovery.[163]

- 1961-75, Southeast Asia: Rules of engagement did not forbid permanent medical service personnel from flying combat missions.[164]

  - Most air rescue missions flown in the area of operations (SEA) had pararescue, a combatant specialty, providing life saving medical services.

- Circa 1993, Post Cold War: USAF medical personnel and medical establishments and units may not be used to commit, outside their humanitarian duties, acts harmful to the enemy. In regards to the conflict (wartime and peacetime contingency operations), the medical service remain neutral, outside the struggle; and refrain from all interference, direct or indirect, in military operations outside the performance of humanitarian duties.[165]

  - It is assumed that when a flight surgeon goes on a combat mission, although designated as part of the crew, he is simply there for medical purposes and in no way participates in the operation of the aircraft or the mission.[166]

  - Medical service personnel are also limited by the proviso applied to the flight surgeon.[167]

  - Physician-pilots should not be employed in operational roles. To use physicians in combat needlessly jeopardizes the ability of this country to demand compliance by an enemy with the provisions of the Geneva Conventions which accord

special status to medical personnel. An enemy could argue, for instance, that the status of all U.S. military physicians was questionable due to our demonstrated use of physicians in combatant roles.[168]

- 282200ZAPR93, message from HQ USAF Washington DC//CC// to ALMAJCOM-FOA, Removal of combat aviation exclusion: Opens almost all Air Force career fields and combat aircraft to women. Two USAF specialties remain closed to women; Pararescue and Combat Control because of ground combat restrictions.

- Combatant Specialty: Pararescue forces detailed to render on-scene physical expertise for the location of military airmen downed in enemy territory. For incidents exceeding the capabilities of the aircraft, pararescue teams penetrate incident sites (by parachute, helicopter insertion methods, or surface means) to render emergency medical care and provide survival expertise until evacuation can be achieved.[169]

  - The only line element of the air rescue function which responded to support the combat operations of the United States Air Force from 1947 to 1994.[170]

  - Officers removed from the pararescue specialty and teams in 1953, a few officers maintained mission capable qualfications until 1960. Exception, three positions: Commander and Director of Operations, 1730PRS, 1987-1990; Division Chief for Pararescue Operations, HQ MAC/DOY, 1986-1990. Note: Basic qualifications only, did not maintain mission capable or mission ready status.

  - Medical officer, i.e., MC, MSC, NC, etc., involvement limited, since 1953, to administration of pararescue's medical programs and activities.[171] Professional medical oversight nowadays provided by: MAJCOM Surgeons and staffs; two or three medical officers (physician and non-physician) instructing at the pararescue school; and squadron medical elements providing informal oversight to pararescue teams. Pararescue's qualification to render life sustaining emergency procedures and care depend on degree of interest of the involved flight surgeon; a physician generally not trained in emergency medical services.[172]

In summary: Pararescue is the singular most potent military occupation dedicated to the rescue and recovery of aircrews downed in an area of conflict. Pararescue used also for the air evacuation of the critically wounded and injured from remote battle areas. Though the flying machine projects rescue and recovery to all the Earth's surface, aircraft technology has certain limitations.[173] Pararescuemen cope with demands of rescue that don't pertain to flight. Demands needing expertise not mastered by pilots, other crewmembers, or permanent medical personnel. Pararescuemen adapt to the physical conditions surrounding the survivor and provides the link between the rescue aircraft and the downed flyer. When the aircraft is unable to do the recovery, pararescuemen extend beyond the confines of the aircraft into adverse areas and conditions to aid and recover distressed and injured personnel. It is the USAF Pararescue Specialty that melds the skills of other professions—medicine, survival, parachuting, combat swimmer, and small team tactical expertise—into a unique capability that deals with the many problems and dangers facing rescue "so that others may live."

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[13]Francis M. Dawdy, SMSgt Ret., Pararescue Superintendent; Service Period, 1942-69; Interview with author. 1 Jan 94

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