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COVER: LT Michelle Ortiz, NC, USNR, holds the boy of male/female twins delivered during her assignment in Djibouti. Story on page 3. Photo courtesy of LT Ortiz.

The Role of Navy Medicine in Medical Readiness

LT Joseph E. Ollivier, MSC, USN

The war with Iraq showed the capabilities of the Navy and Marine Corps and their ability to mobilize men and equipment quickly and efficiently. The logistics of putting a fighting force into the field was an achievement in itself. Yet the success of Noble Eagle and Enduring Freedom was actually a testament to the individuals and organizations that came together. This involved the goal of mobilizing combat troops and equipment, initiating logistical support, forward deploying personnel and supplies to the operational areas in an efficient and critical fashion. This was no more evident than in the assurance of the medical readiness of all the Sailors and Marines involved.

With the mobilization and deployment of the Marine Expeditionary Forces and Navy medical personnel, support on the homefront shifted to the reservist and those in the inactive reserve readiness [IRR] to fill the vacancies. Physicians, physician assistants, nurse practitioners, nurses, hospital corpsmen, and a whole host of other allied healthcare professionals were recalled to active duty.

Maintaining the operational readiness of military installations worldwide and providing support for those troops in the theater of operation required an increase in administrative personnel, supply departments, and payroll. With the ever present threat of terrorist attacks against U.S. installations there was an increased need for troops to provide force protection and, if needed, combat replacement assets. All these individuals eventually were supported one way or another by Navy medicine.

Medical readiness actually began at reserve centers across the U.S. Drilling Naval reservists in preparation for possible recall were put through mock mobilization drills where they were screened by their respective medical departments to make sure all immunizations were up to date, periodic physicals and dental exams were current, and that changes in health status were documented

and addressed. Reserve center personnel made sure that reservist had the opportunity to have power of attorney, wills, and their page twos updated. Wives and dependents were given briefs as to what to expect and who to turn to for assistance when their spouse was recalled.

An extensive number of personnel were recalled from the IRR. Some Marines may have only been discharged 6 months prior and others may have been close to completing their 4-year obligation of IRR. With the uncertainty of what may transpire during this period, all IRR were required to fill out a medical history form 2807 (Report of Medical History). Recalled IRR personnel were screened for current and complete physical examinations and if one was necessary they were seen by a Navy provider. This accounted for about 70 to 80 percent of the IRR being recalled.

The recall of individuals from the IRR required screening of all individuals who may have suffered injuries or illnesses that would disqualify them for active duty. These included individuals who may have been discharged with injuries that they sustained while on active duty previously, and that they never completely recovered from, or which occurred while in IRR status. The BUMED Manual of the Medical Department, chapter 15 provided guidelines on specific cases.

At the Hadnot Point Clinic, Camp Lejeune Marine Corps Base, medical readiness of IRR and reservists was a top priority. All military personnel were given a dental exam and, if necessary, restorative work to bring them within dental standards for deployment. A NOSTRA (Naval Ophthalmic Support and Training Activity) detachment was available to make glasses for recalled personnel. Optometry was also available for those who needed prescription eyewear or adjustments in their prescription.

Changes in the servicemember's health status since their prior enlistment were addressed and any condition

in the individual's health, which could be a factor in their being recalled to active duty and forward deployed, was examined closely.

Disqualification factors included orthopedic surgery on the spine, shoulders, knees, and ankles where recovery did not come back to expected levels. While any surgical repair of a major joint may allow them to function normally on a routine basis, the rigors of preparing for and implementing combat readiness meant that if the joint failed in a combat area it could be a liability for the individual and his unit. These orthopedic conditions were sometimes complicated by the individual being out of body standards, (i.e.: obesity); with body mass index sometimes exceeding 30. Patellar Femoral Syndrome (PFS) was another condition commonly seen among recalled Marines. Patients usually complain of poorly localized knee pain that is aggravated by running, jumping, stair climbing, marching, and prolonged sitting. Subtle clinical findings are maltracking of the patella as the knee is extended or flexed, to overt episodes of dislocation of the patella. Physical assessment of PFS as it related to the person's ability to be recalled could be difficult. The more questionable cases were referred to sports medicine or orthopedics where a more definitive determination could be made as to the medical feasibility of recalling that individual. Any individual that had a chronic illness that was not under control, or was specifically outlined as a disqualification condition was a candidate for rejection. Examples of chronic illnesses included hypertension and vascular disease, metabolic disorders such as non-insulin dependent diabetes, or Celiac Sprue disease. Any autoimmune disease such as systemic lupus erythematosus, rheumatoid arthritis, and colitis were a disqualification factor. Overall, the majority of recalled candidates were a younger and healthier population in the 20- to 30-year-old range whose major positive findings were musculoskeletal in nature.

All re-activated personnel had their immunizations reviewed and updated if necessary. These included tetanus, typhoid, yellow fever, hepatitis A, and in some cases hepatitis B.

Additional immunizations included MMR and Japanese encephalitis depending on the theater of operation to which personnel were being deployed. Anthrax was another immunization administered. This immunization was given in two stages. A primary inoculation of 0.5cc subcutaneous was given at 0, 2, and 4 weeks. Booster inoculations are given at 6, 12, and 18 months with annual boosters given if indicated.

Troops also had to be immunized against the use of smallpox as a biological weapon. Unlike Anthrax, which has animal vectors, smallpox is unique to humans. Natural smallpox was eradicated by the World Health Organization through worldwide vaccinations with the last reported case seen in Somalia in 1977. After the virus was eradicated, routine vaccination was discontinued. This created a whole new generation that had never been inoculated against this contagion.

The smallpox virus is easily spread from person to person and has about 30 percent mortality. As such the smallpox virus could be used as a biological weapon and significantly affect medical readiness.

With the successful conclusion of the offensive operations in Iraq, mobilization was replaced by demobilization and separation physicals. All returning Navy and Marine personnel from the Gulf region undergo a health screening procedure and have an interview with a Navy medical provider to evaluate them for further medical work up and referral if necessary. With the beginning of the military mobilization a stop loss had been put in place. Troops that had planned on returning to the civilian sector were retained until the successful completion of Operation Iraqi Freedom. With this goal achieved the stop loss was lifted in May and those troops held past their discharge date were allowed to start the process to return to civilian life. Part of this procedure involved a complete physical exam prior to their leaving military service if the last one was over 5 years past.

Medical readiness for Navy medicine meant being able to mobilize personnel rapidly while at the same time providing the collateral duties that Sailors and Marines need on a daily basis. Performing sick call, overseas screening, making referrals to specialists, and maintaining after hour clinics. Noble Eagle and Enduring Freedom demonstrated Navy medicine's ability to rise to the challenge of preparing for and accomplishing those goals set forth by the mission. The success was seen in the smooth transition of IRR individuals and active reservists through the medical process that prepared them for their duties and the overall mission objectives. This in turn is a testament to the dedication and pride of those who work in Navy medicine and their commitment to the men and women they serve. □

LT Ollivier is in private practice in Idaho. He is attached to Naval Hospital, Bremerton, WA, out of Naval Reserve Center, Pocatello, ID.

Stepping up to the Plate NC Officers Meet Challenges on “The Horn”

LT Michelle R. Ortiz, NC, USNR

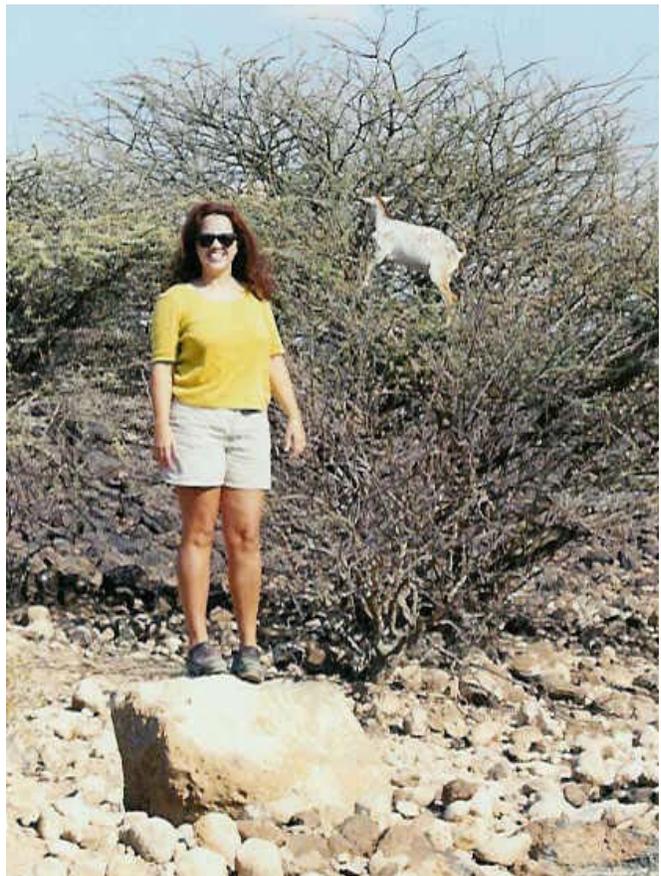
Ask any Nurse Corps officer if they are challenged in their military careers, and you’ll get an enthusiastic “Yes.” For three nurses chosen to be part of the first 10-member U.S. Navy Emergency Medical-Surgical Team (USNEMST) in Djibouti, that “Yes” would be followed with some pretty amazing stories, stories of heart and courage, of adaptability and contribution.

The Team

The team assembled at Fort Benning, GA, from around the continental United States. Team members were CAPT Gerald Demarest, team leader and trauma surgeon; CAPT Cheryl Gandee, general surgeon; CDR Lynn Welling, emergency room physician; LCDR Kevin McKenny, anesthesiologist; LTJG John Conza, physician assistant; HMC Brian Hollen; HN Truman Keith Keplinger; and the three Nurse Corps officers.

The Nurses

LT Harry Hamilton, an ICU nurse from NH Pensacola, FL; myself, LT Michelle Ortiz, a perioperative nurse from NH Beaufort, SC; and LTJG Agnes Ambrosi, an urgent care nurse from NACC Newport, RI, were the Navy nurse component to the USNEMST. LTJG Ambrosi also served in a secondary role as translator for the group. We three served in our traditional roles as Nurse Corps officers, but each was additionally tasked in some very unconventional roles as well.



A goat in a tree. Only in Djibouti! Initially there were five goats in this tree; the others jumped out when I approached.

Photos courtesy of author

The mission for the USNEMST was to augment the local French military hospital, Centre Hospitalier des Armees, Bouffard, in Djibouti City on Africa's eastern coast, commonly called the "Horn of Africa." For those who are unfamiliar with Djibouti, a little information: Djibouti is a developing African country strategically located on the shores of the Red Sea and the Gulf of Aden, just across from Yemen. It is bordered on the south by Somalia, on the east by Ethiopia, and Eritrea to the north. It gained its independence from France in 1977 and is governed by an elected president and a parliament. It has a population equivalent to the state of Alaska, two-thirds of whom reside in the capital city. Temperatures in Djibouti average 72 F in the winter and up to the 120s in the heat of summer. Add in the humidity of 85 percent, and summer temps can feel like 160 F.

The Adventure Begins

That first week at Fort Benning entailed medical screenings, uniform issue, threat briefs, and weapons qualifications. It took Agnes and me three tries to qualify with the 9mm pistol . . . not bad for a pair with no firearm experience. In typical Navy Chief fashion, HMC Hollen told us we were the designated "reloaders," not the "shooters," if we were attacked.

From Fort Benning, we loaded our bags and left for Bahrain. There, we were greeted by the force surgeon and further briefed as to our duties and scope of practice. We then left for the African continent. Stepping off the plane, one is overwhelmed by the incredible heat. We arrived at Camp Lemonier, now renamed "Camp Liberty," the local U.S. Army base that once served as both a French and Djiboutian military post.

First impressions were as varied as the members of the team. Words like "austere," "desolate," and "beautiful" were interwoven to describe the unique environment of which we were now a part. Where were all the giraffes, the elephants, and the monkeys? Turns out we weren't in *that* Africa . . . we were in the dustbowl. However, even dustbowls have their own sense of character and uniqueness, and yes, beauty.

Mission Incredible

We soon found out that our mission, although well defined in our minds, was not yet clearly defined diplomatically and legally with our French counterparts. A lot of paperwork still needed to be completed, so the team set about "carving out" our intermediary mission, while our primary mission was refined. We established a sick call clinic at the camp for the U.S. Army and Air Force personnel. We three nurses quickly found ourselves functioning as field acute care nurses in the clinic handling routine sniffles, bug bites, gastroenteritis outbreaks, dehydrations, and minor injuries. One night I was in the clinic during my off time when the call came in that there had been a vehicle rollover involving four Special Forces members. LTJG Conza and myself assisted the clinic staff to evaluate and triage the two most severely injured soldiers. One soldier had a fractured shoulder and the other had suffered a possible cervical spine injury. It became necessary to transport the soldiers to the local French military hospital for care. This was the very same hospital we as the team were assigned to and still awaiting clearance! I quickly found myself in the role of translator between the soldiers and the French emergency room physician.

After getting the patients settled into their rooms for the night, we were then stopped on the way out by the hospital gate guards where they demanded payment for the services of the emergency room visit. Again, I became translator and momentary chief diplomat eventually convincing the guard into letting us leave. I think they just gave up out of desperation.

LTJG Ambrosi was the most unique asset assigned to the team. Having been born and raised a French national, she possessed the advanced language skills that opened many diplomatic doors for both the team and herself. She was immediately in demand by top-ranking U.S. military officials for various high-level meetings and social functions with both French and Djiboutian counterparts. She taught French to the team members on a daily basis so that they would have a working vocabulary of the language and would be able to conduct some very basic conversations. She also taught English to our French counterparts, so they could communicate better. Everyone learned the basics, and she also managed to keep interest peaked by throwing in "colorful" phrases. One of the "milder" favorites was, "You're full of bologna." LTJG Ambrosi was sought out by the American ambassador to Djibouti as an invaluable resource to his office and as a liaison facilitator between both the English and French speaking parties in all diplomatic matters.

LT Harry Hamilton was assigned to work in the ICU/PACU area of the hospital. In a typical week, Hamilton saw patients with snake bites, children who'd drowned in pools, tuberculin patients, burn victims, victims of vehicle rollovers . . . the list goes on and on. Add to his list of talents: human elevator. "When we first arrived, the



LT Hamilton assists with carrying a patient up the stairs to the ward.

elevator was broken and we had to carry patients up flights of stairs in litters,” said LT Hamilton. “At times, it was like being in the ‘Twilight Zone’,” he said. I could not resist standing in the hallway with my patients and pushing an “imaginary button” for the elevator, while Harry just rolled his eyes at me. It wasn’t so funny to him. A replacement part from France could take months, because the repair person was afraid of flying and would only come by ship.

As for culture shock, it was universal to both the French and the Americans. Hamilton says, “The French nurses were all enlisted personnel, which is a contrast from U.S. military nurses who are officers. Like us, they provided excellent nursing care and specialized in different aspects of nursing.” The French doctors

could not understand how the American system allowed nurses to be officers too, and even be of equal rank as them. We had some pretty heated lunches over that one.

When not in the ICU, LT Hamilton worked with the Special Forces to build assault targets. Additionally, he provided medical coverage for the weapons ranges for various units, and often was able to practice with his own 9mm. LT Hamilton and I participated in warfare training with the elite teams. We served as temporary morgue officers for the camp of 1,800 personnel. All three nurses trained as medevac nurses on several aircraft platforms, and almost every member of the team performed a medevac mission. These missions were comprised of taking the most seriously injured American service personnel to

Germany for more intensive care and recovery than could be provided locally.

Working in the operating suite in Djibouti was very interesting. Supplies and medicines being difficult to obtain, costly to purchase, and slow to restock, we were encouraged to be very prudent with their use. This applied to all aspects of the operative experience: prepping, linens, anesthesia, post-operative pain control, everything. Something we Americans were not accustomed to and an early source of frustration for the French.

Imagine our horror to see window air conditioning units with grills missing and simply boarded up. Then, there were the flies to contend with. A fly in the room, while sending me into orbit, didn’t even phase our professional peers. A fly in the room is part of being in Africa ... just put a little more Betadine on that spot and start “shooing.”

Learning the names of the instruments was also a challenge. They were all in French. Later, after I returned to Naval Hospital Beaufort, it would be a source of entertainment for my technicians when they would ask for “Kelly clamps” and I’d look at them inquisitively and say, “You mean, ‘Achetes?’” It took a while to stop saying, “NEF-SO!” to my waking patients also. Nef-so meant “breathe!” in Afar.

One patient we treated was an 18-year-old male who had attempted suicide at age 14. He drank a liquid similar to Drano and had survived the incident with an esophagus strictured down to mere millimeters wide at the smallest point. The result was that he survived only on milk and water and was unable to consume solid food. He felt constantly hungry and was extremely malnourished. It seemed his body stopped maturing and growing

at 14 years old. There were four nations represented in the operative suite on this case: France, America, Italy, and Djibouti. Talk about a linguistical nightmare! The young man ended up with a great result and was back to eating solid food and gaining weight within weeks of his surgery.

Another patient I'll never forget was one that never came to the OR. The patient was a 3-year-old boy who'd wandered over to the swimming pool and fallen in while his family napped. The first time I saw him, he was intubated in the ICU and his mother was standing at the bedside crying. LT Hamilton had told me about him. Being the mother of a 2 year old, I couldn't just walk on by. I went in and very simply said, "He's beautiful. I am a mother too . . . I have a mother's heart, and I understand. We can cry together." I put my arms around her, and we did.

And there are those patients that you never ever wanted to see, but will surely never forget. Her name is Asma. She was in a house fire that killed several members of her family. When I saw her, she was coming for dressing changes to her head. Her ears were gone, as was her hair, and she was completely petrified. She screamed over and over again in Afar, "PUT ME TO SLEEP!" She would grab the oxygen mask and heave breaths trying to get to sleep before her dressings were removed. My heart went out to her. Here in this country, where so much of a woman's worth is based on her appearance and not on her education, her chances were slim of carving out a life of her choosing rather than one of survival. I took Asma on as my personal investment, and tried to be there for all her dressing changes. I got my mother to mail me stickers to put on her head dress-



Early on, the only way to "dress up" Asma's bandages was to write on them. On the other side, I wrote "Je t'aime" (French for "I love you") Later, my mother would send stickers to brighten them up.

ings to brighten them up. The commanding officer of the camp, COL Forrest, donated some candy for her. An Air Force nurse donated a toy and some children's character paper plates. Even my brother, AE1 Bailey Center II, sent a box of "girly" things for her via the Vice CNO's plane: plastic jewelry, more stickers, beads, coloring books, etc. Asma seemed to brighten with each passing day. By the time my deployment was over, she would go into the OR quietly and calmly, and even smiled a few times. The day I introduced her to my replacement, she grabbed my hand and kissed it to say "goodbye" while my tears rolled.

One of the funniest experiences I had in the OR was a Djiboutian man who had been hit by a bus and waited weeks to have his fractured hip stabilized. Upon waking from anesthesia, he looked at me and noticed I was wearing an American flag bonnet to cover my hair. He said to me in French, "Are you an American?" I

responded in French that, yes, I was an American, not knowing what his reaction would be. He then starts yelling in English, "I hate the French! They're horrible! I love Americans! America good!" I kept trying to get him to quiet down, as everyone in the room was French except me, and yet he continued on. It was so embarrassing, and yet, so funny. After that, every time I would see him hobbling across the hospital campus for his follow-up appointment, he'd stop and wave a crutch at me and scream, "Hello America! America good!"

We spent a lot of our surgical time correcting work that had been done by the local civilian hospital, Peltier. We had one patient who'd gone to Peltier Hospital for treatment of multiple fractures and lacerations of the hand, and was simply sewn up and sent home. He presented to us 5 days later when the sutures had burst, the hand was infected, and he could stand the pain no longer. The orthopedic surgeon was at a loss as to where to

even begin to piece the hand back together. The end result was amazing. A functional hand that worked from what could have ended up an amputation. Another victim of Peltier was a post-partum C-section patient who had also undergone a laparoscopic cholecystectomy. She was so infected, you could literally smell her down the hall. She died of sepsis within days of admission.

I had the unique opportunity to serve as a translator specifically for the Special Forces teams to coordinate security for top-level dignitaries coming to Djibouti. The first time they asked me if I would translate for them, I thought surely they meant LTJG Ambrosi. They didn't. They requested me since I had participated in some training exercises with them. It was quite a compliment.

Another time I was flown out to USS *Belleau Wood* to provide coverage for their OR nurse who was TAD. That was an awesome break from Djibouti. When we first got to Djibouti, I didn't understand what she meant when LTJG Ambrosi said, "It's so nice to work in French." Finally, I understood. It was so nice to work in English.

Liberty

Liberty offered a unique opportunity to explore the local fare. There was a huge market in the center of town that was great for shopping and trying one's luck at "haggling." This was a challenge few on the team had much experience with, but with little practice, I stood out amongst my peers as the master. Essentially, I'd just wear 'em down, walk away, come back, wear 'em down some more, and eventually they'd cut a deal to get me out of their hair!

After September the weather cooled off a bit, which offered some outside activities that before were unbearable. The local Sheraton Hotel had an oceanside pool that was a favorite for perfecting one's tan. One could spend the entire day at the pool, enjoying the ocean breeze, and just relax. A day trip to Lac Assal, the lowest point on the continent, was also very popular. "Lac Assal was incredible," says Ambrosi, "The water is so blue and warm." The salt content of the water is so concentrated it is possible to float effortlessly sitting up. The challenge becomes getting your feet back under you to stand up again. Snorkeling at nearby Plage Goubet was also fun. LTJG Ambrosi recalls, "Think of those aquarium fish you see in the States, and make them about 10 times larger." There were also huge sea turtles happy to serve as escorts as you snorkeled.

Although many tried to see the monkeys of Arta, a local village, I was the only one who was ever successful. They come out twice a day for feeding, and I just happened to be in the right place at the right time. My husband had come for a visit and we decided to drive to Lac Assal to spend our day. On the way home, he noticed a couple of monkeys coming down from the hills towards our car. We threw a handful of Cheetos to them, and out of nowhere hundreds of monkeys appeared! It was amazing. I had the videotape recording at the time, but I was so excited that most of the footage is of the floorboards with me screaming and laughing. So much for recording the memories.

LT Hamilton and LTJG Ambrosi took a weekend trip to go camping with their French counterparts. They shared meals with the locals and slept

under "toucouls" (straw huts), and were even invited to attend a local wedding. Later that evening, LTJG Ambrosi awoke to find a hyena visiting while she slept. They also went diving and hiking throughout the countryside with various units, and discovered a landscape that seemed somewhat familiar and surreal. Turns out the first "Planet of the Apes" was shot in the dry arid desert of Djibouti.

The Future of this Mission

This experience in a new culture and new land has forever changed the lives of that first team. Medicine as we know it in the western world is quite different than that practiced in the ancient land of Africa. Although not afforded the same luxuries commonplace in the West, the challenge to provide compassionate care to U.S. servicemen and women serving "on the Horn" was met head-on. The result is a new application for the Navy's mission, a fresh challenge for Nurse Corps officers, and bridges of professionalism and friendship built between three communities.

The mission continues. The next team arrived in November to carry the mission into its next phase. The new team was picked entirely from Great Lakes, IL, and was of identical makeup as the premier team, with the addition of a surgical scrub technician. This mission is expected to continue for some time into the future. If you are interested in being part of the next USNEMST, get "on the Horn" and contact your detailer. Be flexible, be motivated, pack some shorts, and most of all, enjoy. □

LT Ortiz is a perioperative nurse currently assigned to the main operating room, Naval Hospital Beaufort, SC.

RADM Eugene R. Hering, Jr., MC, USN

The Indispensable Military Surgeon

CAPT Eugene H. Ginchereau, MC, USNR (Ret.)

At the 58th Annual Convention of the Association of Military Surgeons in October 1951, CAPT Eugene R. Hering, Jr. MC, USN presented a paper entitled, *Combat Medical Practice*.⁽¹⁾ In his lecture, he discussed his experiences with the First Marine Division during the Chosin Reservoir Campaign. As the Division Surgeon, he was responsible for the planning, organization, and execution of all medical operations of the Division. He described the preparations for the treatment and evacuation of casualties of what was supposed to be the final campaign of the war.⁽²⁾

CAPT Hering then related the events of those remarkable days at Chosin. On 27 November 1950, the Chinese Communist 9th Army Group attacked the First Marine Division along its line of advance from Koto-ri to Yudam-ni, on the western side of the Chosin Reservoir. Within days the Division, outnumbered nine divisions to one, was surrounded and

near annihilation. MGEN Oliver P. Smith, the commander of the First Marine Division, called for a withdrawal from Yudam-ni on 1 December 1950, and for the next 11 days, the Division fought its way out of the entrapment along 75 miles of icy, winding roads in sub-zero temperatures.

CAPT Hering compared the 5 day and night movement from Yudam-ni to the famous retreat recorded in Xenophon's *Anabasis*.⁽³⁾ At Hagaru, a town midway between Yudam-ni and Koto-ri, forward elements of the Division Medical Battalion treated over 2,400 casualties from Yudam-ni while under continual enemy attack themselves. Working ceaselessly in perilous weather conditions, the two clearing companies and three surgical teams cared for hundreds of additional casualties from the battle at Koto-ri and for Army survivors from the eastern side of the Reservoir.

After highlighting the difficulties of evacuating casualties from a hast-



Photos from the Eugene Hering papers, BUMED Archives

ily constructed airfield in Hagaru, he recounted the “terrific fire fight” during the breakout from Hagaru to Koto-ri.⁽⁴⁾ He did not mention that he remained in Hagaru with some members of the Medical Battalion tending the wounded until the last possible moment for escape. After 2 days of intense combat, the Division reached Koto-ri. Heavy fighting re-occurred during the movement from

Koto-ri, but as CAPT Hering stated, "Once the outfit started down the hill, there was no stopping them," as "weary infantrymen and medics crowded aboard the trucks."⁽⁵⁾ By the time the Division reached the safety of the Hamhung-Hungnam area, the Medical Battalion had managed more than 5,000 casualties; none were left behind.

He ended this part of his talk by saluting "the courageous Navy Corpsmen and the fine young Battalion and Regimental medical officers," who performed their duties sometimes as close as 200 yards from the front lines. "Let us . . . be humble," he said, "in the knowledge of the sacrifice those men made in their *unselfish, cooperative* efforts to save the lives of their comrades."⁽⁶⁾

CAPT Hering then examined the qualifications of a military surgeon. A military surgeon, he insisted, must realize that "there is no finer field for his talents than in saving the lives of young men fighting to defend our way of life." He must have the "physical attributes that will enable him to withstand the rigors of the field." He must "know the fundamental principles of wound care and the prevention and treatment of diseases of military importance." Finally, he must be aware of the military plans and contingencies of a campaign and always be ready to "adapt himself and the functions of his medical forces to the military situation as it presents itself."⁽⁷⁾

This description of a military surgeon was a reminder to medical officers of all the armed services of the high calling of their profession. It was also an authoritative statement by an officer committed to achieving these standards. Ironically, in describing the ideal, he described himself. He was, in fact, the quintessential military surgeon, uniquely prepared and qualified

by his dedication, physical attributes, training, and experience to lead Navy medicine when called to Korea in those early, crucial days.⁽⁸⁾

In Korea, CAPT Hering did not fail or falter in service to his country and the men he dedicated his life to helping. In doing so, he became the most respected and decorated Navy combat medical officer of the war.

The Preparatory Years

Dr. Hering was commissioned in the Navy Medical Corps on 28 June 1931.⁽⁹⁾ After an internship at Naval Hospital Great Lakes, he served as a shipboard medical officer for 2 years. In December 1935, he was assigned to the Fleet Marine Force in San Diego, his first operational tour of duty with the Marines. When the international settlement in Shanghai, China was threatened in 1937, he accompanied the 6th Marines to protect and evacuate American citizens.⁽¹⁰⁾

At the outbreak of World War II, CAPT Hering was in training as a resident in surgery at Naval Hospital San Diego. During February 1942, he reported to the Atlantic Fleet Marine Force. This reunion of CAPT Hering and the Marines was to last; he remained with them until his retirement in 1955. For all intents and purposes, he became a "leatherneck physician."⁽¹¹⁾

Shortly thereafter, he participated in the Aleutian Islands and the Gilbert Islands Campaigns. In January 1944, Hering became Division Surgeon of the Second Marine Division. His dynamic leadership and technical proficiency in combat became apparent at Saipan, Tinian, and Okinawa. For his outstanding performance in the Marianas, he was awarded his first Legion of Merit with a Combat "V" award. The citation recognized his exceptionally merito-

rious conduct in the planning and coordination of medical operations, especially the efficient treatment and evacuation of casualties, and the resulting minimal loss of life.⁽¹²⁾

After the war, he served brief tours as commanding officer of the Field Medical Research Laboratory and senior medical officer of the First Special Marine Brigade. In August 1946, he again became Division Surgeon of the Second Marine Division. Throughout these postwar years, CAPT Hering aggressively pursued solutions to the organization, materiel, and personnel problems caused by demobilization and military reorganization. He assertively held that the Navy Medical Department could not meet the needs of the Marine combat forces unless radical changes occurred. These concerns became the agenda for the remainder of his professional life.⁽¹³⁾

Among his ideas for the advancement of field medicine was the establishment of a Department of Amphibious Medicine within in the Bureau of Medicine and Surgery with a chain of command separate from shore and afloat departments. He hoped that an independent department of experienced combat medical officers would provide a receptive forum and direct exposure to the Surgeon General for his innovative recommendations and those of like-minded colleagues. He was also an outspoken proponent for a realistic training program for junior medical officers. He envisioned that these officers would complete a curriculum designed and presented by combat trained and experienced officers, and that they would participate in amphibious exercises prior to being assigned to Marine units. In addition, he advocated a complete re-examination of field medical practices and the modernization of field medi-

cal equipment, from packaging to pre-positioning. The final element of his revolutionary plans was the development of a manual for medical officers supporting Marine units. This manual would cover all phases of organization, training, and operations, and provide young officers with reliable guidance wrought from the experience of actual combat.

Most of his ambitious program remained unrealized as he returned to Naval Hospital San Diego in 1948 to resume his interrupted surgical residency. He remained in residency until March 1950.

Korea 1950-1951

As CAPT Hering predicted, when the First Marine Division mobilized at the outbreak of the Korean War in July 1950, there was no pool of combat trained or experienced Navy medical officers available to fill the billets required to bring the Division to full wartime strength. All training schools for medical officers assigned to duty with the Fleet Marine Force were discontinued in 1945, and most of those who had served with the Marines in World War II returned to civilian practice.(14,15) A manpower analysis completed in November 1949 revealed that there were only 22 Medical Corps captains on active duty who had previous combat experience with Marine amphibious forces. Of these, only CAPT Hering and one other medical officer were available for assignment to amphibious units, the others being disqualified because of age, nearness to retirement, or assignment to other critical billets.(16)

CAPT Hering, sensing an opportunity to put into practice what he had preached about field medicine, volunteered to command the Medical Section of the First Provisional Marine Brigade.(17) The Brigade, a re-

inforced regimental combat team hastily formed from elements of the First Marine Division, was the first combat unit sent from the United States to Korea in response to General of the Army Douglas MacArthur's urgent request for troops to defend the Pusan Perimeter.(18)

The Medical Section consisted of 14 Medical Corps officers, 2 Dental Corps officers, 1 Medical Service Corps officer, 1 Hospital Corps officer, and 154 hospital corpsmen and dental technicians. The Section personnel were distributed among the Brigade Surgical Section, B Medical Company, and the operational Marine units. With the exception of CAPT Hering, no member had previous combat experience, and few had any field service training.

With limited preparation and planning, the Brigade disembarked at Pusan, Korea on 2 August 1950. Within 24 hours, it was deployed to defend the Masan area in the southwest part of the Pusan defense perimeter. That night, B Medical Company received its first serious casualty and evacuated the patient by helicopter to Pusan. This was the first frontline air evacuation of a wounded Marine.(19) From then on, the Brigade and its supporting Medical Section were in near continuous combat for 41 days.(20) On 13 September the Brigade was deactivated and integrated into the First Marine Division.

BGEN Edward A. Craig, commanding officer of the Brigade, cited the doctors and corpsmen of the Medical Section for their heroic support of Marine operations.(21) CAPT Hering, himself, was awarded the Navy and Marine Corps Medal for heroism in saving the life of a wounded officer on 7 August. He also received his second Legion of Honor award for meritorious conduct during

the period 2-27 August. The citation praised his organizational work and recognized him as "capable and inspiring officer" who risked his life on "numerous occasions under heavy fire to insure smooth operation of the evacuation of casualties."(22)

Upon arrival of the First Marine Division in Korea in early September 1950, MGEN Oliver P. Smith appointed CAPT Hering the Division Surgeon. Almost immediately, plans were developed for an amphibious landing of the Division at Inchon, on the west coast of Korea.(23) Again, Navy medicine and the Marine Corps were fortunate in this most critical period to have an officer with the requisite amphibious operational experience to lead the Medical Battalion of the First Marine Division. Beginning 15 September, CAPT Hering's battalion treated over 5,500 casualties in 25 days of continuous frontline support.(24) Seoul was occupied and the siege of Pusan was broken. For his extraordinary performance at Inchon, CAPT Hering received his third Legion of Merit award. He was cited for "his broad professional knowledge, tireless energy, and able leadership" that contributed to the saving of countless casualties, and for his resourcefulness in solving critical supply problems.(25)

The last epic event of the Korean War that CAPT Hering participated in was the Chosin Reservoir Campaign. To say that CAPT Hering was proudest of his days of service at Chosin would not overstate his thoughts. He considered the fighting withdrawal from the Chosin Reservoir to be a "masterpiece of military accomplishment," and the performance of his personnel a textbook example of combat medical treatment, triage, and evacuation. He believed that the "Medical Department was . .

. one of the keys” to the success of the operation.(26) Most of his Navy and Marine colleagues agreed. Many also thought that the success of Navy medicine at Chosin was possible only because of CAPT Hering’s presence. Of his performance at Chosin, RADM Joel T. Boone, a World War I Medal of Honor recipient, said, “He served country, Navy, and Corps with superb distinction, inspiring leadership, great courage, new glory, and highest honor.”(27) The citation of his fourth Legion of Merit award emphasized his achievements:

. . . During the withdrawal from the Chosin Reservoir, he directed the personnel under his command with exceptional skill, foresight, and resourcefulness and was directly instrumental in the success achieved by his units in collecting and treating over 5,000 Marine and Army casualties and in evacuating the stricken men by air at a time when the division was surrounded and cut off by numerically superior hostile forces. No wounded were abandoned and many lives were saved by the timely and effective medical attention rendered by his personnel . . . By his outstanding professional ability, marked courage, and selfless devotion to duty, Captain Hering served to inspire all who observed him and contributed materially to the successful accomplishment of the mission assigned the division, thereby upholding the highest traditions of the United States Naval Service.(28)

The Final Years

In February 1951, CAPT Hering relinquished his duties as Division surgeon of the First Marine Division, and left Korea.(29) After temporary duty at the Bureau of Medicine and Surgery, he became the commanding officer of the Field Medical Service

School, Camp Lejeune, NC, in May 1951. There, he worked tirelessly to upgrade the training program to make it more relevant to the difficulties he knew the inexperienced medical officers and corpsmen would face in Korea. Along the way, he continued to press his agenda, which now included the recognition of field medicine as a military specialty with its own distinguishing uniform insignia, and the suggestion that the Marine medical services be separated from the control of the Bureau of Medicine and Surgery.(30) He advanced, as well, the idea of an Armed Forces Institute of Military Surgeons, an “institute capably staffed with the best available talent that will rank,” he hoped, “with the top educational establishments in any field,” an “institute that would give stature to the title Military Surgeon.”(31)

Upon the nomination of the Surgeon General of the Navy in June 1954, CAPT Hering, became the first medical officer assigned to the billet, Staff Advisor to the Commandant of the Marine Corps on Medical Matters.(32) As a member of the Commandant’s staff, he was now in a very favorable position to press forward his ideas about field medicine. But, while he did much to improve the professionalism, training, and personnel staffing of the medical units supporting the Marines, he met continued resistance to his visionary program. In frustration, he submitted his request for voluntary retirement on 26 January 1955, giving only perfunctory justifications.(33) He laid out the real reasons for retiring in a letter to the Commandant of the Marine Corps. Among these was his dissatisfaction with the assignment of untrained, reluctant “second-rate personnel to fill . . . key staff billets,” thereby jeopardizing what he felt was

the primary mission of Navy medicine, providing “the best possible care for our wounded in battle.” He also decried the emphasis on hospital based specialty training and the lack of interest of the Medical Corps in operational medicine. Perhaps most infuriating to him was the failure of the Bureau to promote two officers who had served “with distinction with the Marine Corps in combat in World War II and the Korean War.”(34)

CAPT Hering retired on 1 July 1955 with the rank of rear admiral. The ceremony was conducted in the office of the Commandant of the Marine Corps. The Secretary of the Navy presided and read a letter of appreciation. Every available Marine Corps general in the Washington, DC, area attended. There was, however, no representative of the Bureau of Medicine and Surgery present to “offer a ‘Well Done’ to one of the its most decorated and distinguished combat Medical Officer(s) on the occasion of his retirement.”(35) Three weeks later, the Surgeon General sent RADM Hering a letter thanking him for his service to Navy medicine and expressing best wishes for his retirement.(36)

After retiring, RADM Hering began a medical practice in Lakeside, CA. He became a leader in his community, profession, and polo, a sport he favored and likened to war in its strategy and danger.

Despite his decorations and promotions, Dr. Hering never received the recognition from Navy medicine he deserved. After his death at age 79 in 1987, he became a part of the “Forgotten Generation,” a generation of men and women who served in a misunderstood, unpopular war that became known as the “Forgotten War.” The recent 50th anniversary marking the signing of the armistice in Korea

gives members of the Navy Medical Department an opportunity to remember and honor their service.

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1. The address was published in *The Military Surgeon, Journal of the Association of Military Surgeons of the United States*, Vol. 110 (January-June, 1952), 102-106.

2. CAPT Hering wrote a letter to his father dated 15 October 1950, about a month and a half before the First Marine Division was surrounded on the verge of annihilation. In the letter he comments on the success of the Eighth Army and surmises, "Maybe we will get home for Christmas after all." The letter is in the file, Correspondence with Parents, folder 9, Eugene R. Hering Papers, BUMED Archives, Washington, DC.

3. Xenophon, a Fifth century Greek historian, wrote *Anabasis*, a book about a Spartan army sent to Persia to assist Cyrus. Xenophon recounts the events of their defeat at the Battle of Cunaxa in 401 BC, and the subsequent heroic march of the surviving 10,000 back to the safety of the Black Sea.

4. "Combat Medical Practice," *The Military Surgeon*, Vol. 110 (January-June, 1952), p. 104.

5. Ibid.

6. Ibid., p. 105.

7. Ibid.

8. CAPT Hering excelled in sports. He was a single digit handicap golfer, an expert marksman, and low handicap polo player.

9. For biographical details of his life, see the documents: Navy-Biographies Section, OP-296B, 14 December 1951, and Officer Biography Sheet dated 30 October 1953. Copies are in folder 13, Hering Papers, BUMED Archives.

10. The Japanese invasion of China began on 7 July 1937. There was a major land battle around Shanghai during August 1937. Because foreigners, including

Americans, were endangered, the international community mobilized to rescue them.

11. VADM James Zimble, MC, USN, gave a speech in the spring of 1989 at the Korean War Veterans Day Commemorative Services in Washington, DC. In the speech he gave special recognition to CAPT Hering for his outstanding performance in Korea and referred to him as a "physician-leatherneck." A copy of this speech is in folder 13, Hering Papers, BUMED Archives.

12. For a copy of the citation, see file, Commendations, Personal and Official, folder 11, Hering Papers, BUMED Archives.

13. CAPT Hering's detailed personal thoughts on these issues are in a letter to CAPT Warwick T. Brown, MC, USN, dated 25 March 1946 file, Personal Letters (incoming) 1946, folder 4, Hering Papers, BUMED Archives.

14. A discussion of the problems of field medicine training after World War II are in an enclosure to the Chief, Bureau of Medicine and Surgery memorandum to the Chief of Naval Operations (BUMED-216-mjf) dated 8 January 1954. BUMED Archives, Korean War file, Washington, DC.

15. The shortage of medical personnel is discussed in depth in Medical Department, U.S. Navy document, *Analysis of Problems Created by Korean Situation, June 1950 to March 1952*. Code 216, undated. BUMED Archives, Korean War file, Washington, DC.

16. Medical Department, U.S. Navy document, *Military Medical Experience (sic) During The United Nations Police Action in Korea, June 1950 to 1 April 1951*, Code 216, undated. BUMED Archives, Korean War file, p. 12.

17. His reasons for volunteering are presented in an undated letter to his father probably written just before the First Provisional Marine Brigade, FMF, (Reinforced) left California. The letter is in

file, Correspondence with Parents, folder 9, Hering Papers, BUMED Archives.

18. When the Korean Conflict began in June 1950, GEN MacArthur was the Far East Commander, U.S. Eighth Army. He became the Commander in Chief, United Nations Command and was charged with the defense of South Korea. By August 1950, the United Nations forces occupied only a small area around Pusan, a port city on the southeastern tip of the Korean Peninsula. The demarcation line of this area was called the Pusan Perimeter.

19. Two of the most important innovations in combat casualty care during the Korean War were the use of helicopter evacuation and the placement of helicopter landing pads on hospital ships. Because of these innovations, casualties could receive definitive, lifesaving care within minutes, even if wounded in remote areas.

20. A complete report of the activities of the First Provisional Marine Brigade, FMF, (Reinforced) appears in a memorandum from GEN E. A. Craig, Commanding General, to the Commandant of the Marine Corps dated 12 September 1950. A copy is in the file, Reports on Campaigns, folder 11, Hering Papers, BUMED Archives.

21. Ibid., p. 5.

22. The original citation is in the file, Commendations, Personal and Official, folder 11, Hering Papers, BUMED Archives.

23. The amphibious assault on Inchon was GEN MacArthur's idea. The attack was designed to relieve enemy pressure on the Pusan Perimeter by interrupting North Korean supply lines. Surprisingly to many critics, the operation was flawlessly and successfully conducted. The Pusan Perimeter held; the breakout from Pusan and the drive to the Yalu River began.

24. For an excellent summary of the medical operations of the Inchon landing,

see Department of the Navy, Bureau of Medicine and Surgery, *The History of the Medical Department of the United States Navy, 1945-1955*. NAVMED P-5057, pp. 126-135.

25. The original citation is in the file, Commendations, Personal and Official, folder 11, Hering Papers, BUMED Archives.

26. CAPT Hering's thoughts immediately after Chosin are recorded in a letter to ADM Groesbeck dated 15 December 1950. The letter is in the file, Personal Letters (outgoing), 1950, folder 5, Hering Papers, BUMED Archives.

27. These comments are in a telegram from RADM Boone to RADM H. Lamont Pugh, Surgeon General of the Navy dated 16 February 1951. It is in file, Commendations, Personal and Official, folder 11, Hering Papers, BUMED Archives.

28. The original citation is in the file, Commendations, Personal and Official, folder 11, Hering Papers, BUMED Archives.

29. An amusing story about Dr. Hering appears in GEN O.P. Smith's Korean War memoirs. Hering was asked to attend a dinner with GEN Smith and his staff the night before the former left Korea. As a surprise for Smith, Hering spent the afternoon shooting pheasant and provided the main course.

30. His recommendations appear in memorandum to the Chief of Naval Personnel dated 17 Dec 1952. It is in file, Other Official Letters (sent), folder 8, Hering Papers, BUMED Archives.

31. His ideas are developed in a long letter to RADM Boone, undated. It is in file, Personal Letters (outgoing) 1951, folder 5, Hering Papers, BUMED Archives.

32. Currently, the title of this billet is "Medical Officer of the Marine Corps."

33. The request is in file, Personal 1954-1955, folder 6, Hering Papers, BUMED Archives. In it he offers reasons of financial hardship, family separation,



MGEN O.P. Smith, USMC, congratulates CAPT Hering after he was presented with the Legion of Merit for "exceptionally meritorious conduct" in Korea.

and the sickness of his wife to justify his request.

34. One of the officers was CDR Howard Johnson, his executive officer in the First Marine Division, and close friend. CDR Johnson became the Division Surgeon when Hering left Korea. The letter is in file, Personal 1954-1955, Hering Papers, BUMED Archives.

35. LCOL Peter C. Killeen, USMCR, letter to RADM B.W. Hogan, MC, USN, dated 30 June 1955. The letter is in folder 13, Hering Papers, BUMED Archives.

36. Why a representative of Navy medicine did not attend CAPT Hering's retirement is unresolved. Dr. Hering chose not to address this serious breach of etiquette in his papers. It seems, however, that the Surgeon General sent his congratulatory letter to Hering in response to a critical letter from LCOL Peter C. Killeen, USMCR, who attended the ceremony. RADM Hogan's letter, dated 21 July 1955 is in folder 13, Hering Papers, BUMED Archives.

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Remembering Navy Medicine in the Korean War



On 19 June 2003, some 200 Korean War veterans, family members, and well wishers crammed the auditorium of the U.S. Navy Heritage Center in Washington DC, to witness a very special commemoration. The Marine Corps, the Bureau of Medicine and Surgery, and the Naval Historical Center sponsored “Navy Medicine in the Korean War,” an event which honored the Navy doc-

tors, dentists, nurses, Medical Service Corps officers, and hospital corpsmen whose daunting courage, under unspeakable conditions, during the “forgotten war” saved many lives.

Also on hand to honor the veterans was a throng of distinguished guests including the Commander of Naval District Washington, RADM Christopher E. Weaver, USN; Deputy Surgeon General RADM Kathleen L.

Martin, NC, USN; MGEN General Thomas S. Jones, USMC; LGEN William R. Maloney, USMC (Ret.); former Commandant, GEN Alfred M. Gray, USMC, (Ret.); CAPT Roger D. Edwards, MSC, USN; and a number of foreign military representatives.

RADM Martin served as the event host and lauded the veterans’ heroic achievements. “Navy doctors, nurses, dentists, medical specialists, dental

technicians, and corpsmen rose to the occasion and saved lives with new innovations, a willingness to risk their own lives to save the lives of others, through pure grit and determination. Theirs is a legacy that makes all of us in uniform stand proud.”

GEN Alfred Gray, who served with the 11th and 7th Marines, 1st Marine Division on the Korean peninsula emphasized the importance of Navy medicine in the Korean War, and pointed out that three corpsmen serving with his Division were awarded the Medal of Honor and the Navy Cross for their service under fire. At war’s end, five hospital corpsmen received the Medal of Honor, four of them posthumously.

Undoubtedly, a highlight of the event was the premier showing of the documentary “Remembering Navy Medicine in the Korean War.” The 28-minute video features eight interviews with Navy medical and Marine Corps veterans, bringing to life their forgotten war. Stories varied from Navy doctor Henry Litvin describing how he practiced medicine during the Chosin reservoir campaign while trying to survive 30 below zero tempera-

tures and an enemy bent on annihilating him and his comrades. There was also the testimony of Marine Sergeant John Fenwick. He was saved by a Navy corpsman after nearly being torn in half by a North Korean machine gunner. These and other stories told through the recollections of both warriors and their caregivers brought home the war, and left the entire audience touched with emotion.

Navy medical historian Mr. Jan Herman then encapsulated what the Korean War meant from the Navy Medical Department’s perspective. “When the Korean War began in the summer of 1950, who could have predicted how long it would last, how unprepared we were, what kind of enemy we would face, and what kinds of hellish conditions our fighting forces would find themselves in?” As Mr. Herman pointed out, “Navy medicine’s ability to adapt quickly and skillfully to crisis had been proven heroically in all theaters during World War II. In Korea, that institution was tested as never before.”

After recognizing the many Korean War veterans in the audience, each greeted with stirring applause, Mr.

Herman introduced a panel comprised of Korean War veterans—two Navy physicians, a Navy nurse, a hospital corpsman, and two Marine patients. Each took a few moments to tell about their war and then answered questions from the audience.

One question was particularly thought provoking. “In our society we are daily confronted with a barrage of sports figures and celebrities who are presented as American heroes. There is a whole generation of kids who don’t know any better. How can we get those young people to recognize that it’s really people like you—the real heroes—who should be their role models?” The corpsman member of the panel denied any kind of hero status for himself. “We really weren’t heroes; we were just doing our jobs.” For the caregivers of Navy medicine who participated in that 50-year-ago conflict, a famous proverb might suffice. “The greater thou art, the more humble thyself.” (Ecclesiasticus 3:18) □

Story by Andre´ B. Sobocinski, Assistant Historian and staff writer for *Navy Medicine*, Bureau of Medicine and Surgery (M09H), Washington, DC.

Project Windstorm

A Cold War Memoir

CAPT James Helsper, MC, USNR

Part IV



Photo courtesy of author

PBY in a museum.

The island was covered by tundra for which the mukluks, a high rubber boot with a thick felt liner, were made to navigate over the tundra. Thankfully we didn't have to do much of that since the road building crews had found a source of gravel and were making new roads and even footpaths to allow us to stay out of the tundra when walking between buildings. The tundra was composed of thousands of years of new growth of grasses and shrubs from a short growing season, a few weeks

each summer. With the return of autumn, this growth became frozen in place, and only partially decayed. It held water like a sponge and seemed to suck your footgear off as you sank into it. It was dreary black in color. Heading out over the tundra alone was a hazardous undertaking. In spring it became covered with flies and giant mosquitoes. You would become so tired after 100 yards of plodding through it that you would have to rest, but stopping caused you to sink deeper into the muck. Each footprint

became filled with water, making the trip back to solid ground at risk for water overflowing into your boots. The alternative was to create a new and tiring trail over intact tundra.

Compelling reasons to venture out there were the small streams snaking through the tundra. They were as little as 3 feet wide and a foot or two deep, but they contained the Dolly Varden, a fish that could exceed 4 feet in length. These streams connected the hundreds of lakes and ponds scattered over the island. This was the first time

I had ever seen fish longer than the streams were wide. It seemed surreal seeing fish in streams so narrow they could hardly turn around because of their size. It seemed as though you could catch them with your bare hand, but a net made it easier, especially with the poor footing on the stream banks. More than one would-be fisherman slipped and fell into these waters, and the cold wind made such a dunking hazardous. The galley crew, however, made the risk quite worthwhile.

The activity was all outdoors, with a lot of hand work. The heavy equipment drivers were fairly well protected in their cabs but they were chilled riding to and from the worksite in the backs of open trucks. The men wanted a steam room to warm up after their shift at the worksite, and they created one, using the steam from our oversized heating equipment from the infirmary building. They built a giant radiator made of multiple 6-inch iron pipes against one wall in this cement room. Water was dribbled down from a pipe over the radiator and almost immediately became steam. This ran almost continuously and became very popular with the workmen.

Dick and I couldn't have been more compatible. We discovered we both had the same goal in life, to become the best surgeons we could be. Our tours of duty in the Navy were just a minor interruption for 2 years and would possibly be good for both of us. We would get to see a little of life out in the big world. Then we would each finish our training and get on with building a family. Dick was much more optimistic than I. I was always the cautious one, planning ahead. Perhaps it was living with the checklist that all flyers need to do "to become an old and bold pilot." The

situation we were in was forever discussed. Who could have thought that we would be the only two doctors on an isolated, miserable little island, helping to plan for the first underground atomic bomb? We had a thousand men to care for, providing them with whatever medical care they needed.

We had been watching the weather, and there were 2-week stretches when no plane could land. Fog, wind, sleet, and snow...we had it all, and usually all at once.

Down to Business

As you could imagine, the infirmary building was a mess after being unoccupied for 6 years in this inhospitable, extreme climate. The wind howled constantly, with incessant rain or snow. Many major repairs were needed to the roof, walls, and windows, but we seemed to enjoy a unique place in the hearts of these Seabees. Whatever we needed was fixed, often on their own time. Men would come over after supper and work another couple of hours. The only thing that wasn't done was exterior painting. The building still looked like hell but it would be a lesson in futility to paint the outside of the building in that climate.

Inside, we were spick and span within a couple of weeks. The usual Navy standards for cleanliness applied here as they did elsewhere in the world, with regular inspections each week. We even had a few "white glove" inspections by the skipper and his yeoman, with the ever-present clipboard and poised pencil. Nevertheless, within a month we passed them with flying colors. In the regular Navy, latrine duty was considered punishment for minor offenses; however, in our infirmary the job was ro-

tated, and each tried to do a better job than the previous group.

The corpsmen had a special place in the minds and hearts of many of the men working on Amchitka. Men and women who go into health care usually do so because they want to help people. The Navy took many high school graduates, as well as a few who hadn't finished high school. And after they completed basic military training, and if they appeared solicitous of other people and anxious to help, and were of stable personality, could be sent to Hospital Corps school. After a few months of general medical training they could specialize in one of the many fields of medicine. There were special schools in x-ray, radiation therapy, laboratory, respiratory therapy, and other fields as seen in a civilian hospital. These young men became very adept at what they did, and though they were very proud of their talents, they were always trying to improve. No corpsman was unhappy with his job or his duties. The young men who were not yet rated were all eager to advance. Perhaps it was the Navy way; these men were anxious to please.

In the OR we were fortunate to have a corpsman who was a real gem. Even though he wore the single stripe of a third class corpsman, his knowledge and abilities went far beyond his years and training. To prepare for surgery we wrapped and sterilized enough instruments for one operation, double wrapped and autoclaved them, and then stored these packs on shelves in the operating room so they were easily accessible when needed. Dick and I each had instruments of preference, and as soon as our tech learned these he took down all the packs, added the special instruments, and labeled the packs for us individually.

Since each operation required different instruments, he had to take down at least two dozen packs and totally re-sterilize them. Our somewhat primitive autoclave was terribly slow, and this procedure took him most of 2 days and half the night. We would never have requested him to do this, and yet he did it.

Some surgeons demand absolute silence in the OR and instruments are requested by hand signals. An extended index finger is for a hemostat, and so on. Even though I was not of the school for silence, our tech wanted to learn the hand signals. We taught them to him, and then did several cases without speaking so he could practice. Soon he had mastered this. Part of the secret of the silent OR is having the scrub tech watch the case very closely and anticipate the surgeon's request even before he signals. I much preferred to discuss the case and point out the anatomy, as well as the options in surgical techniques. Dick concurred in this.

The corpsmen showed the men some of the equipment they would like in a medical supply catalog, and these were created in the shops from a drawing or a picture, and delivered the next day. An x-ray dryer and film processing tanks were acquired in this fashion. Our operating room lights were attached to pipes and hung from the ceiling, almost like a real OR. They had to be carefully balanced and be stable in the correct position in order to aim the light properly. Plumbers rigged them perfectly. Though their physical appearance wasn't much, their function was ideal. Our tech wrapped the light in cloth, which made them look much better.

Mayo stands (where the instruments being used are placed during an operation) and stainless steel tables

were created for use in the OR. Shelves and test tube holders for the lab and pharmacy were all provided without the need for work orders. The windows were made double-paned in the OR to keep the room temperature more stable, and the sealed edges kept out the infernal wind. X-ray view boxes were created and installed in many locations so that we could easily view the films.

The twice-a-day sick call began to build up in numbers, until we were at 50 to 60 per session, and some days up to 100. The exposure was taking its toll, and we began to see real pneumonia instead of just sore throats. We were able to x-ray and confirm diagnosis, and document the improvement with bed rest and antibiotics. There were several hernia cases, and with our mandate not to evacuate (even if we could), we repaired them ourselves as soon as the OR was in operation.

First Surgery

A simple hernia repair was the first surgery in our new operating room. Our OR tech was so excited he stayed up all night re-sterilizing the packs we would use and, just in case, he prepared two back-up packs in case we needed them. We decided to use spinal anesthesia; however, we asked Gus to monitor the patient. Since it was our first case we would, of course, help each other. The chief decided that this first event required his talents, and he assigned himself as circulating nurse.

We soaked, scrubbed, and came into the OR where our tech was ready to gown and glove us in the most professional manner. The patient was scrubbed and painted at the planned operative site and we were ready to begin. He was prepped, draped, and

as chief surgeon I placed the incision; everything went well. Dick assisted me as if we had always worked together. As we operated, we discussed various techniques for hernia repair, probably scaring the hell out of our patient since, with spinal anesthesia, he was awake. However, this is something surgeons often do, just to be certain the best technique has been selected. Being a doctor is a forever-learning task, even more so for surgeons. The spinal anesthesia worked well for the procedure. Dick closed the wound, which gave me an opportunity to observe how he did it. We had created a mini-hospital, a real operating room, and we were doing what was important to us.

The chief was on the telephone--a very primitive system with a hand crank--even before we had finished the operation, and plumbers were there to create real scrub sinks for us. We had crossed our first major hurdle and everything had gone well. Now came the bottom line--the patient--and he didn't turn a hair; he was back to work in under a week. We didn't realize it immediately but our "clientele" (the battalion) was watching closely. The success was obvious. We had passed the test and had gained the confidence of the whole group. The word was out that we were okay. "The Docs know what they're doing."

The next surgeries were appendix removals and all went well despite our rather primitive equipment. The skipper asked us to make a list of what we really needed, and to this we added a few things that would be nice to have, but we knew it would be some time before we could get them. Our laboratory facilities were really sparse because of lack of equipment. We had a microscope and could perform blood counts and urinalyses as

well as a few basic blood tests. We could manage some bacteriology and check for blood in the urine or stool. It was less than we wanted but things went well, and all our patients improved and returned to their jobs.

We repaired a few serious injuries, including fractures and we began to feel good about our accomplishments. Our general anesthesia was open drop ether administered by the dentist, or an occasional spinal anesthesia that Dick or I gave for belly cases.

However, our “steam room” with cement seats almost up to the ceiling was the most popular thing in the infirmary.

Cogs in the Wheel

One day Gus came over when someone didn't show for his dental appointment and brought up the subject of our mission on Amchitka. An underground atomic explosion just to see what would happen was frightening to think about. The horror of the civilian casualties following the two atomic bomb explosions in Japan had been more than anyone had realized at the time, even though these events concluded World War II. COL Paul Tibbets, the pilot of the *Enola Gay*, and some of his crew were shown a movie of the Trinity explosion in New Mexico before the flight, and no one comprehended what “Little Boy” could really do when it was dropped from the B-29 over Hiroshima that August morning in 1945. Many asked if it was necessary to drop “Fat Man” over Nagasaki 3 days later, for surely the Japanese were ready to capitulate soon after Hiroshima. Some even thought we did it just to see if the more refined plutonium style bomb worked. Now with all these second thoughts expressed by many about the carnage of the bombs, some

of the previously hailed heroes--the carriers of the bombs--were being looked at again. Of course we knew they were just cogs in the wheel, and were anonymously selected for their roles, just as we had been selected for our roles here on the island.

How would history look on those who were so intimately involved with the delivery of these bombs, let alone those who created them? Time would tell. But here we were with another bomb that would be exploded to find out what it did, and we were all involved in the preparation to allow it to happen. Perhaps we wouldn't “pull the trigger,” if there was a trigger, but we were all here to help explode it. How would history look upon us if a catastrophe occurred? Could we cause nuclear winter, as the radioactive cloud circled the earth on the prevailing east wind? Were we careless in protecting the human race from the nuclear destruction that perhaps could happen? We were all considerably sobered by this kind of talk, led principally by Gus, who was certainly more thoughtful than Dick or I.

Gus' dental tech came in to announce his next patient, and he left us to go back to work. Long after he was gone, Dick and I were mulling it all over, trying to reach a conclusion about our own support of this seminal event in which we were involved and not of our own choosing, but by someone in Washington. For by now, we were convinced that we were just filling billets. We, too, were just cogs in the wheel, and consoled ourselves by noting that President Truman was the Commander in Chief and would assume the blame.

Sea Otter Jones

Soon after we arrived on Amchitka we occasionally saw an Alaskan

trawler about 50 feet long, sailing slowly around the island. Several times we saw it tied to the dock in the harbor. The hangar and the site of most of the living quarters were on high ground, affording us a splendid view on the few days not blocked by fog, snow, or rain. Seeing a boat like this seemed strange, especially since we thought we were all alone on this windswept island. There was a flag on the boat, which we later learned was the flag of the U.S. Fish and Wildlife Service. The crew appeared small, perhaps two or three people, and they went about their business without communicating with anyone. It was quite some time before we met the captain of this small vessel. He told us that he had been ordered to collect all the sea otters and remove them from the island before the bomb was exploded. So, even the Fish and Wildlife Service knew our big secret!

The captain was a small man, thin and wiry, and the ravages of living in the outdoors most of his life were readily apparent. He was dour and quite uncommunicative, as people often are who live alone much of the time. However, when the subject of sea otters came up, his face brightened and he became much more animated as he told us about caring for sea otters for many years, helping to bring them back from near extinction. He told of nursing sick sea otters back to health. He admitted that he was pretty upset about our mission on the island, and we realized that he was one of the true protectors of the land and the animals who live on it. In that era, when ecology was a word hardly understood by the majority of people, he lived it. His name was Jones. “Just call me Sea Otter,” he told us.

The sea otters were difficult to catch, and were even more difficult

to hold despite the pens “Sea Otter” Jones had built to hold them on the beach further out on the island. They ate huge amounts of food, up to 20 percent of their body weight daily; it was hard to find enough to feed them. He said they lost their happy attitude when caged.

We invited him to stay with us for meals but he declined, preferring the solitude of his small crew and boat to our more raucous company. Our nightly movies on the hangar floor didn’t tempt him at all. His name, “Sea Otter” Jones, seemed to be the perfect name for the savior and protector of these unique sea creatures.

A few weeks after our arrival the first mail came by PBY, a Navy patrol amphibian from Adak, an island with a naval base about 170 miles to the east. The mail had to be addressed to a Fleet Post Office (FPO with a number). There was no place where the island could be named. There were whole bags full of mail for our thousand men, each anxious for any news from home. Even the most hardened came looking for their mail. A few received little more than bills and requests for car payments, but the majority had letters from loved ones, which they invariably took away from the crowd to read privately. There was an occasional whoop of joy from a new father, sharing the news of the birth of a son or daughter. A few “Dear John” letters also arrived. Certainly a year’s separation for a young woman was more than some could bear. There were magazines with news and pictures of events, but already old news.

From the PBY we received some new supplies, mostly drugs and medicine, though there were still things that we needed, and a few that we wanted, to improve our ability to provide the necessary medical care. We

began to agitate to get these things at the compulsory daily morning meetings. We wanted better x-ray equipment and an anesthesia machine, plus more modern surgical instruments, along with a wider choice of materials. The routine suture materials were too thick, just to be sure they held; we were used to finer, more delicate suture materials which provided better wound closure. We likened the available sutures to rope and insisted that finer and better materials be made available. After all, there’s not a surgeon out there who doesn’t want to point out the almost “invisible” scar on his patient after performing the surgery! Scars were the surgeon’s “signature” and with that damned rope, we couldn’t show how good we were at creating nearly scarless surgery.

Shopping Trip

We needed a better autoclave than our little field unit which was made to function in a tent and required hours to run a load. These, and many other items were on our “wish list.”

When the skipper heard about the real or imagined complaints of one of our surgical patients, who endured general anesthesia with open drop ether (a primitive but reliable type of general anesthesia at that time), he finally approved an expedition to Adak to commandeer equipment. Little did we realize that’s what we would do! We thought we were going to a medical warehouse to take our pick of equipment there. Our own, taken out of footlockers to equip our infirmary, was really pretty primitive, usually issued to support combat Marines. We had been told to be ready for anything, medically, and certainly we didn’t have the equipment to support that mandate. The skipper as-

signed two warrant officers, big husky guys with deep voices and commanding appearances. One of them had been a union organizer, who insisted he could get anything just by walking in with a clipboard and pencil and demanding it. They brought along two other men who apparently were selected for their imposing sizes. I finally had an opportunity to express my leadership as the senior medical officer, and I elected to go on the trip.

The PBY landed on our runway the next morning and we were set for the trip to Adak, 175 miles to the east.

Both engines were started with some fuss and lots of smoke coming from the exhausts. The engine controls were all overhead, which I had never seen before, but I could appreciate the advantage of this placement since the engines were in the wings over our heads. A Sailor with a fire extinguisher had duty outside during engine starts. He came running back in, tumbling through the bubble canopy opening. We then lumbered out to the end of the runway and, after what seemed to be an interminable length of time, we took off. I was amazed at the long takeoff run and the slow climb rate. We gradually reached an altitude just under the cloud deck, and proceeded in a slow and rather stately fashion on our course. I could see the airspeed over the pilot’s shoulder, an 95 knots. I could beat this in a Cessna 170 even with the wheels down.

Navigation was basic, and it was good practice for the navigator to shoot the sun a few times to chart our progress across those stormy seas. This had to be done quickly during small breaks in the clouds where the sun could be seen. It was obvious that flying under the cloud deck was safer than going up through the clouds and

flying on instruments. Besides, we could use the numerous islands in the Aleutian chain as our pathway to Adak. These islands all appeared deserted, showing no sign of life anywhere; they were just more tundra.

The tail wind was a boost for us and we saw Adak in about an hour and a half. This nearest-to-us site of civilization was a sorry sight, indeed. There were muddy streets, more tundra, and a few real houses and buildings, as well as the huge radar facility. Mount Moffett was right next to the runway and we would have to land from the north since the large mountain blocked access from the south.

The weather in Adak was the same, with more howling winds, sleet, and mist. After landing and taxiing back, the chief warrant officer commandeered a truck from the motor pool and we went to the medical warehouse. We were dragging our feet a little so we could spend the night on Adak and supply our depleted wine mess and load up more beer. The medical warehouse had very little of what we really needed, except for medicines and linens. We filled out the requisitions, loaded the supplies aboard the truck, and headed for the island infirmary. We met a captain there, the senior medical officer. He was a little hostile, but the size of our party and the special requisition that we carried mollified him. The warrant officer and I started through his facility, the other men trailing along behind. The captain asked what I wanted. I pointed out an anesthesia machine. He signaled some Sailors and they had it crated and loaded in the truck in a matter of minutes. Next I pointed to a nice x-ray unit. Soon it was crated and out the door. We continued on and found an autoclave, two OR tables, and other miscellaneous

items that were added to the truck load, now with much sputtering from the senior medical officer. I began to feel quite happy that I was a reserve officer and not regular Navy where I might come under this man's command some day. I left him enough equipment to operate, but perhaps not the best. I felt we needed the best available on our frontier position, as we had more personnel to care for and we were more isolated.

That night we had dinner in their officer's club, and even danced with some real women, a little touch of civilization. The men were enjoying themselves somewhere also, but I didn't want to know where. The next morning, nursing a small hangover, we headed for the plane with our booty. We had accumulated so much to transport that the pilot decided to leave some of the plane crew behind. There were cases that I didn't recognize, but I didn't ask any questions.

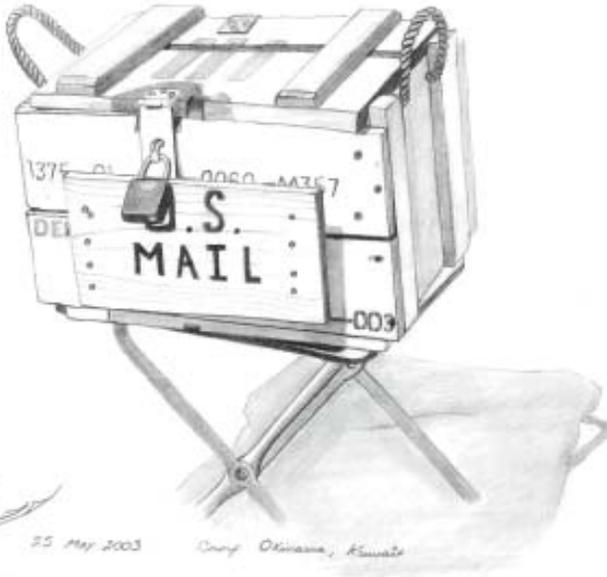
We had a strong crosswind on our right and the ominous mountain on our left. The pilot, a big, overweight commander, plopped himself down into the left-hand chief pilot's seat. He had a ruddy face and a red nose, not exactly inspiring confidence in his flying abilities. His uniform was disheveled and we suspected that he had been assigned to this end-of-the-earth duty station to finish out his Navy career. In contrast, a young LTJG with a crew haircut, crisp uniform, and a real military bearing climbed into the co-pilot seat. He had a clear voice compared to the rather mumbled speech of the senior pilot, and was much more reassuring. I was allowed to remain in the engineer's seat and again watch the proceedings. They were quite formal with each other and didn't display the usual friendly banter that I had seen with other Navy

pilots. The LTJG started through the checklist but the pilot kept skipping responses. The LTJG checked the callout himself. Not a good beginning!

Eventually the engine start was called, and the sequence began. However the left engine just wouldn't catch. The smell of gasoline began to fill the inside of the plane. The commander then called for right engine start, and it came up immediately. After several more attempts the left engine finally caught. We went through all the engine run-ups and checks. The pilot then said he'd take it, indicating that he would do the takeoff. The wind was coming from the right in a strong crosswind. We taxied into position and were instructed to hold there.

Finally we were cleared for takeoff. The pilot advanced the throttle and we started the takeoff run. There were several loud detonations coming from the left engine, sounding like backfire, but we rolled on, picking up speed. The co-pilot was calling the power numbers and the air speed, as well as the distance of runway remaining. We reached liftoff speed with only a thousand feet of runway left, and slowly lifted off. We climbed to about 400 feet and there was another loud backfire followed by a marked decrease in engine roar. We had lost an engine and were in trouble! (To be continued)

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"Mail Call"

Frank D. Walsh

25 May 2003

Camp Othman, Kuwait



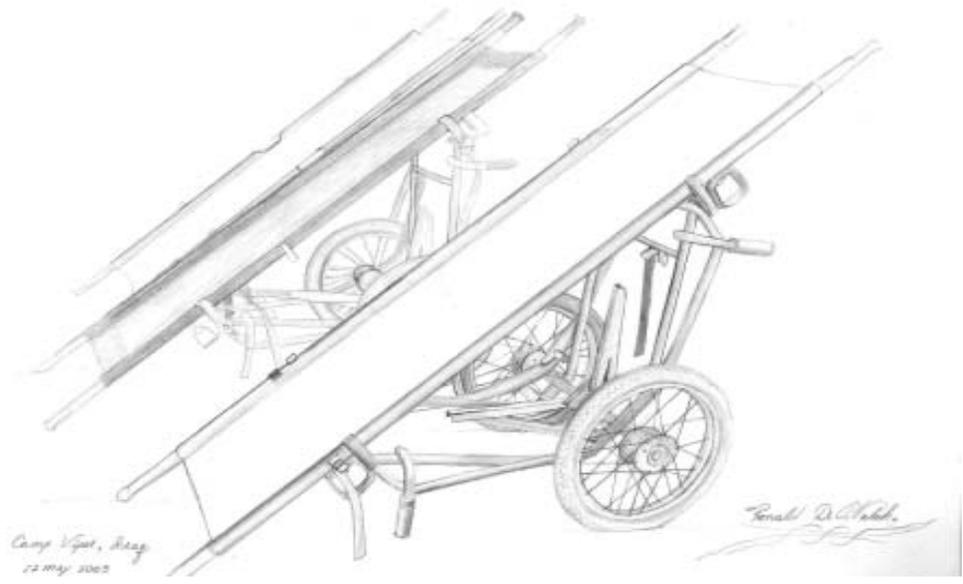
Camp Viper, Iraq 11 May 2003

Frank D. Walsh



The artist HM2(SW) Ronald D. Welch, USN, is presently assigned to Naval Hospital Pensacola, FL, attached to Fleet Hospital Three. While in Iraq and Kuwait, HM2 Welch filled his spare time preserving memories in sketches.

Essentially a self-taught artist, he has been sketching for about 10 years. He favors figure studies and military art. His medium is mostly graphite pencil but occasionally HM2 Welch does colored pencil work. □



The Great Flu Crisis at Mare Island Navy Yard, and Vallejo, California

CAPT Thomas L. Snyder, MC, USNR (Ret.)



Photos BUMED Archives

Female ward, Naval Hospital Mare Island, August 1918.

Mare Island Navy Yard, the oldest U.S. Navy base on the West Coast, was founded by CDR David Farragut in 1854. The Yard was located across the Napa River from Vallejo, CA.

From the founding of the Navy Yard, Vallejo was a “Navy town.” The yard civilian work force largely populated the city. Yard workers dominated city political, economic, and social structure. A lively social life between Navy personnel and the civilians of the city flourished.(1)

The Spanish Influenza Epidemic

Next to HIV-AIDS, the 1918-1919 epidemic was the worst public health

disaster of the 20th century. Estimates put American influenza deaths at 675,000, mortal to more Americans, by far, than all the wars fought in that century.(2)

Several phenomena new to the 20th century contributed to the rapid spread of the contagion:

- Masses of personnel were being moved in multiple directions around the world as the Great War was being fought.

- Large groups of coughing and sneezing people attended war bond rallies and parades.

- Movies encouraged people to gather in groups, all the while promoting the transmission of the virus.

- In a Navy town like Vallejo, several dance halls provided the opportunity for the spread of contagion.

- A less virulent influenza epidemic in the spring of 1918 had but little impact on military or civilian personnel, thence on public health thinking.

Accordingly, when the much more virulent form attacked in the autumn, health officials did not take the occurrence very seriously, and were late to institute appropriate public health measures to slow the contagion.

Preparations on the Mare Island Navy Yard

On 23 September 1918, the senior medical officer at Mare Island received a letter from the Naval Training Center at Great Lakes, which reflected the Great Lakes experience: 20 percent of the yard’s manpower complement would become infected, and of those afflicted, 10 percent would develop pneumonia.(3) The Mare Island medical officer and his assistants quickly calculated that they should prepare to care for as many as 1,600 influenza victims and 160 pneumonia cases. They immediately began planning for two “emergency hospitals” to supplement the permanent 200-bed Navy hospital, which would care only for the most ill, those with pneumonia.(4) Calls for addi-



General view of influenza tents and open-air mess tent.

tional corpsmen, nurses, and medical officers went out.

The Navy yard commandant published instructions on how to recognize the symptoms of disease and what to do if they occurred. Any person presenting with upper respiratory-like symptoms was to be hospitalized and quarantined.

Things were thus in readiness when the first case of influenza, a Navy corpsman returning from leave in Oklahoma, presented at sick call on 25 September 1918.

Conditions in Vallejo

The situation in the City of Vallejo was quite different. Not only had little or no advance planning occurred, but the solitary local hospital, a very small facility, was under quarantine because of a smallpox outbreak there, and doctors were involved in a smallpox vaccination program.(5)

At the same time, just as the epidemic began to break out, the city was filled with patriotic fervor over the Fourth War Bond Drive, for which

large groups of people frequently gathered.

Housing in the city, whose population had swelled by the influx of 8 to 10 thousand war workers, was crowded and inadequate. Some workers and their families were housed in quickly constructed shacks; others lived in tents thrown up in the backyards of established homes.(6) Crowding and its attendant spread of contagion was inevitable.

Because there was nothing, early on, to differentiate this virulent strain of flu from the “ordinary influenza prevalent here at various times”(7), no provision for quarantine was made.

The first civilian cases, two, occurred on 27 September, according to the yard medical officer report. The local press reported the outbreak on 4 October.

The Epidemic Runs Its Course at the Navy Yard

With the diagnosis of influenza in the community, Navy authorities quickly responded. Liberty in the city

was canceled and functions involving large groups of personnel were prohibited. On 5 October the emergency hospitals were opened. The peak of the epidemic among service people in the yard was around 13-15 October, and it was virtually ended by 30 October. There were 1,536 (1,600 predicted) service personnel treated for influenza. An emergency hospital for civilian employees of the yard opened on Navy yard grounds on 3 November and closed 30 November. Two hundred eighty-seven civilians received care.(8)

The Epidemic in Vallejo

As the first few influenza cases appeared in town, physicians, with assistance from three Navy surgeons, were vaccinating all school children against the local smallpox epidemic. Local press reports indicate that the vaccination program was successful; after 4 October no new smallpox cases were reported.(9)

Attention could now be directed to fighting influenza. On 4 October, the *Vallejo Evening Times* headlined “Fumigation of Public Buildings in Next 48 Hours.” The Navy medical officer decried this procedure as a futile gesture and complained in his report to BUMED that local authorities were ignoring advice from naval authorities to institute effective public health strategies. However, on 8 October, by City Council resolution, public authorities did close all public buildings. Church services, while not prohibited, were moved out of doors in order to reduce crowding. The press noted though, that no efforts had been taken to prevent the influx of contagion from outside the city.

In an editorial on 9 October, the *Evening Times* was reassuring. “There is no cause for alarm. As far as can be learned, no Spanish influenza is prevalent here and the steps taken [the closure of public buildings] have been

taken merely as a preventative.” The next day, however, the headlines reported 12 civilian cases. On 11 October, local Red Cross officials met to prepare for the coming onslaught by formation of an “influenza unit” involving physicians and nurses working in a local building which would be converted into a hospital, “should the need arise.”

The need quickly arose as headlines, just 4 days later, declared “between 60 and 70 cases are being treated”(10), in their homes. It is probable that each civilian doctor made at least 60 house calls a day during this period. The 17 October *Vallejo Evening Chronicle* headlined that a 60-bed unit was to be opened, but noted that “. . . While medical officers of the [Navy] station think that a 60-bed hospital is a good thing to start with, they also state that if Vallejo hopes to care for her sick, she should have at least 300 beds ready.”

“City Emergency Hospital”

On 21 October, under the auspices of the Vallejo Red Cross, the Emergency Hospital was opened in an annex of the Y.M.C.A., “in an effort to concentrate the patients [according to the Navy special report] and thus relieve the wild running about of physicians, conserve nursing facilities, and provide hospital care for the sick.” The *Evening Times* had a different take on the purpose of the facility, reporting that Red Cross workers would look after those afflicted who had no homes and who were not eligible for care at the Navy hospital, that is, people who were not civilian employees of the yard. There are no records to indicate how many people were hospitalized there.

By 23 October, 350 cases of influenza were reported in town. The *Vallejo Evening Chronicle* reported that the Emergency Hospital was staffed by a single nurse, who had

been on duty for 48 hours without relief. The President of the Vallejo Board of Health tried, without success, to obtain help in the civilian community.(11) On the same day, about 1 month into the epidemic, the City Council directed the use of gauze face masks by all citizens. Non-compliers faced stiff fines.

October 24th found 20 patients hospitalized in City Emergency Hospital, many seriously ill with pneumonia. Still unable to properly staff the hospital with civilian workers, the Red Cross made an urgent appeal for help from the Navy Yard. Navy authorities quickly ordered six hospital corpsmen to assist at the facility. They found that it was “a deplorable place for patients. It was unheated, low ceilinged, poorly ventilated, poorly provided with nursing personnel, commissary, and toilet facilities.”(12) There was no effective administration, and the lead corpsman, a Hospital Apprentice 2d Class “stepped in and practically ran the hospital.” Each private physician admitted, attended, and discharged his own patients independently, which troubled the Navy medical officer, who reported: “[s]uch lack of management and system gave rise to untold confusion and largely defeated the object of the hospital, namely to conserve the time and strength of the doctors and afford proper care of desperately sick patients.”

The *Evening Times* reported that physicians were too busy to report accurate numbers of sick, “but indications are that several hundred are suffering.”

The Crisis Worsens

By 26 October, Navy yard officials became acutely aware of the loss of a large number of civilian shipyard workers to illness. Navy doctors working in town reported they had discovered whole families ill, with no

one to care for or feed them. They found unmarried Navy yard workers sick and unattended in rooming houses; at night, uninfected workers from the Navy yard would return to these same rooming houses, to share poorly ventilated quarters with the sick. In poorer areas of town, people were simply unable to obtain the services of doctors and had to fend for themselves.

The *Evening Times* reported that local physicians were overwhelmed by the number of calls they received, and noted that “one physician received 15 calls in 2 hours” in the evening.

Conditions were so serious by 30 October that three representatives, the local Red Cross Director, a local physician (and Navy reservist), and a Trades and Labor Council leader, met with the City Council to “demand . . . that some steps be taken to alleviate conditions existing here at the present time . . .”(13), and to “have the entire situation placed under the command of CAPT Harry George [the Navy Yard Commandant] to be handled by his medical forces.”(14) An editorial in the *Evening Times* concluded that “The summoning of the naval hospital unit should have been carried out several days ago, or as soon as the disease was well in hand at Mare Island and the physicians and their aides were at liberty . . . to answer the call of the people of the community.”

“Saint Vincent’s Navy Hospital”

The City Council acknowledged the inability of the city’s resources to deal with the crisis, and requested the aid of the Commandant of the Navy Yard. At the same time, the local Dominican Order offered the use of a newly constructed school for another temporary hospital. The Commandant promptly authorized a 100-bed facility to be opened.(15) The Navy pro-

vided 4 medical officers, 24 corpsmen, and 58 support personnel. Six Dominican sisters acted as nurses. This hospital opened on 2 November. Three days later it is was caring for 71 patients.

The Epidemic Finally Wanes

No sooner was the new hospital opened than newspapers began to report a decline in the number of new cases of influenza in town. By the 6th of November the *Evening Times* editorialized that “reports of today on the influenza situation indicated that the epidemic at last is under control and on the decline.” By 16 November the Emergency Hospital at the Y.M.C.A. annex was closed. The St. Vincent’s unit still had 68 patients but was closed on 30 November. Its Navy staff and the Dominican sisters had cared for a total of 190 patients, including 80 women and 42 children.

A Brief Resurgence of Infection

In January 1919 the epidemic recurred. While few cases occurred at the Navy Yard, local resources were again quickly overwhelmed. Mare Island Navy Yard employees telegraphed the Secretary of the Navy on 10 January: “Vallejo Calif calls for help. Your Mare Island Navy Yard civilian men are dying. Wives and children lay stricken without help. Hospitals full, no nurses. Doctors working day and night. Please advise Commandant Harry George of Mare Island Navy Yard to quarantine Vallejo and take full charge. Live up to your good record and show us some action. Yours for service.”(16)

In a City Council meeting on the 11th, the mayor of Vallejo stated “there is no provision in the budget for any emergency.” However, the Dominicans again offered the use of their school, and on 13 January “St. Vincent Navy Hospital” was re-

opened. Face masks were again required, and theaters closed once more.

That same day the Commandant of the Yard reported to the Secretary of the Navy by telegram:

“Influenza in Vallejo serious and fast becoming epidemic. St. Vincent’s Catholic Church has placed school building at disposal Commandant as temporary hospital. Large majority of residents are Officers and enlisted men Navy and civil employees Navy yard and their families, and immediate steps should be taken to afford them medical assistance. Request authority to maintain temporary Naval Hospital at St. Vincent’s school and to expend necessary funds. Consider project most urgent to save life and protect Navy personnel and civil employees.”(17)

The *Vallejo Evening Chronicle* (January 13) editorialized that “[the Navy Yard Commandant] was quick, as he has been in all things, and at all times, to see the necessity for checking and controlling the new trouble.” By 22 January the *Evening Times* headlined “NO NEW CASES REPORTED” and reckoned the quick demise of the epidemic was “. . . due to the systematic way in which the epidemic was handled . . .”(18) Public places were re-opened on 25 January, and the St. Vincent’s unit closed on 28 January. A total of 55 patients had been hospitalized.

Commentary

The Spanish influenza epidemic represented a public health emergency of the highest order.

Mare Island medical personnel properly prepared for the onslaught of expected influenza cases. They “got their Public Health right” in that all patients presenting with symptoms of influenza were promptly quarantined. Similarly, contacts with the community where infection was rife

were curtailed early on. Civil health officials were not so well prepared. Nor were they open to suggestions from Navy medical personnel about how to organize their efforts. Because the U.S. is an “open society,” however, local citizens successfully urged Navy intervention. Naval personnel performed magnificently, to the copious approbation of citizens and civic authorities alike.(19)

What of today?

Our current concerns about possible terrorist-induced epidemic, or another SARS-like outbreak, throw the experience of Mare Island Navy Yard and Vallejo into high relief. A very contagious, virulent virus could produce so large a volume of illness so quickly as to overwhelm local medical capabilities.

In California there is “no specific authority” for public health officials to “deputize” or otherwise organize local medical personnel to respond to an emergency. While quarantine can be ordered with judicial approval, medical response to a public health emergency is [still] based on a “gentleperson’s agreement” among the various parties.(20) County health officials and local hospitals work together developing action plans to be instituted in the event of a large public contagion.

Clearly, there could be a large role for military medicine in some future contagion. This would call for civilian-military contingency planning for such an eventuality. Strategies for a public health response and for the management of large numbers of very sick people must be put in place now.

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4. *ibid*, page 4, paragraph 4.

5. *Vallejo Evening Times (VET)*, Wednesday October 2, 1918.

6. Neilson, page 3, paragraph 9.

7. *VET*, Friday October 4, 1918.

8. Neilson, page 19, paragraph 38.

9. *Vallejo Evening Chronicle (VEC)*, Friday October 4, 1918.

10. The *Vallejo Evening Times*, in a page three article titled "Ways to Prevent Contraction of the Spanish Flu" emphasized: "THE SPECIAL PRECAUTIONS TO TAKE ARE: LOTS OF FRESH AIR, NUTRITIOUS DIET AND AVOID THE EVILS OF OVERCROWDING."

11. *VEC*, Wednesday October 23 1918.

12. Nielson, page 30, paragraph 57.

13. *VET*, Wednesday October 30, 1918.

14. *VET*, *ibid*.

15. *VET* headlines cried "NAVAL UNIT IS DETAILED TO HOSPITAL AT

THE SCHOOL. Captain Harry George Answers Call of Health Officials to Protect Our People".

16. Telegram received Secretary of Navy 10 October 1919.

17. Telegram received at Navy Department 13 January 1919.

18. *VET*, Wednesday January 22, 1919.

19. Neilson, page 44, copy of letter from B. J. Klotz, M.D., President, Vallejo Board of Health.

20. Thomas Carron, MD, PhD, Medical Director, Solano County (California) Public Health Department, telephone conversation with author, 2 January 2003. □

Dr. Snyder was Chief of Urology at the Kaiser-Permanente Medical Center in Martinez, CA, for 10 years. He retired in April.

Forum

The following essay was the second place winner of the Surgeon General's Navy Medicine Essay Contest

Life More Vigorous Death More Remote

CAPT M. A. Anderson, MC, USN

*H*ygienic is that branch of the medical science which concerns itself with the preservation of the health of individuals and communities. It aims to render "Growth more perfect, decay less rapid, life more vigorous, death more remote." James C. Pryor, A.M., M.D.

During the Great War in 1918, Dr. James Pryor, Medical Inspector, United States Navy, authored a text

on *Naval Hygiene*. In that era, hygiene was viewed as a medical discipline that was concerned with all the factors that could affect an individual's physical condition or mental state. Dr. Pryor recognized the need to share the experiences he had gained from his extensive service all over the world to give new members of the naval medical profession an idea of life afloat, aloft, and under the sea. He

believed that the preparation of a guidebook for naval medical officers on a topic as comprehensive as hygiene required "knowledge derived from actual extended service at sea." His premise that shipboard experience was necessary to appreciate the hazards and rigors of naval service and, in turn, to better serve the needs of Sailors remains valid today. In 1918, both aviation and submarine

service were just beginning to become additional career possibilities for naval personnel, but Dr. Pryor recognized that both the aviator and the submariner required the guardianship of practitioners who were knowledgeable about the hazards of altitude and depth.

Today the short chapters that Dr. Pryor devoted to such topics as submarines, aviation, diving, and infectious diseases have evolved into multitudes of texts if not entire libraries of material. Samplings of statements from the various chapters suggest how far we have come from both the knowledge and the practice mentioned in that one compact volume.

The crews of submarines are subjected to considerable exposure due to wetting as the result of running awash, and consequently are predisposed to tonsillitis, rheumatic, and respiratory infections ... **Submarines**

Rainstorms produce much discomfort to the aviator (as also would hail or sleet). When the drops strike his face as the machine goes at a high rate of speed they are said to “cut like a knife” in addition to wetting and chilling ... **Aviation**

A diving dress has been devised which enables the diver to operate in shoal water not exceeding 33 feet without air-pump connections, and merely a life-line attached ... **Diving**

In our 21st century Navy, we have come a long way from coal-fired ships, diesel-powered submarines, and open cockpit aircraft. We have progressed from accepting discomforts and dangers to finding ways to reduce or eliminate them. Developments—now taken for granted—include aircraft that are pressurized and heated, submarines that can remain submerged for months at a time, and scuba gear that is free of tethers and connections to shore. None of this progress has been made without team-

work. Our modern practitioners of naval hygiene influenced these advancements in either their form or their application.

Who are these practitioners? Some may be surprised to know that the list of specialists is long and the areas of expertise represented are many. Today’s practitioners are physicians, nurses, optometrists, entomologists, microbiologists, psychologists, hospital corpsmen, and other medical personnel. Many of them wear a warfare device earned through service at sea, in an aviation or undersea environment, with the SEALs or Marines. These practitioners of the operational medicine art bear such titles as Aerospace Experimental Psychologist, Undersea Medical Officer, Aviation Physiology Technician or Hospital Corpsman (SW/AW). They have fulfilled the expectation of Dr. Pryor by training, working, and learning in the same occupational environment as the Sailors and Marines they serve. Their various backgrounds and their scientific expertise have given them the ability to assess the environments and the equipment that affect the performance of duty of their colleagues who go about the business of directing unmanned aerial vehicles to their targets, boarding a merchant vessel to look for contraband cargo, or launching a ground attack in the mountains of Afghanistan.

What have they done? The physiologist who designed an exercise regimen to improve performance on physical qualification tests for Search and Rescue (SAR) crewman enabled “growth more perfect.” The flight surgeon who studied the effects of hypertension medications on the alertness of personnel in high vigilance tasks and found that some were compatible with special duty helped to make “decay less rapid.” The entomologist who was able to prevent the

transmission of tropical disease through vector control allowed deployed personnel to enjoy a “life more vigorous.” The medical officers, dental personnel, and hospital corpsmen who triaged and prepared the injured for evacuation following a major fire aboard an aircraft carrier, made “death more remote.”

Do we need them? The simplest historical review of books such as Pryor’s *Naval Hygiene* written in 1918 and a similar volume entitled *A Manual of Naval Hygiene* written in 1943 as well as various editions of the *U.S. Naval Flight Surgeon’s Manual* and other military publications illustrate that there is never an end to the need for additional progress in occupational safety, preventive medicine, and the discovery of better ways to accomplish our missions. The need to understand the unique hazards associated with a person’s environment as recognized by Hippocrates, and the extension of that thought—to understand the occupation of the worker—remains critical to the preservation of the health and flexibility of our forces. We must support the training of our operational specialists and the development of the tools they use. We must also continue to recognize that operational medical research that improves the performance and increases the protection of our personnel is the foundation of our future success. □

Dr. Anderson is assigned to Naval Aerospace Medical Research Laboratory, Pensacola, FL.

In Memoriam

RADM Almon C. Wilson, MC, RUSN (Ret.) died 30 July 2003. He was 79.

Dr. Wilson was born on 13 July 1924 in Hudson Falls, NY. He attended Union College, graduating in 1946 with a BA in history and economics. He subsequently received his MD from Albany Medical College in 1952, and an MA in international affairs from the George Washington University in 1969.

Dr. Wilson joined the Navy's V-12 Program as an apprentice seaman in 1943. He was commissioned a line ensign in 1944, served on USS *Liddle* (APD-60) from January 1945 to April 1946, and was released from active duty as a lieutenant (j.g.) in 1946.

He returned to active duty in the Medical Corps for his internship at Naval Hospital Bremerton from 1952 to 1953, and then became squadron medical officer on the staff of Mine Squadron Three from August 1953 to July 1954, before being released from active duty. From 1954 to 1959 he received surgery training at the Veterans Administration Hospital, Salt Lake City, and returned to active duty in 1959. He was then assigned to Naval Hospital Oakland, CA. Dr. Wilson then served as Chief of Surgery at U.S. Naval Hospital Subic Bay, Philippines from 1959 to 1961. From 1961 to 1964, he was staff surgeon at Naval Hospital San Diego, and from 1964 to 1965, he was Assistant Chief of Surgery at Naval Hospital Chelsea, MA.

In 1964, Dr. Wilson transferred to the Republic of Vietnam where he assumed command of the Third Medical Battalion headquartered at Danang. He then became Chief of Surgery at U.S. Naval Hospital Yokosuka, Japan, where he served from 1966 to 1968. From 1968 to 1969 Dr. Wilson studied at the Naval War College, Newport, RI, before assuming command as Fleet Medi-

cal Officer on the staff of CINUSNAVEUR, Senior Medical Officer, Naval Activities, United Kingdom, London.

Dr. Wilson then reported to BUMED as Deputy Director/Director, Planning Division. Concurrently, he served as Medical Advisor to the Deputy Chief of Naval Operations (Logistics). From 1972 to 1974, he also had additional duty as personal physician to the Chairman of the Joint Chiefs of Staff.

In 1974 Dr. Wilson became commanding officer, Naval Hospital Great Lakes, IL, before being promoted to rear admiral and again reporting to BUMED in 1976 as Assistant Chief for Material Resources with additional duty as Fleet Hospital Program Manager. During that period, he was also a member of the Defense Medical Materiel Board.

From 1979 to 1980, he was CO of the Naval Health Science Education and Training Command, Bethesda, MD, at which time he was also Special Assistant to the Surgeon General for Navy Medical Department Education and Training.

From 1980 to 1981, RADM Wilson was Medical Officer, U.S. Marine Corps and Special Assistant to the Surgeon General for the Fleet Hospital and Hospital Ships. He was then Project Manager for the Fleet Hospital Project from 1981 to 1982. Dr. Wilson then became Director, Resources Division, Office of the Director of Naval Medicine (OPNAV), a post in which he served until 1983. From 1983 to 1984, he served in the Office of the Director of Naval Medicine (OPNAV). He retired in October 1984.

Dr. Wilson was a Fellow of the American College of Surgeons; a member of the Board of Governors, American College of Surgeons; a member, Graduate Education Committee, American College of Sur-



geons; DOD ex officio member, Graduate Medical Education National Advisory Committee; Alternate Ex Officio Member, National Library of Medicine Board of Regents; and Chairman, Health Care Committee, Interservice Training Review Organization.

His decorations include the Legion of Merit with gold "V" and two stars, the Meritorious Service Medal with one star, the Joint Service Commendation Medal, the Presidential Unit Citation, the Navy Unit Commendation with one star, the China Service Medal, the Asiatic-Pacific Campaign Medal with one star, the World War II Victory Medal, the Navy Occupational Service Medal with bronze "A," the National Defense Service Medal with bronze star, the Korean Service Medal, the Vietnam Service Medal with two bronze stars and Fleet Marine Force Combat Insignia, the Naval Reserve Medal, the Philippine Presidential Unit Citation, the Republic of Vietnam Meritorious Unit Citation with Gallantry Cross of Valor, the Philippine Liberation Ribbon with one bronze star, the United Nations Service Medal, and the Republic of Vietnam Campaign Ribbon with clasp.

RADM Wilson will best be remembered as the father of the modern fleet hospital. It was through his efforts that fleet hospital medical support was up and running during the Gulf War of 1990-91, and for Operation Iraqi Freedom. □

Book Review

Brave Ship, Brave Men by LCDR Arnold S. Lott, USN (Ret.). Naval Institute Press, Washington, DC, 1994. 288 pages.

What is it like to have your warship battered by no less than 10 Japanese kamikaze planes? Try to imagine corpsmen frantically trying to preserve life and triage casualties as another plane hits aft and yet another along the center of the ship as anti-aircraft guns roar and fires blaze away all around. In *Brave Ship, Brave Men*, author LCDR Arnold S. Lott, USN (Ret.) tells the true, horrific story of USS *Aaron Ward* (DM-34). The destroyer minelayer would undergo 10 suicide plane hits on 3 May 1945 as it was performing its mission providing forward protection for a carrier task force and landing force in support of amphibious landings.

The story of *Aaron Ward* could have been that of any other destroyer in the Pacific campaigns of World War II. They would endure the mines, torpedoes, and the divine wind “kamikazes” thrown at them by a determined Imperial Japanese Navy. The book was originally published in 1964 and reprinted by the Naval Institute Press in 1994 as part of their Bluejacket Books series.

Enter USS *Aaron Ward*'s Medical Department

“Somewhere between deck and engine rooms, between galley and bunk rooms, was the sick bay, the antiseptic sanctuary where LTJG J.K. Barbieri, MC, USN, and his crew of medics CPHM O. F. Tedford, PHM 2/c C. W. Crider, PHM 3/c J. J. Kennedy, and S/2c F. R. Fletcher ministered to the aches and pains of mortal man and soothed mental bumps and bruises when they could. The sick bay was a convenient hangout for men with nowhere else in particular to go, a social center where officers and men met on a slightly less than military basis.”

For those of us who have been to sea this scene is eerily familiar, although it happened in 1945. Many members of a crew seek haven in sick bay and the author's description of a typical day in medical is classic. The relationship between Navy doctor and hospital corpsman is tight and unwavering.

Seasoned corpsmen would support the doc in other ways. “They talked doc into keeping the supply of penicillin in the wardroom refrigerator. It would be safer in there...Doc was not a man to put all his pills in one place. His supplies were all over the ship from the wardroom refrigerator to the first-aid locker in the fantail. The usual allowance for plasma was 24 units and doc crammed the ice-cream machine and other parts of the ship with 250 to 300 units.” Also illustrating that any good medical department afloat cultivates relationships with many departments within the ship, “The medics cultivated all the

right people. Gerry Simon, a storekeeper, had the keys to the big ice box and could be depended on for fresh eggs, vegetables, and fruit. Larry Castagnola, who worked in the galley, kept the medics happy and healthy with fresh bread and rolls from the bakery.” The author describes how “A sailor could never tell when he might have to appeal to the medics for small favors...pulling into Pearl Harbor for liberty those who had been mean to the medics would be invited for a fungus treatment with Gentian Violet, resulting in sparkling white uniforms and purple hands, causing even the most timid souls to move aside on Ala Wai Street.” Despite these shenanigans that could only result from prolonged periods at sea, the men of *Aaron Ward* loved their medics and the doc.

Okinawa

The Battle of Okinawa which began in April and finally reached its conclusion in May 1945 was the last naval gasp of the Japanese Imperial Navy. The U.S. Navy suffered 30 ships sunk, 300 damaged, and more than 9,000 men killed, missing, or wounded. *Aaron Ward* was in the eye of this storm. “AIR ACTION PORT. ALL GUNS AIR ACTION PORT, the 5-inchers opened up, the forties joined in. While the guns barked and roared above their heads, an enemy plane crashes against the destroyer, the wardroom is converted into a triage and operating room. “Moose Antell, stark naked, skin hanging in shreds from his arms, hair and eyebrows gone. Behind him came a gruesome parade—Coward, Peterson, Parker all in nearly the same condition. The medics prepared for a long night.”

“Soon the wardroom was jammed with wounded. Doc sent Tedford down to set up another emergency station in the mess hall, and those treated moved to the mess hall. Other's were dropped into convenient bunks in the officer's room.” One junior seaman awoke to find himself in the Captain's bunk. In the wardroom the pace never slackened. “Plasma!”, “Right Here,” “Sulfa”, “Coming”, “Penicillin,” “I'll get it”... “No more needles!” “Use the one you have!” “It's not sterile!”, “Sterile hell, wipe it on your pants.”

They would repeat this scene over a dozen times as yet another plane crashed into the hull. The troop transport USS *Gosper* (APA-170) would pick up 39 badly wounded men.

Aaron Ward received recognition from Fleet Admiral Chester Nimitz and from a grateful nation in the form of a Presidential Unit Citation. Forty-one of her Sailors were killed in action during this attack including Seaman Second Class Fletcher who assisted medical in dealing with the horrendous casualties. Take time to read this extraordinary account of a brave ship and the brave men who tried desperately to save life amidst the fury of battle. □

—LCDR Aboul-Enein is a Medical Intelligence and Middle East Foreign Area Officer serving in the Pentagon.

Navy Medicine 1948



BUMED Archives

RADM George Russell, Judge Advocate General of the Navy, administers the oath to the first six enlisted women of the Naval Reserve who transferred to the Regular Navy. PhM1c Ruth Flora (third from right) became the first female hospital corpsman in the Regular Navy.