The AMEDD Historian

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Chief's Corner

Happy Holidays from the AMEDD Center of History and Heritage staff! This edition of the *AMEDD Historian* marks the start of our third year, and your positive feedback encourages all the authors to continue to research and write, expanding everyone's knowledge of AMEDD history.

In this issue of the *Historian,* our authors have written articles on significant or well-known members of the medical department, the not so well known, and even the unknown, medical soldiers who made significant contributions by taking care of those in need of medical care. Today we take for granted the Health Professions Scholarship Program (HPSP) for aspiring physicians, dentists, and optometrists, but what did the Army use prior to HPSP? One thing was the AMEDD ROTC Program. Another program that we just accept as always being in the Army is the Combat Lifesaver, but who created the program? Find out in this issue.

As we begin 2015, we start thanking and remembering our AMEDD Vietnam War veterans. In this issue are two articles that discusses the military working dog hospital in Vietnam, and Army Reserve medical units in Vietnam.

(continued on page 3)

Lieutenant Colonel "Beau" Register: Soldier, Healer, Hero

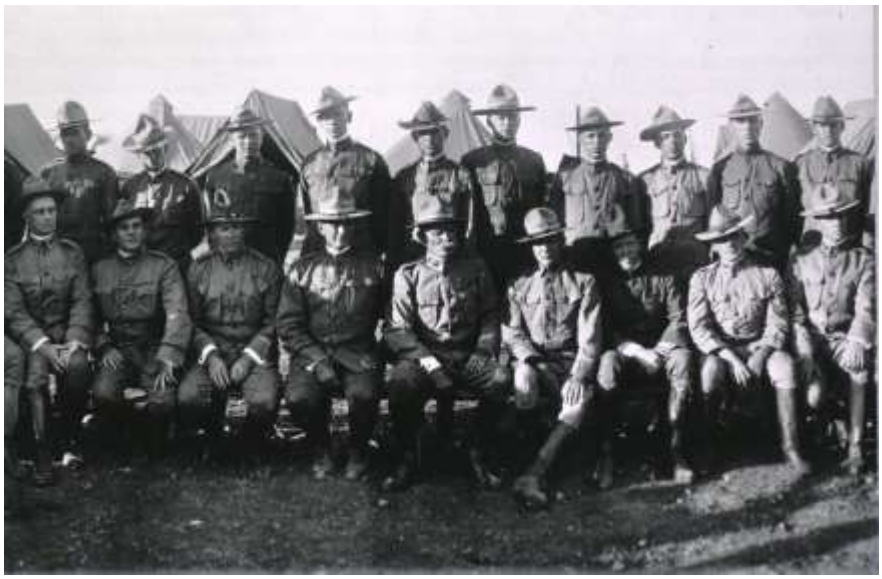
Scott C. Woodard, Office of Medical History

"Always interested in others' welfare, even though it may be to his own hurt, and thus he was enthroned himself in the hearts of all his companions, who wish and predict for him the brightest of futures in his chosen profession of medicine."

- Excerpt from Register's senior biography in the *Sphinx*

Dr. Edward Chauncey Register was a heroic figure putting others before himself and answering the call of duty to the nation and his fellow man, ultimately sacrificing his life on January 3, 1920. After graduating from The Citadel in 1905, he completed his degree in medicine from the Medical College of Virginia in 1908. Upon graduation from the Army Medical School he was commissioned a First Lieutenant in the Medical Corps of the Regular Army. In his early career Register served in the Philippines, Mexico with the Punitive Expedition, and China. During WWI he performed medical reviews of soldiers prior to their deployment to Europe. In 1919 he was called to France to medically screen repatriated German prisoners.

Cadet Register, from the 1905 Citadel Academy yearbook.



1LT Register (top row, center) in 1911, at Fort Sam Houston. Courtesy National Library of Medicine.

By the spring of 1919, Europe was facing a crisis where 10,000 Poles died each day from typhus. An estimated 200,000 would die by June of 1920. As an initial measure to combat this threat, President Wilson ordered the Polish Typhus Relief Mission from the Army Medical Department; it would soon broaden into the American Polish Relief Expedition. The mission had a dual effect of providing humanitarian aid, by stopping the spread of the lice-born typhus, while simultaneously slowing the westward spread of communism. The regulars drew on their extensive delousing experience in France. Through review of past medical experience, they took the lessons derived from the fight against plague, yellow fever, and cholera in the Philippines and Cuba. Polish healthcare providers paid a particular heavy price in their close proximity to the lice-infested victims. In one Polish hospital 88% of their doctors died while another hospital lost 83% of their doctors to the deadly contagious enemy. At the time it was well known that the Bolshevik army was deliberately expunging their ranks by transporting typhus infected soldiers to the Polish border in armored rail cars. Almost every house in Poland had one to five occupants with typhus fever.

Polish Typhus Relief Expedition hospital at Tarnapol, Poland, where Register worked and died. Courtesy NLM.

It was in this environment that Lieutenant Colonel Register volunteered to relieve the suffering and avert possible disaster and human suffering spreading through war-torn Europe. US Army officers were appointed to work alongside officials appointed by the Polish Minister of Public Health. Initially, Register was assigned to Lwow, Poland. Top priority was cordoning off and quarantining typhus-carrying refugees coming over the eastern border. Once the refugees were quarantined, Register supervised bathing, delousing and medical care in the city of Tarnopol. It is here that Register died from typhus fever surrounded by patients lying on floors, huddled together desperately trying to stay warm within their rags for clothing. There were no linens, straw mattresses were old and unclean and "blankets" were made from paper. Out of the 12 doctors in Tarnopol, 10 had died. Fully knowing that Tarnopol was the worst typhus infested place in Poland, "Beau" Register

personally answered the call "Whom shall I send?" Lieutenant Colonel Register's commanding officer, Colonel Harry Gilchrist, remarked in his eulogy,

> It is believed that no officer in the army ever did a more courageous act. He went alone to fight a silent enemy, without the blare of trumpets the booming of cannon and the usual excitement connected with the glories of the battlefield. His was a silent battle and although losing he made a gallant fight against many odds. He died the death of a soldier, performing his work well and sacrificed his life for the people of Poland. His was a most honorable death.

Recognized for his work, he was also honored for his answered service by a posthumous presentation of the Army Distinguished Service Medal:

> For exceptionally meritorious and distinguished services to the Government of the United States, in a duty of great responsibility during World War I, while a member of the Polish Relief Expedition, volunteering for service at Tarnopol, Poland, the entire city being prostrate from the effects of typhus fever, forty-five doctors having sacrificed their lives within the preceding two months. Upon arrival at Tarnopol Lieutenant Colonel Register assumed entire charge of the situation, organized and established a 1,500-bed hospital equipped with supplies, which had been concealed from enemy forces, and found by him. Fifteen days after his arrival in the city he contracted typhus fever and died from its effects on January 3, 1920.

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Chief's Corner, continued

So… We want you! This is your journal and we ask you to be proud of Army Medicine history and submit your articles, photos of artifacts with description, documents and memorabilia to share our Army Medicine historical experience. "Knowing history begins with studying it, then making it useful to our profession by applying what we're learned."

I look forward to hearing from you about our past!

Bob Driscoll
Chief, ACHH

Colonel Florence Aby Blanchfield, 1884-1971

COL Betsy Vane, Army Nurse Corps Historian

Sometimes the best way to describe someone is through a story. One of the ANC staff officers who worked with Colonel Florence Blanchfield during her time as Chief of the Army Nurse Corps wrote this about her:

> "A short, sandy-haired woman entered the Pennsylvania Railroad Station in New York during WWII and made her way briskly to the ticket window. She was in her middle fifties and wore the uniform of an Army colonel.
>
> Two military policemen, assigned to observe military personnel enroute to and from New York, to assist when necessary, and to arrest if indicated, looked at each other in amazement. This was not Colonel Oveta Culp Hobby of the Women's Army Corps-there was only *one* woman colonel authorized for them. This woman must be an imposter! They approached her as she neared the ticket window. "Ma'am, could we see your identification card?"
>
> "Certainly, Sergeant," she said quietly. She set her brief case on the floor and produced the regulation card with her picture and the name: Florence A. Blanchfield, Colonel, AUS.
>
> The first soldier examined the card and passed it on to the second, saying doubtfully: "It *looks* all right."
>
> "It is all right," Colonel Blanchfield assured them. "You just haven't heard as much about the Army Nurse Corps as you have about the Women's Army Corps."
>
> "Are you the head of the Nurse Corps?" The Colonel nodded.
>
> Are you catching a train?"
>
> "I *was*," she smiled, "but I may have missed it now."
>
> "We'll take care of it," one said. "You get her ticket, Joe, and bring her down. I'll go down and get a seat for her and hold the train." He dashed off and the other got her ticket, picked up her small bag, and steered her through the crowd and down the stairway. When the "all aboard" sounded, the Colonel was settled in her seat and the two MPs were giving her an apologetic good-by.
>
> This episode indicates a good deal about Florence Blanchfield – her diplomacy, her sense of humor, her pride in the Army Nurse Corps, her humility concerning her own importance and her consideration for the men of the military. The combination of these qualities has made her one of the great figures in the history of American nursing".

Colonel Blanchfield had wanted to be a nurse since her childhood, and she graduated from South Side Hospital Training School for nurses in Pittsburgh, PA at the age of 22 and took a post-graduate course in operating room supervision and technique at Johns Hopkins in Baltimore, Maryland. She had a sense of adventure, and served at Ancon Hospital, Panama Canal Zone, as a Civil Service employee as a general duty nurse and nurse anesthetist at age 29. She had been a passenger in one of the first ships to sail through the locks of the newly completed canal.

She joined the Army Nurse Corps as the United States entered WWI. She went to France with the American Expeditionary Forces from 1917-1919. She described how, as the nurses traveled to France, they all were required to sleep in woolen swimsuits "with feet in them" as they sailed through submarine-infested water. The idea was the women would better survive the frigid waters should they be attacked and the ship would sink. When they safely arrived in France, she first served as a surgical nurse with Base Hospital 27 in Angers. This unit had 28 nurses for 1300 patients. She said "keeping up morale" was as big a job as professional duties. One of her WWI commanders wrote: "She has handled very difficult situations most successfully, is extremely efficient and quite invaluable under existing conditions."

When Florence Blanchfield joined the ANC nurses had no military rank, but had titles as "Chief

COL Blanchfield's official portrait.
Courtesy AMEDD Museum

Nurse" or "Assistant Superintendent." In 1920 Army nurses achieved "relative" rank which still did not mean equal pay, privileges, or authority as commissioned officers. Promotions were limited for nurses: a nurse could expect to enter the Army as a second lieutenant and could serve her entire career at this rank unless she was successful in passing the test to allow her to hold a chief nurse position. At that point she could be promoted to first lieutenant, but only when a chief nurse position became available.

From 1920-1947 her tours of duty included: California, Georgia, Indiana, Michigan, Missouri, Washington, D.C., China, and twice in the Philippines. Her positions with the ANC included staff nursing, operating room nursing, nursing instructor, chief nurse of six Army hospitals, and special duty for six months at the home of the Secretary of War. She said "I've had the itinerary of a traveling salesman." A key assignment was to the Surgeon General's staff in 1935, with promotion to the relative rank of captain. That put her in position to be Assistant Superintendent of the Army Nurse Corps in 1939, and become a lieutenant colonel in 1942.

She was promoted to superintendent of the ANC and the relative rank of colonel in 1943. She became Chief, ANC at the age of 59. At five feet one inch tall, she was known as "The Little Colonel" or "The Soldier's Nurse." In OTSG she emphasized recruiting as the ANC grew to 57,000 strong. She used her personal experience as an industrial nurse, educator, administrator, operating room nurse, and anesthetist to attract those specialties. A monthly magazine The Army Nurse, the Army Nurse Corps Song, the Army Nurse Corps Ring, and the ANC Song Book came out of this publicity and recruiting effort. Recruiting nurses was only part of the solution. Colonel Blanchfield realized that newly appointed nurses also needed basic training programs to introduce them to military regulations and courtesies. She said: "In the early months of WWII nurses had been sent overseas without special preparation for military service. Such training was subsequently given them at a staging area in Great Britain and the South Pacific. Late in 1943, 4-week basic training programs were set up in each of the Army's Service Commands. Emphasis was placed on physical fitness through drill; on sanitation; and on self-protection during chemical air, parachute, or mechanized attack. The use of gas masks was realistically taught in gas chambers; they learned how to dig foxholes quickly. Special instruction was given in the care of mental patients and of chemical casualties." She recognized that the nursing profession, both military and civilian, needed nurses who were qualified in administration, teaching, and supervision. She also had AR 40-6 published as a guide for commanders on legal implications of nursing responsibilities.

Colonel Blanchfield placed nurses near the front lines during combat because "the greatest need for expert nursing is immediately following front-line surgery." She was determined to save lives. "Don't let anyone tell you that the combat zone is no place for nurses. It is definitely. Just see what a bedside nurse can do to boost the morale of any injured soldier. Just a pat on the head, blankets smoothed, and a woman's smiling face for a man to look up into – sometimes it's better than plasma." She was responsible for a more practical and modernized design of the nurses' fatigue uniforms for the nurses landing on Anzio Beachhead in Italy in 1944 as the hospital whites were not practical for this environment. She commented in a speech: "Nurses who landed under fire on the beach at Salerno in mid-September were the first members of the ANC to arrive in continental Europe since WWI. They wore 'tin' hats and fatigue uniforms with long trousers and, like regular

soldiers, they dug their foxholes. They lived in tents in mountainous country and endured the rigors of an extremely wet and cold winter with fortitude. During air raids, while caring for wounded men, they seemed to ignore the possible danger to themselves but became expert at dropping down and diving under beds or other equipment that might be available until a raid was over. With other medical personnel, nurses were so close to the front lines in evacuation and other mobile hospitals that they cared for patients a few hours after they were injured. At such points the services of operating room nurses, nurse anesthetists, and keenly observant and technically skilled surgical nurses were of the utmost importance. Those who had that privilege worked under intense physical and emotional strain, but forever after cherished the memory of participating in the team work that had saved lives." One of her favorite stories was about nurses who entered a town full of wounded men, ran short of supplies, and tore up GI underwear to make bandages. "An Army nurse must thrive on emergency" she said.

Blanchfield's WWII dark blue jacket.
AMEDD Museum.

Colonel Blanchfield and Congresswoman Frances Payne Bolton worked together to pass temporary commissions for Army nurses in 1944, which lasted for the duration of the war plus six months. This was the best they could hope for during the war. She was a driving force in developing the Army-Navy Nurses Act of 1947 which granted permanent status to U.S. Army nurses and established the Regular and Reserve components of the ANC. Public Law 36, enacted 1947, established the Regular Army Nurse Corps with permanent commissioned rank and benefits equal to those accorded male officers. This achievement took forty-six years after the establishment of the Army Nurse Corps. Colonel Blanchfield was the first woman to receive a Regular Army commission, and Chief of Staff of the Army Dwight D. Eisenhower personally promoted her at the Pentagon. As the first officer commissioned in the new Army Nurse Corps, her serial/service number was given as N1. She was the first director with the title "Chief of the Army Nurse Corps."

While working for nurses, she kept in mind their role for patients. After WWII nearly 50,000 nurses were demobilized, but Blanchfield was acutely conscious of the needs of thousands of wounded still hospitalized as well as the armies of occupation. One of her arguments for Regular Army rank (with attendant pay and benefits) was its effect on recruiting the nurses needed to care for soldiers. She recognized specialty training in operating room nursing, administrative nursing, psychiatric nursing, anesthesia and emergency care was established in 1947. She allowed nurses to arrange recovery areas for immediate care of post-operative patients. She also established a program where nurses trained technicians in giving care to patients.

COL Blanchfield receiving the first Regular Army commission for a woman from Chief of Staff of the Army Eisenhower, 1947.
Department of the Army photograph.

Others recognized Blanchfield's qualities. In 1946 her rater (Deputy Surgeon General Raymond Bliss) wrote: "this officer is one of the leaders in the nursing profession in the world, mentally alert and possessing outstanding professional ability." Colonel Inez Haynes (later herself to be Chief, ANC) recalled: "She challenged us to do our utmost. She inspired and encouraged us to further the extent and depth of our knowledge of medical and nursing practice. She cared so much for quality nursing care, administration, and continuing education we learned to care and try. We identified with the goals she held out to us. She was a model. Rather than preach quality and leadership, she demonstrated quality and leadership."

After retirement she continued to be active as a consultant in military nursing and in professional nursing associations until she died on Florence Nightingale's birthday (May 12) at Walter Reed Army Medical Center at the age of 87. She was buried with full military honors in Arlington National Cemetery.

Colonel Blanchfield's career included meritorious service in both world wars, with assignments in the U.S. and overseas. She believed one should know "everything about things that affect our daily lives…as well as one's chosen field" which leaves us with wise words to live by as we remember her contributions to the Army Medical Department.

The AMEDD ROTC Programs

Sanders Marble, Office of Medical History

The 1920 National Defense Act established a framework for American defense, pulling the Regular Army, National Guard, and Army Reserve into the "Army of the United States." The peacetime forces would be small (since that was all Congress was willing to fund) and most of the nation's strength would be in the reserve components. In turn, that meant reserve officers would be needed. For a few years the Army could rely on the WWI generation of officers, but their commissions would start expiring in 1923. Clearly, a new source of reserve officers was needed, and Congress expanded the Reserve Officer Training Corps. Now ROTC could be offered wherever 50 or more students would volunteer to become cadets. They were not contracted, nor paid beyond their time in summer camps, but they would get uniforms and commissions. These men would be the officers of the future as the WWI veterans left the ranks.

Starting in the autumn of 1920 the AMEDD was included in this program. Medical, dental, and veterinary schools offered ROTC courses, adjusted from the basic ROTC course to produce physicians, dentists, and veterinarians. Instead of 90 hours of instruction, AMEDD ROTC courses had 32 hours; the Army was not looking for AMEDD officers to be combat leaders and the normal clinical lectures taught most of what cadets needed to know. Cadets were in the Basic Course their first two years and the Advanced Course their second two years and had one six-week field camp required; most took it after their third year of professional school. Most of the schools joining the program were in the East, and the great majority of AMEDD ROTC cadets spent their six weeks at the Medical Field Service School at Carlisle Barracks, PA, although 30-50 cadets usually gathered at Fort Lewis, WA.

The AMEDD scrambled to develop a syllabus; professors were sent to the various schools before any program of instruction was ready. The first few years of medical ROTC programs saw several revisions of the syllabi, and several scenes at the 1922 summer camp at Carlisle Barracks were filmed for instructional use.

Participation rose quickly during the 1920s, from 15 schools in 1921 to 36 in 1924, and 14 schools made one or more years of medical ROTC compulsory. 36 schools was a plateau, although numbers of students rose to nearly 4,800 in 1926. The Great Depression nearly caused the demise of the program: not only were fewer students going to medical, dental, and veterinary schools, but to save money Congress ended the medical ROTC programs in 1933, at first for one year. Existing students could stay in the program, but there were no new enrollments. The one-year ban was renewed in 1934 and 1935; the AMEDD had to reassign the uniformed professors and detail officers to be instructors on an additional-duty basis. To continue the flow of reserve officers, the AMEDD created a new route for commissioning: the dean of a medical school would recommend candidates, and the Corps Area Surgeon (the US was divided into nine geographical corps areas) would approve.

In 1936 the ban lapsed, and medical ROTC re-started, with the strong support of the American Medical Association. 19 schools joined the program between May and the start of the academic year, and just under

1,100 students were in the program. A good number of medical ROTC graduates were called up to work at Civilian Conservation Corps camps in the 1930s, and more were called to as the Army was expanded in the national emergency of 1939-1941. Exact numbers are not available, but around 6,000 physicians, over 2,000 dentists, and over 500 veterinarians were commissioned through medical ROTC units. These were around 40% of the reserve AMEDD officers available in 1939.

A mid-20s summer demonstration of AMEDD field activities, the sort of summer camp Medical ROTC cadets would have seen. Courtesy AMEDD Museum.

Medical ROTC units continued into WWII, but were discontinued when the Army Specialized Training Program began since the ASTP students were already enlisted with a service obligation. The Army resumed medical, dental, and veterinary ROTC in 1946 and added pharmacy ROTC. The program returned to two years Basic and two years Advanced, with a single six-week summer camp required. In announcing it to the AMEDD, one of the attractions was the time for the instructors to study. However, participation was relatively low, and the Korean War suggested the wrong topics were being taught. Medical students wanted military-related clinical instruction, such as how to cope in mass-casualty situations, rather than lectures and movies on military organization and administration.

The American Medical Association and the Association of American Medical Colleges still supported some military-related program. They designed Medical Education for National Defense (MEND), partly to end the ineffective and unpopular medical ROTC. DoD at first balked at the cost of instructors (especially since some of the curriculum would have been taught anyway, for instance tetanus, or the details of shock) but it gained acceptance, probably as it was the best that DoD was going to get from medical colleges and medical students. It cost less than medical ROTC, even if much of the funding was for faculty travel, only loosely related to the curriculum. Dental, veterinary, and pharmacy schools were dropped from the program, but MEND became part of the curriculum at all medical schools in the US, teaching tens of thousands of physicians. MEND taught topics that would be useful in civil defense, not just in the military, such as coping with chemical and nuclear weapons. Supporters had to admit most of the benefits were indirect, "better understanding by the student of the special kinds of medical problems encountered in military situations, a better attitude toward military service, and an informed medical faculty" but they pointed to relatively low costs. Early in the Cold War the costs were acceptable to DoD, but as inflation and Vietnam ate into the DoD budget MEND was judged too expensive and it was ended in 1969.

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Dog Hospital: Military Working Dog Health Care in Vietnam

By Nolan A. (Andy) Watson, Office of the AMEDD Regiment

Although common today, the first real battlefield casualty care system for military working dogs began during the Vietnam War. US Army use of canines began officially during World War II and would steadily increase. By the time of the war in Vietnam military canines were recognized as a part of the Army's arsenal. Similar to humans serving in Southeast Asia, there were numerous dangers.

Dogs serving in Vietnam faced health issues in addition to combat dangers and bounties placed on their lives. In Vietnam there was a deficit of protein and local procurement was generally not possible; hence malnutrition was a problem that was closely monitored by veterinary personnel. Veterinary support continued to be vital as fevers, the oppressive heat, and other diseases were constant issues for the dogs. Additionally, rabies was endemic to the country.

In Vietnam rockets, bullets, and Military Working Dogs were all part of the arsenal and in this case all were heliborne. ACHH collection.

In 1965, Military Police Soldiers brought in the first US military dogs to support American forces in Vietnam. By November of that year 180 sentry dogs were in the country at 10 locations. The Marines brought their first scout dog platoon in July 14, 1966 and by the end of 1966, the total number of US military dogs in Vietnam rose to 673. Air Force security forces would also add to the number of working dogs in the country in following years.

The veterinary care system, patterned after the human medical care system, started at the primary level with the Military Occupational Specialty 91T (now 68T Animal Care Specialists) organic to each scout and sentry dog platoon, later rising up to the dispensary level and the veterinary hospital level for long term care. The improved care also included an evacuation system to each level. Due to the wide dispersion of dog platoons and the increased number of dogs (1,200 dogs by 1967), veterinary food inspection (JA and JB) detachments also provided dispensary level care.

Budda 4A82, was WIA'ed by a booby trap. It was a spear type booby trap and he took the spear in the neck. Prior to tripping this trap he had alerted on 2 punji pits and one other booby trap. This particular trip wire was set in such a way that one would trip it upon making a sharp turn in the trail. We have no other explanation as to why he didn't alert. He was medevaced and is still on medical hold but is recovering quickly.

(Above) While most canine health problems in Vietnam were related to malnutrition, the heat, and disease, they were also wounded. This is from the January 1969 report of scout dog operations from the 39th Infantry Platoon Scout Dog, 173d ABN BDE.

(Below, left to right) Captain Rodney F. Taylor, VC, cuts away bandages on injured scout dog "Gunn" as Specialist 4 Richard S. Shanks, dog handler, holds down the dog and Captain William T. Watson, VC, administers fluids. Image taken at the 936th Veterinary Detachment's "War Dog Hospital" at Tan San Nhut Air Base, November 30, 1968.
US Army image.

By January 1966, three veterinary detachments were in the country, the 4th Medical Detachment (Veterinary Service), 75th Medical Detachment (Veterinary Service) and the 936th Veterinary Detachment. Initially, veterinary hospital care was a responsibility of the 936th, which maintained a small animal hospital located at Tan Son Nhut, in early 1966. The 504th Veterinary Detachment, a small animal dispensary, arrived in Vietnam in October of 1966. The unit moved into a permanent hospital in July 1969, at Long Binh next to the 212th Military Police Company (Sentry Dog). With adequate veterinary assets available, preventive medicine and improved kennel facilities, became canine health priorities.

The initial working animal evacuation system did not include helicopters, and Air Force plane evacuation procedures were not very dependable. In 1969, helicopter evacuation became available for dogs and handlers, and an evacuation policy was established for dogs requiring more than seven days treatment; however, dogs were not evacuated outside of Vietnam. As American forces withdrew from the conflict in ensuing years fewer MWD and the veterinarians needed to provide treatment for them were deployed. After the war, military working dog use and their medical support continued.

There is a popular **misconception** that is still believed today that all military working dogs were euthanized as American forces left the country or as the dogs' handlers redeployed to America. This is not true. While some animals were euthanized for various reasons, the vast majority of animals were transferred to service with the South Vietnamese Army or quarantined to the Southwest Asia Theater due to transmissible Canine Pancytopenia, a disease that had killed 300 dogs by 1969. Lastly a small number of dogs cleared the health screens and were returned to CONUS.

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Origins of the Combat Lifesaver

Robert L. Ampula, Administrative Officer, US Army Medical Department Regiment

Today it is commonly known that the Combat Lifesaver (CLS) is a non-medical Soldier trained to provide immediate, far-forward medical care beyond the level of self-aid or buddy-aid. Each squad or crew sized unit has at least one CLS and they have proven effective in saving lives for more than two decades. While nearly everyone knows what it is, fewer know where the concept originated and who championed the cause to have the U.S. Army embrace and incorporate the Combat Lifesaver.

In the 1970s combat developers studied statistical data on casualties and deaths during the Vietnam War which suggested approximately 50% of the combat deaths were the result of exsanguinating hemorrhages. The majority of those hemorrhages were in areas of the body not easily assessable and not much could be done to save those Soldiers at the front lines. However, about a fifth of those wounds could be controlled with pressure methods. The natural assumption was that most of these Soldiers should have been saved. In turn, this raised the questions, where were the combat medics and why weren't they putting on tourniquets? Further data gave the impression combat medics died at a higher rate than their infantry counterparts largely due to the nature of their duties, which included treating the wounded under fire. Also, although the medics had been imbedded in combat units since WW II, they were not allocated in numbers that allowed their disbursement down to the squad level. Additionally, medics that were badly wounded were unable to perform their duties. Thus, the answers to the questions posed: there were just too few medics available to provide immediate care at the point of injury and there were no alternatives in place.

In 1981 Doctor Robert Mosebar, Colonel, U.S. Army retired, started work as a civilian at the Academy of Health Sciences (AHS), now the U.S. Army Medical Department Center and School. Dr Mosebar had just concluded a distinguished 37-year Army career which began when he was drafted in WWII and culminated as the commander of General Leonard Wood Army Hospital. During WWII he was a combat medic in the 1st Cavalry Division and rose in rank to First Sergeant before he was commissioned as a Medical Administrative Corps officer (the forerunner of today's Medical Service Corps). After occupation duty in Japan following WWII, he was a medical registrar for the 8055 MASH, the first MASH to enter Korea during the Korean War. Although he was already a pre-med pharmacy student when he was drafted into the Army in WWII, watching a Soldier bleed to death his first day in combat played a part in his decision to finish his medical degree at the University of Washington. During the Vietnam War he was the XXIV Corps Surgeon. Such vast and varied experience made him an ideal choice to work in Combat Developments.

COL Robert Mosebar, MD.

Courtesy Borden Institute.

One of his early projects required a trip to Israel. While there he observed that Israeli Defense Force personnel carried additional medical equipment. He was impressed that the Israelis were training as many troops as possible in what he described as *enhanced first aid* which included the application of tourniquets. The Israelis had learned during the Arab Israeli Wars that tanks would pull out of action to deliver injured crewmen to medical treatment facilities. By training a member of each tank crew to deliver an advanced first aid to the wounded man, the crew could stay in action until the injured man could be removed by medical personnel. In addition, medics were too few to reach all infantry casualties quickly. By training certain soldiers in basic medical procedures (tourniquets, intravenous infusion, etc.) and equipping them

to perform these procedures, the wounded received fast treatment and their condition could be stabilized until medical personnel reached them. Both efforts resulted in fewer deaths and better morale. Dr Mosebar, ever mindful of the Vietnam statistics and his own WWII experience, thought this was a tremendous idea.

Having been a long time U.S. representative to the American, British, Canadian, Australian Armies' Standardization Program, Dr Mosebar checked with his British counterparts to ascertain if they had a similar program to the Israelis. His colleagues replied that they taught their soldiers first aid in basic training, but they did not give them advanced medical training nor did they give them any additional equipment. They presumed the combat medic would be there with the necessary equipment to provide the appropriate care.

Dr Mosebar began putting together a preliminary curriculum and the equipment that would be necessary to accomplish his vision of the *auxiliary aid man*, the term he would use early in the process. He knew the Army would never agree to train 20 or 30 thousand auxiliary aid men at the AHS and thus he conceptualized the course as an exportable package that could be taught at each installation. The program would be centrally written at the AHS to include the instructor manual, training materials etc. While Dr Mosebar was working on his concept, the idea of advanced first aid was bolstered by the British experience during the Falkland Islands War in 1982. The British decided to train their troops in advanced first aid procedures during their long trip by ship to the war zone. After the 74 day conflict, Dr Mosebar found the British were pleased with the results of the additional medical training and thought it was an endeavor well worthwhile.

Having been a commander on many occasions, Dr Mosebar was readily aware of the resistance this program would receive at the unit level. Training time is precious in combat arms units and to take weeks away from that would be an impediment to readiness. Although he expected this kind of response from the combat arms units, he was unprepared for the resistance he would receive from within the AHS. Many of his counterparts thought he was going too far and was attempting to make junior doctors out of everyone in the field. This resistance to the program would hamper its progress.

Dr Mosebar was invited to participate at an Army Science Board meeting on Chemical Warfare and while there he befriended a physician who was a member of the board. After that meeting they kept in touch and about a year later the physician asked Dr Mosebar if he might have a good topic for the board. Dr. Mosebar immediately thought of the *auxiliary aid man* concept. He discussed the prospect of the Army Science Board coming to Fort Sam Houston with BG Robert Buker, the Commandant of the Academy of Health Sciences. BG Buker, who was an enthusiastic backer of the concept, thought it was a splendid idea and welcomed the board's visit. The Board studied the program in depth and approved it and with BG Buker's concurrence the *auxiliary aid man* now moved beyond the concept stage.

Resistance and suspicion within FORSCOM would still plague the program, however. After putting a prototype together, Dr. Mosebar and associates took the *auxiliary aid man* program to Fort Hood for an assessment. While it appeared to work well, the commanding general at Fort Hood thought that the Army Medical Department was using this program as a way to obtain more medics. This resistance would keep the program in an indeterminate state for a couple more years. It was obvious some things would need to change. The first was the name; and the program name was changed to **Combat Lifesaver**. It was also decided that it needed to be written into an Army Regulation (AR). This would make commanders responsible for CLS rather than doctors or medics.

In the meantime General Maxwell Thurman, Commanding General of the U.S. Army Training and Doctrine Command, came to Fort Sam Houston for a routine visit. It was suggested that Dr Mosebar get on his schedule to discuss CLS. Dr Mosebar and a sergeant (whose name, thus far, is lost to history) presented the program to General Thurman, to include the medical kit and its contents. General Thurman was impressed and told Dr Mosebar to write it up and send it to him. Once received, General Thurman directed that the Combat Lifesaver proceed immediately. This was the push the program needed, although implementation was still slow to come. The 82d Airborne Division was one of the first divisions to train some of their Soldiers as CLS.

In September of 1989 General Thurman was selected by President George H. W. Bush as the Commander of the United States Southern Command. Within months he would plan and execute Operation Just

Cause, the invasion of Panama. One of the participants in the invasion was the 82d Airborne Division. The 82d left North Carolina in an ice storm and jumped into the tall elephant grass of Panama where it was 90 degrees. Many of the Soldiers started going down from the heat, and commanders feared their units might become ineffective. The combat lifesavers recognized the problem from their course on dehydration and began administering intravenous fluids and within a short time the Soldiers were back up and the units were moving again. This made an immediate impression on battalion commanders. Comments on after action reviews and lessons learned during Operation Just Cause reflect very positively on the combat lifesaver. The program gained acceptance and there was no looking back.

While the Panama invasion brought credibility to the combat lifesaver, it was the first Gulf War where the program really gained widespread implementation. In the early days of the buildup, the planners estimated that U.S. casualties could be very high. As a result, units took heed and upwards of 30,000 combat lifesaver kits and instructions were requested. Fortunately, the ground war was short-lived and the casualty estimates did not materialize. The Combat Lifesavers performed their duties admirably and helped boost the morale within their units and hereafter CLS were a fundamental part of all combat arms units.

After the terrorist attacks of September 2001 and the subsequent actions in Afghanistan and Iraq, Dr Mosebar would routinely receive messages from commanders and Soldiers in the field relating stories of lives saved as a direct result of the Combat Lifesaver. These messages further validate the remarkable value this concept has brought to the Army, its Soldiers, and their families. Dr. Mosebar would go on to retire from civil service in 2004 and, sadly, he passed away in August of 2011. He will always be synonymously associated with the Combat Lifesaver but will be remembered by most as the "Father of the Combat Lifesaver".

Sources

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Troops from 3-159 Aviation conduct Combat Lifesaver training in Balad Iraq, May 2009.
DoD photograph.

Infantry Combat Medics in Europe, 1944-45. By Tracy Shilcutt. Palgrave MacMillan, 2013. ISBN 978-1-137-34768-8. Bibliography. Pp. vi, 136. Book Review by Robert S. Driscoll

After reading several books on the topic of combat medics serving during World War II, it is fair to say that I rate Dr. Tracy Shilcutt's, *Infantry Combat Medics in Europe, 1944-45* as one of the best! This book held my interest and I simply could not put it down. It is a generic narrative focusing on a narrow period of 1944-1945 and described the experiences of a combat medic. The reader can be assured this book passed scrutiny for accuracy and authenticity, as it was Dr. Shilcutt's doctoral dissertation.

Shilcutt's belief that little accurate information exists about front line medics who took care of those wounded on the battlefield likely inspired her to write this book. Before reading this book I expected combat medics were thoroughly trained and prepared for the task of taking care of the wounded in time of war. However, in Chapter 1 "Chalkboard Training" Shilcutt discusses the minimal training received at one of the five Medical Replacement Training Centers (Camp Lee, Camp Pickett, Camp Grant, Camp Robinson, and Camp Barkeley). Due to a shortage of equipment, combat medic training in most cases was conducted in classrooms, with only periodic field training. Dr. Shilcutt adds that because training was improvised and poorly simulated, with medics role-playing wartime scenarios, it inevitably deteriorated into a platform for humor.

In Chapter 2, (*Baptism of Fire),* and Chapter 3 (*Combat Reality)* Shilcutt does a great job describing the combat medics' first encounters with combat. Here she introduces you to Privates Dave Fought, Ben Burnett, Allen Johnson, and Charles Cross. On page 43 Shilcutt quotes an infantryman: "few could have gone on had they fully understood the consequence of combat and challenging role of the combat medic. The sensory mosaic of the medic's first blooding – the confused movements, the crash of weaponry, the screams and labored breathing of the wounded, the mingled stench of cordite and death, had the power to immobilize. Yet battle demanded immediate responses from men who had at best practiced on simulated casualties, if they had any combat aid preparation at all." This was a far cry from the training that had deteriorated into humor!

Combat medics served in different roles to include the Battalion Aid Station (BAS) medics and line medic. In Chapter 4, Shilcutt describes the BAS medic. Here medics worked in teams under the guidance of the battalion surgeon taking care of wounded in the BAS, and evacuating wounded from the company aid post to the BAS. Shilcutt's thrust in this chapter was to demonstrate the versatility of medics to assume tasks they had not been trained to perform.

War is not always combat against a human adversary. The enemy can masquerade as cold weather, illness, disease, and other ailments. Chapter 5 examines the routine medical work (not direct combat wounds) performed by the medics when taking care of their comrades as well as non US Soldiers. Although cold weather injuries were many, Shilcutt devotes a large portion of the chapter to neuro-psychiatric casualties, which she claims medics, again, were inadequately trained to handle. Additionally, medics cared for German civilian women and children once the American divisions crossed into Germany. According to Shilcutt, medics "adopted a willing attitude toward this task."

The book offers diametrically opposed opinions pertaining to the resilience of the war time medic. Captain Frank Ellis, a battalion surgeon, believed medics "bore some immunity to combat exhaustion because they did not carry the responsibility of taking life; their purpose was to save, not destroy." To the contrary, another battalion surgeon, Captain Brown McDonald is quoted as saying, "each battle or dangerous situation took its toll, until you (medic) finally snapped."

Chapter 6, *Company Aid Men* may be considered a tribute to the medic. Shilcutt articulately describes the relationship between the medic and the infantry Soldiers he supported. "Before the baptism by fire, neither the combat troops nor the medics understood the gruesome tasks which lay ahead. But following the first combat exposure, riflemen not only welcomed their aid men as comrades, but they also acclaimed them as first-class soldiers." In the remainder of chapter 6, Shilcutt has many more vignettes to illustrate the valor and admiration infantrymen held for the combat medics who took care of them in the worst of conditions.

The conclusion ties the book together. Shilcutt reiterates many of the points in the main text by highlighting the poor and inadequate training medics received and how medics ultimately boosted the morale of the Soldiers they supported. Perhaps most importantly, highlights how infantrymen came to trust that their medic would be there in their time of need.

In conclusion, for the student of Army Medicine history, the book is a great resource. The bibliography is very helpful, as it provides War Department publications, special reports and studies, civilian authored books, and articles for those interested to know more. My only drawback of this book is it costs $63.00. But otherwise, this chronicle is highly recommended!

PFC Edward P Gosse, and PFC Robert Sealbach, of the Medical Detachment, 310th Infantry Regiment, 78th Infantry Division evacuate a casualty on a ski-mounted litter. Outside Lammerdsorf, Germany, 22 January 1945.

Courtesy National Archives.

New Artifacts in the AMEDD Museum

Paula Ussery and Chuck Franson, AMEDD Museum

The AMEDD Museum has recently received several very exciting donations that have expanded our ability to interpret the many contributions that the AMEDD has made to preserve and/or restore the health of America's soldiers throughout the 20th and 21st Centuries.

A once common piece of hospital equipment, a Shock Block, has been donated to the artifact collection. In the days before adjustable hospital beds, shock blocks were placed under the foot or head of the bed of a patient to mediate surgical shock, hemorrhage, assist with traction, etc. The blocks had two positions, low and high. This one is from Madigan Army Medical Center and was used as a book end after it was no longer needed for patient care; it was rescued when Madigan moved into a new facility.

August 2014 began the centennial commemoration of "The Great War" or World War I as it is commonly called in Europe. Adding to the Museum's ability to document the contributions of the AMEDD to the Allied victory is a recent donation of memorabilia from the family of an Army nurse.

The memorabilia from nurse Alma Larsen includes her World War I Victory Medal, her Army identification tags, her insignia and an American Red Cross Medal. Miss Larsen graduated from the Bethesda Hospital Training School in St. Paul Minnesota in 1916. She volunteered as a reserve nurse and was enrolled with the American Red Cross. Called to active duty in March 1917, she was assigned to Base Hospital # 66 that served at Neufchateau, France as a medical and surgical hospital. Sailing on 1 September 1918, Larsen joined the hospital in France but was quickly re-assigned to Camp Hospital # 12 in Le Valdahon, France. Camp Hospital # 12 was combating the influenza epidemic at that time. The number of admissions at Camp Hospital # 12 was so great that line officers and non-medical department enlisted personnel were assigned duties in the hospital. Around one-quarter of the Army fell sick with influenza during the 1918-19 pandemic.

COL Michael M. Fuenfer's donation of his uniform, Special Forces beret, Medical Equipment Bag No.3 and Otoscope & Ophthalmoscope Set are wonderful additions to the museum's collection of artifacts from the Global War on Terror. Fuenfer, a surgeon with the 11th Special Forces Group (Airborne), U. S. Army Reserve, graduated from Northwestern University and received his Doctor of Medicine degree from the University of Louisville. He began his service as a flight surgeon with the U. S. Air Force Reserve in 1981. After transferring to the U. S. Army Reserve in 1985 he served as a battalion surgeon, and then Assistant Group Surgeon, 20th Special Forces Group. Over 2003-4 he was assigned as a general surgeon at the 452nd CSH at Bagram Airfield, Afghanistan. Upon completion of his tour, COL Fuenfer volunteered to serve a second tour in Afghanistan with the 3d Special Forces Group (Abn).

The wooden Shock Block in the "high" position from Madigan Army Hospital, and a Special Forces Beret and Medical Equipment Bag No. 3 from COL Michael Fuenfer's deployments to Afghanistan.

Army Reserve Medical Units in Vietnam

Robert S. Driscoll

The Vietnam War is perhaps the most controversial war in our nation's history. One of the controversies stemmed from the reluctance to call up the Reserves (Army Reserve and Army National Guard) to deploy to Vietnam. The implied reason behind this reluctance supported the notion that use of the army reserve component should be a strategic reserve for a sustained conflict with the Soviet Union. However, the politicians knew that "reservists and guardsmen were better connected, better educated, more affluent, and whiter than their peers in the active forces, and the administration feared that mobilizing would heighten public opposition to the war."

On March 31, 1968 President Johnson announced on television that he would not run for re-election, eliminating the last political obstacle to calling up the reserves. With a Reserve call-up approved, the selection of type and numbers of Reserve units to be mobilized was based on two criteria: the requirements of the US commander in Vietnam and the percentage of the Reserve force to the total strength of the army. In 1968 the medical Reserve components represented 61 percent of the AMEDD go-to-war strength, of which none had been mobilized and subsequently deployed to Vietnam. When the decision was made to mobilize the Reserves for Vietnam, 42 various units were ordered to active duty, of which 11 were medical units. Eventually 35 of the 42 US Army Reserve units deployed, including 11 of the medical units:

RC medical units deployed to Vietnam

312th Evacuation Hospital, USAR, North Carolina
74th Field Hospital, USAR, New York
311th Field Hospital, USAR, Ohio
305th Medical Detachment (Ortho), USAR, Pennsylvania
313th Medical Detachment (Surg), USAR, Virginia
316th Medical Detachment (Blood Distribution), USAR, New York
378th Medical Detachment (Neuro), USAR, Tennessee
472d Medical Detachment (Ambulance), USAR, Maryland
482d Medical Detachment (Equipment Repair), USAR, Illinois
889th Medical Detachment (Surg), USAR, Virginia
350th Medical detachment (Dental), ARNG, Alabama

The call-up was not smooth or according to standard operating procedures: "most of the members of these units first learned of their call to duty through the media, rather than through official Army notification channels."

Once in Vietnam, the Reserve units set out to do their job. The "biggest gripe from unit personnel was the Army's policy of 'infusion,' i.e. taking members out of the USAR units and replacing them with non-unit personnel." The chief nurse of the 312th Evacuation Hospital, LTC Sue Walker, said about the infusion program, "they seemed to take our best quality personnel and send us ones who were not so good." The 312th Evacuation Hospital was the biggest of the 3 Reserve hospitals sent to Vietnam and within one month of arriving in country it expanded its capacity from 120 to 400 beds.

On several occasions the 312th came under heavy indirect fire and hospital personnel refused to take cover and continued to provide medical care to their wounded patients. Army nurse 1LT Sharon Lane, a member of the 312th Evacuation Hospital was posthumously awarded the Bronze Star with V device for her courage and valor to care for patients while under enemy mortar attack. 1LT Lane was the only female and only Army Nurse to die from enemy fire in the entire Vietnam War. The 312th Evacuation Hospital was awarded the Meritorious Unit Citation for duty in Vietnam.

The 74th Field Hospital was given the mission of caring for wounded prisoners of war. "A Swiss representative of the International Red Cross visited the 74th and remarked that the level of professional medical

treatment given the prisoners was equal to and perhaps even better than that given civilians in many Western nations."

Reserve units, unlike individual soldier fillers sent to Vietnam, came home as a unit, and they shared the same common unwelcoming reception upon their return to the United States. LTC Walker of the 312th said upon her return, the unit received a brief official ceremony and when the ceremony was over, "we were afraid to wear our uniforms" in public.

In 1973 the Department of Defense would implement the Total Force Policy ensuring that the United States would not go to war without calling up the reserve components. Since then Reserve medical units have served in Operation Desert Shield/Storm, Operation Iraqi Freedom, Operation Enduring Freedom, and many other contingency operations.

As a side note, two Reserve medical units, the 304th Medical Detachment (Equipment Repair), and the 35th Surgical Hospital (Mobile Army) served on active duty 1968-69 but did not deploy to Vietnam; they stayed in the United States as part of the strategic reserve.

Sources

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Stephen E. Everett, "Reserve Component Medical Units Mobilized in 1968," Information Paper, Center of Military History, 2001.

Writing for The AMEDD Historian

We are seeking contributions! We believe variety is the way to attract a variety of audiences, so we can use:

Photos of historical interest, with an explanatory caption

Photos of artifacts, with an explanation

Documents (either scanned or transcribed), with an explanation to provide context

Articles of varying length (initially we will try a 500 word minimum), which must have sources listed if not footnotes/endnotes

Book reviews and news of books about AMEDD history

Technical requirements:

Photos will need to be at least 96dpi; contact us about file format. Text should be in Microsoft Word (.doc or .docx) format. Please do NOT send text with footnotes/endnotes in .pdf format.

Material can be submitted to **usarmy.jbsa.medcom.mbx.hq-medcom-office-of-medical-history@mail.mil**

AMEDD Center of History and Heritage

Director, Mr Robert Driscoll

AMEDD Museum ameddmuseum.amedd.army.mil/ 210-221-6358

Office of Medical History history.amedd.army.mil 210-295-0977

Office of the AMEDD Regiment ameddregiment.amedd.army.mil/ 210-221-8160

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