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DEPARTMENT OF THE ARMY  
OFFICE OF THE ADJUTANT GENERAL  
WASHINGTON, D.C. 20310

AGDA-A (M) (22 Feb 71) FOR OT-UT-71B014

1 March 1971

SUBJECT: Senior Officer Debriefing Report: [REDACTED] US Army Medical Command, Vietnam and Surgeon USARV, Period 3 June 1969 to 2 December 1970

SEE DISTRIBUTION

1. Reference: AR 1-26, subject, Senior Officer Debriefing Program dated 4 November 1966.
2. Transmitted herewith is the report of BG David E. Thomas, subject as above.
3. This report is provided to insure appropriate benefits are realized from the experiences of the author. The report should be reviewed in accordance with paragraphs 3 and 5, AR 1-26; however, it should not be interpreted as the official view of the Department of the Army, or of any agency of the Department of the Army.
4. Information of actions initiated under provisions of AR 1-26, as a result of subject report should be provided to the Assistant Chief of Staff for Force Development, ATTN: FOR OT UT within 90 days of receipt of covering letter.

BY ORDER OF THE SECRETARY OF THE ARMY:

BY:

VERNE L. BOWERS  
Major General, USA  
Acting The Adjutant General

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DEPARTMENT OF THE ARMY  
HEADQUARTERS, UNITED STATES ARMY VIETNAM  
APO SAN FRANCISCO 96375

AVHDO-DO

9 FEB 1971

SUBJECT: Senior Officer Debriefing Report - BG David E. Thomas

Assistant Chief of Staff for Force Development  
Department of the Army  
Washington D.C. 20310

1. Inclosed are three copies of the Senior Officer Debriefing Report prepared by BG David E. Thomas. The report covers the period June 1969 to December 1970 during which Time BG Thomas served as Commanding General US Army Medical Command, Vietnam (PROV) and Surgeon USARV.

2. BG Thomas is recommended as a guest speaker at appropriate service schools and joint colleges.

FOR THE COMMANDER:

1 Incl  
as (trip)  
2 cy wd HQ DA

A handwritten signature in black ink, appearing to read "Clark W. Stevens Jr.", written over a printed name.

Clark W. Stevens Jr.  
Captain AGC  
Assistant Adjutant General

# SENIOR OFFICER DEBRIEFING REPORT

(RCS-CSFOR-74)

Country: South Vietnam

Debriefing Report by: BG David E. Thomas, M.D., MC

Duty Assignment: Commanding General, United States Army Medical Command,  
Vietnam (PROV), and Surgeon, United States Army, Vietnam

Inclusive Dates: 3 June 1969 to 2 December 1970

Date of Report: 21 November 1970

1. a. At the conclusion of eighteen months in USARV I would like to preface my remarks by saying that this assignment has been an honor, a challenge and a pleasure. The successful accomplishment of the mission, with the help of thousands of others, makes one realize that the young Americans of today are as capable, dedicated and patriotic as their forefathers.

b. The theme during the entire tour was - conserve personnel, supplies, equipment and money; get along with less but do the job as well or better. We have succeeded. Of the original 22 hospitals, 13 remain. By mid-December this number will be reduced to 11 with one of those remaining being reduced drastically in size and relocated. These 11 hospitals will provide a total of 2,548 operating beds in support of US and FWMA Forces in Vietnam. There was a requirement for 3,007 AMEDD officers in June 1969. By early November 1970 this requirement was reduced to 2,065, a loss of 942 spaces which, on a percentage basis, is significantly less than the USARV PRA. These trends will continue (TAB A).

2.a. The turnover of medical facilities to ARVN can, to date, only be described as a failure. The 8th Field Hospital in Nha Trang was turned over 8 September 1970. In mid-October the facility was standing empty. At approximately the same time the 36th Evacuation Hospital at Vung Tau, after interim use as billets, was prepared for turnover for a paraplegic center. To date, this has not been done. The buildings are sitting empty, are not adequately guarded by the area coordinator and have been vandalized of ceiling fans, air conditioners and items of like nature.

b. The 12th Evacuation Hospital at Cu Chi is ready to be turned over. In fact, as of 30 October 1970 only 56 of the 119 patients are US military. We have attempted to have a skeleton ARVN medical staff move in preparatory to taking over. We have been unsuccessful due to ARVN lack of human and financial resources. Our current instructions are to remove all equipment to bare buildings at the appropriate time. This is most unfortunate since it is the only hospital in the area and its loss will be paid for in lives. The same situation exists at Pleiku where the local ARVN medical people do not wish to take over our facility, again citing lack of people and money.

c. Further hospital inactivations will be tied to our troops physically leaving a geographical area, with the exception of a hospital at Long Binh and Chu Lai where, in each case, one of the two in the area can be inactivated at the proper time.

3. a. During the buildup over here hospitals were built in a wide variety of configurations. The ORLL from this is that there is one design that should be made standard for the future. That is the shoulder-high cement sides with Quonset roof, a Quonset central corridor and the joining in an H configuration of most sets of two wards. This design is efficient, makes maximum use of ward personnel, is easy to clean and keeps the patient covered at all times. A copy of line drawings of such a facility has been forwarded to The Surgeon General, Department of the Army.

b. I have gone on record in the past concerning my opinion of the MUST concept. Permit me to just suggest at this time that we forget the MUST and start all over. While MUST has served the purpose of a test-bed, we must return to the drawing board and provide the forward medical echelon with equipment and facilities that are truly mobile (air and ground), sufficiently rugged to withstand the environment in which maintained and which are supplementary to and not necessarily duplicative of definitive treatment facilities.

c. To project into the future for a moment, a new hospital for Long Binh is still being worked on from an architectural and engineering standpoint. However, at the moment there is little evidence of financing being forthcoming. My guess is that we will repeat the mistakes we made in Korea. I cannot imagine a sovereign government, once our presence is minimized, being happy with having our soldiers concentrated in the MACV Saigon-Tan Son Nhut area for the local nationals and visitors to gaze on. I believe the government will wish us to be at Bien Hoa and Long Binh

as out of sight and mind as possible. Ergo, the 3d Field Hospital, if used for definitive military care, will also be a thorn in the side. In an attempt to keep the new Long Binh hospital project alive we are in the process of doing a ten-year comparative cost analysis study.

4. Maintenance of medical equipment has been a constant problem. There have never been enough or sufficiently well trained technicians in country to give adequate support in this sophisticated area. The one item that is practically never in repair is the blood gas analyzer. This item is just too delicate for field conditions in the tropics. A medical R&D effort might be indicated in this area.

5. The Civilian War Casualty Program (CWCP) with its 600 dedicated hospital beds, needs some rethinking. If this effort is not scaled down, we will wind up at MAAGV with many more beds and medical budget money devoted to the CWCP than to that of the US Army, not to mention the necessity for four instead of two hospitals. I have no quarrel with the value of the concept but do wish to surface cost, reaction of non-volunteer professional people, and the incongruity of the relative effort to be expended in the two programs. Is the time approaching when this program should be scrapped?

6. a. If this war has done nothing else, it has proven that physicians of the various services can work together for the common good. The 483d Air Force Hospital at Cam Ranh Bay is a shining example. Currently, over 60% of their patients are Army. This has permitted us to close out the 8th Field Hospital at Nha Trang and has kept the census at the 483d at a level which justifies the staff, and has given them much more experience in the field of combat surgery. In addition, this hospital operates a jointly staffed MHCS [Mental Health Consultation Service] for all troops in the area, with the 6th CC [Convalescent Center] handling the administration, transportation and logistics for referred in Army troops.

b. Other examples of this operation are the use of the 6th CC by the Marines, primarily for convalescent falciparum malaria patients, the use of hospital ships by all services, and the good management shown in IMR through a monthly meeting of the senior medical officers of all services to handle joint problems and effect coordination.

7. More effective use of in-country resources by lateral transfer of patients through MRO has been discussed in previous communications. Recently MRO has received a new mission--the regulation of patients either to Japan and Okinawa or directly to a CONUS hospital with overnight stops

in CSF facilities as necessary en route. This concept was discussed in a staff study about one year ago. On professional grounds, only the physician decides whether a patient is well enough to be regulated directly to CONUS or needs further care and convalescence in Japan or Okinawa. We are still in the process of smoothing the rough edges off this new concept. As a very preliminary statement, it appears that about one-half of the patients may be regulated directly to CONUS. This, of course, reduces our off-shore bed requirement and reduces gold flow.

8. a. Early in CY 70 outlying dispensaries and clinics were placed under command and control of the hospital in the closest geographical proximity--the MEDDAC concept. This system has functioned well and has improved the morale of the outlying personnel since they feel they have a professional home they can call, refer consultations and problems to, and visit. It also permitted the inactivation of two of four medical battalion headquarters and headquarters elements.

b. The remaining two battalions have been restructured and given the mission of command and control of all medevac helicopter, field ambulance and bus ambulance TOE assets in country, one medevac battalion being assigned to each of the two remaining medical groups in country. Without belaboring the point, since comprehensive reports are available, these units have provided for more efficient use of resources, identified units to be inactivated, have permitted rapid shifting of resources to meet needs, standardized aviation safety procedures, developed a comprehensive aviation safety regulation, improved ongoing aviator refresher training, improved aircraft availability rate, maintenance and supply procedures and technical inspections.

c. In the wheeled vehicle area a daily technical inspection program was instituted as was a PLL and TAAMS clerk training program. A complete maintenance regulation was developed. Frequent assistance and inspection visits have made commanders far more vehicle maintenance conscious.

d. Major accomplishments include an increase in overall aircraft availability, an increase in overall CMMI readiness scoring, improved and more economic use of air and surface resources, standardized aviation safety and operational procedures, and lessened need for hospitals to provide their own surface ambulance support. I believe that CDC [Combat Developments Command] should consider this organization concept for employment in the field army and ComZ.

9. a. As our combat participation decreases it has been bothersome to note that our percentage of ARVN and VN civilians hauled by dustoff has increased, the workload has remained relatively constant, and the personnel death and injury rate as well as the helicopter combat damage rate continues at an unacceptably high figure. During CY 70 through September we find that US patients have constituted less than one-third of patients flown. During the same period 283 helicopters sustained combat damage compared to 309 for all of CY 69. During CY 69 there were 19 crew members killed, 103 wounded; 3 patients killed, 103 wounded. Through September corresponding figures were: 21, 110; 7, 13. As the war becomes less hazardous for the infantryman, danger increases for the dustoff crew member and his patients (TAB D)

b. An evaluation of the situation reveals that, although RVNAF is supposed to have three helicopters per helicopter squadron dedicated to medevac on a rotational basis, they very seldom accept a daytime mission and never after dusk. The result is that we do it all. Additionally, landing zones are called in as secure when they are not, since ARVN is rationed on gunship blade time. A further difficulty is the inability to talk to the troops on the ground, and a request for smoke might result in it being popped in more than one location. Pick one and lots of luck.

c. Additionally, missions are routinely overclassified and are also often completely unjustified. Naturally, these factors do little for the morale of dustoff people who have been used to working on a "you call, we haul" philosophy. As a matter of fact, the VC could, and probably have called in a dustoff.

d. In an attempt to reverse the trends, get RVNAF in business, pinpoint the person responsible for calling the mission, give the commander backing for refusing missions, make professional consultation available, lessen unnecessary missions, and make abuse of the service a matter of flag interest, USARV Regulation 40-10 was rewritten. A copy is inclosed as TAB C. This regulation is meeting resistance in line channels, and command support at the USARV level will be required to enforce the regulation completely.

e. My own conviction is that RVNAF will not do the work as long as we do it for them. We plan to accelerate the inactivation of dustoff units and create a scarcity which will necessitate participation by RVNAF

or rigid priorities on our part. A thought-provoking statistic is that we have totaled in excess of \$17,000,000 worth of UH-1Hs so far this year.

10. The changed operational concept for the division medical service has been extensively evaluated before. The 25th Infantry Division continues to function well with 19 medical officers. One point I would like to remention is the creation of a warrant career pattern for the better 91C. He could ease the strain in the combat unit, post, camp and station dispensary, and supervisory level in hospital nursing services. This would keep him in the 91C field instead of having him seek new worlds to conquer after making E7. It would also ease physician strain.

11. Under a succession of able commanders and staff officers, all parameters of our supply posture have consistently improved. At present we have a customer satisfaction rate in excess of 92% and a depot inventory of less than \$8 million. At present a demand on the system stimulates an order to Okinawa. Having done a great deal of living off the shelf during the last fiscal year, we received an inadequate budget this fiscal year. At the current rate of obligation we project a short fall in excess of \$3 million. It is quite possible that further inactivations and redeployments will result in recovery of assets and lessened demands which will permit us to live within the budget. It should be mentioned that the amount of work we do for FWMF, ARVN and VN civilians consumes supplies (TAB D).

12. a. The Army population in our hospitals has progressively declined and will soon be under 1,600; the non-US Army patient population remains in the vicinity of 40%. The percentage of combat wounded has steadily declined as the maneuver battalions have lessened in number and aggressiveness. At the same time, the NBI, incident, accident and disease rate has risen. 'Twas ever thus.

b. Significant surgical advances have been made during the past 18 months. Colonel James P. Geiger, in a brilliant clinical investigative effort, effected an improvement in morbidity and mortality in the wet lung syndrome by anticipating the situation and instituting treatment with effective diuretics before the appearance of x-ray changes on the chest plate.

c. The value of fresh frozen plasma or, even better, freshly drawn blood for control of the bleeding diathesis which appears after multiple transfusions has been proven.

d. A method of repair of bleeding dural sinuses using a vein graft has been developed.

e. An exchange program between Regular Army general surgeons and orthopedists in Japan and Vietnam has resulted in an appreciation of each other's problems and an improvement in the level of professional care.

f. The WRAIR team made a significant contribution through their studies of the pulmonary physiology of the severely wounded at higher altitudes in flight between Vietnam and Japan. Additionally, they demonstrated the inefficacy of bank blood transfusion just prior to aerial flight.

g. The problem of extensive pulmonary contusion with arteriovenous shunting and the occasional indication for therapeutic pulmonary resection was highlighted.

h. The cold patient as the result of multiple blood transfusions has been a serious problem. The "coil" of blood tubing through a warm saline blood warmer simply is not efficient at rates of 75 - 100cc per minute. Accordingly, a pilot project is now underway at two evacuation hospitals utilizing microwave ovens which warm a unit of blood from 4 degrees centigrade up to 33 degrees centigrade in 45 seconds. If these ovens prove durable, additional units will be placed in each of the remaining hospitals.

i. The problem of intra-abdominal sepsis developing in patients evacuated to Japan has been evaluated with an eye towards prophylaxis. A pilot project is being initiated in which patients with massive contamination by colon contents receive continuous postoperative irrigation of the peritoneal cavity by antibiotics (kanamycin).

13. a. The relationship between dapson and agranulocytosis was evaluated and work at WRAIR suggested this may be due to drug breakdown products. It is noteworthy that, since discarding older stocks, only one case has been seen.

b. With the assistance of the SEATO laboratory the summer outbreak of encephalitis has been shown to be the Japanese B variety.

c. Malaria and its complications and relapses, including drug efficacy, has been extensively studied with controlled protocols at the 6th Convalescent Center.

14. a. Field teams of the 9th Medical Laboratory have been incorporated in the MTOE of the nearest major hospital.

b. The 9th Medical Laboratory has had a variety of equipment -supply, maintenance and environmental problems. Upgrading this installation must be equated against its reducing mission (TAB E).

15. a. The drug abuse problem is a real one. It is a matter of supply and demand. For 500 piasters a day a man can support a \$100-a-day CONUS habit. Almost any drug you care to name is readily available. Another important point is that the heroin here is pure, in comparison with the 5% heroin available in CONUS. The result of this is that a man can become habituated over here just by sniffing the drug. The increase in drug overdosage, hospital admissions and drug deaths can only be described as explosive.

b. It is unfortunate that we have no rapid way of separating the user from the source. We are left with the necessity of using the separation apparatus provided by AR 635-212. While this lengthy route is being followed, the user continues to have the drug available, and the possibility of inadvertent death remains (TAB F).

16. To date there have been few dental units inactivated. This is due to the supply of dentists having been inadequate to handle the workload. As redeployment continues, inactivation of KJ teams will be stepped up. I can only say that the dental profession should be proud of the performance of duty dentists have provided in Vietnam. They have been hard working, innovative, dedicated, and have done an excellent job of training the Vietnamese (TAB G).

17. Bringing optometrists as far forward as practical has been one of the smart moves in this conflict. The number of troop man days saved is almost incalculable. Improvement continues with progressively moving more sophisticated techniques forward with a concomitant reduction in order-delivery time. The presence of an optometry consultant on my staff has been of inestimable value (TAB H).

18. There has been a chronic shortage of nurses in theater until the present time. Our requisitioning objectives were not projected as well as they might have been and some of these people will receive drops in order to keep from developing an overage. This is necessary because

there is a shortage of quarters and a terrific shortage of adequate field grade quarters. We have not done well by our women in this regard (TAB I).

19. a. The specialty of preventive medicine and its ancillary disciplines has [sic] had a field day in Vietnam. The good they can do is limited only by their intelligence, energy and imagination.

b. In addition to the usual tasks, inspection for cleanliness of retrograde cargo is an added responsibility. This creates the necessity of training retrograde cargo inspectors on a recurring basis (TAB J).

20. a. The veterinarians have performed well and have tried tirelessly to determine the cause of tropical canine pancytopenia and glossitis, the two major diseases which have caused canine morbidity and mortality. Actually, there is less lost duty time due to TCP which suggests that tetracycline may be partially effective.

b. In this regard, I fail to understand why we have not established an indigenous dog training center for the Vietnamese, using the tough local dog. At great expense we purchase and train German shepherds, ship them to Vietnam and then train a 95-pound Vietnamese to handle a 95-pound German shepherd. This practice is shortsighted and wasteful. We should reevaluate the entire program. Incidentally, our whole Stateside program needs another look. Who's in charge? Who procures the dogs? Why? Isn't the dog just another supply item? Are German shepherds, with their hip dysplasia and temperament really the best breed (TAB K)?

21. Efficiency in administration has improved in MEDCOMV as shown by a reduction of medical records backlog, average time to complete congressional inquiries and outstanding line-of-duty determinations (TAB L)

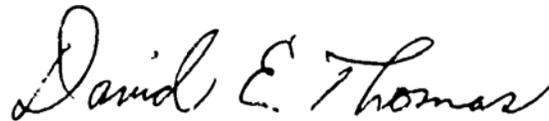
22. Dietetic consultants are well worthwhile. The officers find and bring to command attention deficiencies in food quality and amounts as well as contribute significantly to maintenance and upgrading of equipment. While much has been done, we could train and employ more Vietnamese in our kitchens.

23. Two medical groups yet remain. I can visualize the day in the not-too-distant future when this Army will have shrunk to the point where its duties can be assumed by MEDCOMV unless one is to be retained for the purpose of training (TABS N and O).

24. In conclusion, the Medical Department has amassed a solid record of achievement in the, past 18 months. The performance has been professional all the way. Our current operations are efficient. Our plans for the future are sound and frequently updated. Problems exist. We are working on them realistically and practically.

LIST OF TABS:

- A - Personnel and Administration
- B - Aviation Statistics
- C - USARV Regulation 40-10
- D - Materiel Program
- E - Medical Laboratory Activities
- F - Drug Abuse
- G - Dental Activities
- H - Optometry
- I - Nursing Activities
- J - Preventive Medicine
- K - Veterinary Activities
- L - Plans and Operations
- M - Dietetic Activities
- N - 67th Medical Group Report
- O - 68th Medical Group Report-



DAVID E. THOMAS, M. D.  
Brigadier General, MC  
CG, USAMEDCOMV(P)

## TAB A

### PERSONNEL AND ADMINISTRATION

#### 1. AMEDD OFFICER STRENGTHS

a. USARV Personnel Requisitioning Authority (PRA) is issued quarterly to provide the AMEDD slice of the USARV officer strength. Actual requirements are more realistically provided by the 919 report which shows our actual requirements. TAB A1 shows comparison of these figures for the period May 1968 to present.

b. Current 919 requirements have dropped to 2,065. This is 942 spaces less than the June requirement of 3,007 (TAB A2).

#### 2. CIVILIAN PERSONNEL

At peak strength in June 1969 as authorized by "Program Six" (Civilianization Plan). This program was not effective because of the lack of qualified local national direct hire personnel. The command hire ceiling is 820 at this time and all authorized spaces are utilized.

#### 3. ASSISTANCE IN KIND (AIK) FUNDS

During the period June 1969 to December 1970 VN\$18,739,000 (piasters) were available to MEDCOMV for use in paying daily hire unskilled laborers.

#### 4. REENLISTMENT

Prior to May 1970 each medical group administered its own reenlistment program. This system did not meet desired goals. In May 1970 the program was placed under centralized control of the MEDCOM Reenlistment Office. With this reorganization and recent changes in reporting procedure MEDCOM has risen from last place to second place in the USARV Incentive Award Program.

#### 5. AWARDS AND DECORATIONS

a. During the period June 1969 and October 1970 twenty-four units within MEDCOM were recommended for Meritorious Unit Citations. Of these, six have been approved and the remainder are still pending (TAB A3).

b. A summary of awards approved for MEDCOM personnel from July 1969 to September 1970 is attached as TAB A4.

c. During this period authority was granted to the CG, MEDCOM to impact awards in outstanding cases of valor up to and including the Silver Star.

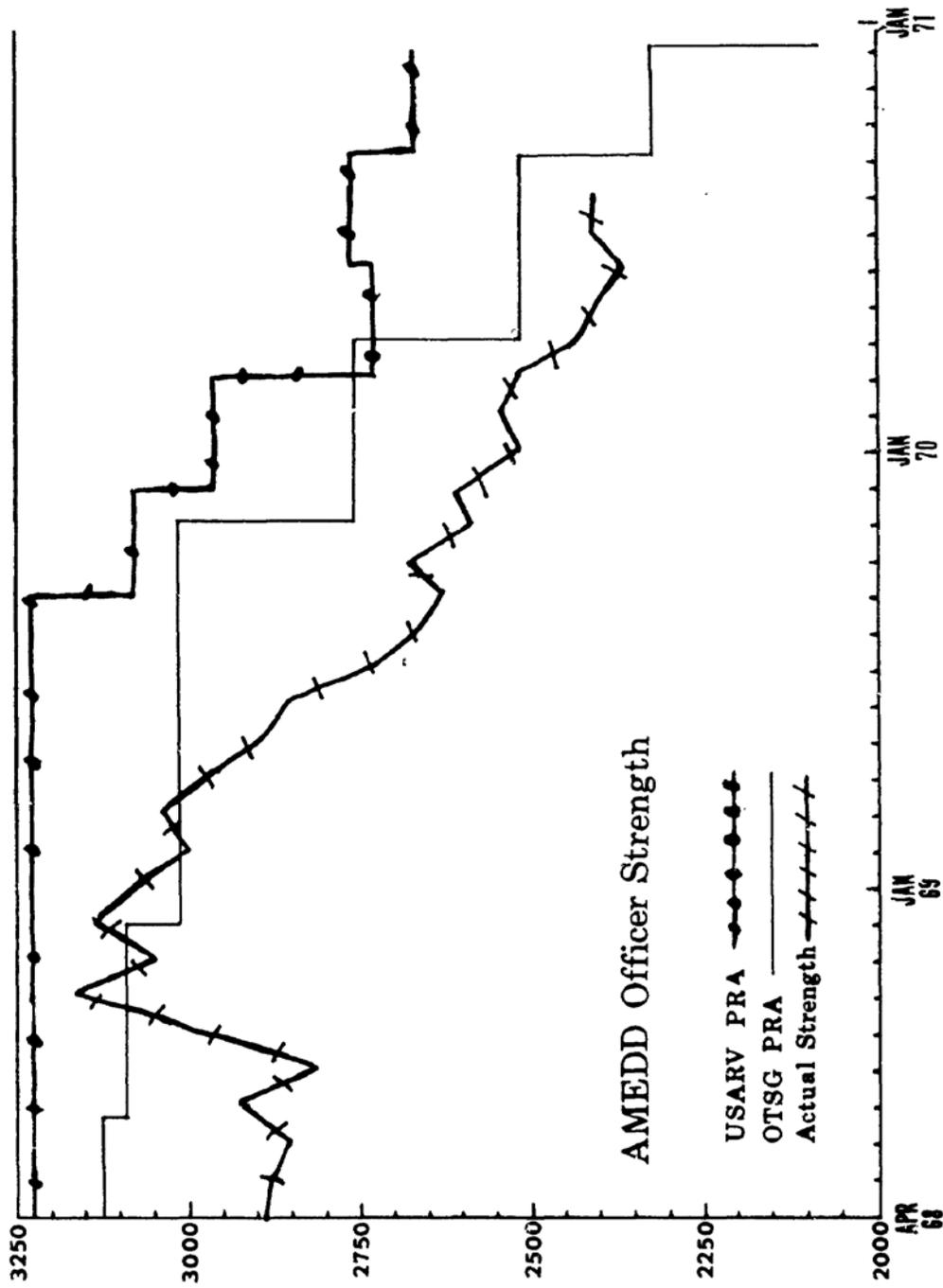
#### 6. CHAPLAIN ACTIVITIES

A new program of clinical pastoral education was established in 1970. This program is held at the 6th Convalescent Center and is scheduled so that each chaplain in the command is able to attend three sessions.

#### 7. 222D PERSONNEL SERVICE COMPANY

Attempts have been made to relocate the 222d Personnel Service Company in buildings which would provide more suitable working and living conditions.

TAB A1



AMEDD Officer Strength

- USARV PRA
- OTSG PRA
- Actual Strength

919 MC PROJECTION DATA

MOS	919 AUTH 15 Oct	PROJECTED			919 AUTH 1 Jan 71	PROJECTED			919 AUTH* Apr 71
		ON-BOARD STRENGTH <sup>1</sup> NOV	DEC	ON-BOARD STRENGTH <sup>1</sup> 1 Jan 71		JAN	FEB	MAR	
0002	1	1	1	1	1	1	1	1	1
3000/3500	28	26	25	23	25	25	22	21	21
3005	23	23	22	13	22	27	19	13	13
3100	295	243	257	251	248	258	242	202	202
3108	3	1	1	2	1	1	1	2	2
3111	8	10	12	7	12	12	11	6	6
3112	5	5	6	6	7	6	6	6	6
3115	37	38	45	35	37	37	37	33	33
3116	3	3	3	3	3	3	1	3	3
3125	8	11	11	6	11	10	8	6	6
3126	10	12	13	9	12	11	11	9	9
3128	2	4	4	2	4	4	4	2	2
3129	14	17	17	16	17	17	16	15	15
3131	9	8	8	7	7	5	5	7	7
3139	50	50	50	37	50	44	43	33	33
3150	131	133	141	108	130	129	119	92	92
3151	9	6	7	8	8	7	7	7	7
3152	2	2	2	2	2	2	2	2	2
3153	32	41	38	30	36	33	32	28	28
3160	82	63	72	79	57	49	51	69	69
3306	20	22	21	17	21	22	21	15	15
3325	13	17	17	13	17	16	16	13	13
TOTAL	785	736	773	675	728	719	675	585	585

\*Tentative

<sup>1</sup> Projected Strength (Current Asg and Name Fills) Known Losses

TAB A3

UNIT AWARDS (PENDING)

MERITORIOUS UNIT CITATIONS (MUC)

1st Medical Laboratory (Mbl)	Oct 68 - Jan 70
2d Surgical Hospital	9 Dec 68 - 9 Dec 69 (2d OLC)
24th Evacuation Hospital	1 Sep 68 - 31 Aug 69
32d Medical Depot	1 May 69- 30 Apr 70
36th Medical Detachment	1 Aug 68 - 1 Jan 70
HHD, 43d Medical Group	30 Jan 68 -7 Feb 70 (2d OLC)
45th Medical Company	1 Jan 69 - 30 Apr 70
45th Surgical Hospital	1 Jun 69 - 15 Aug 70 (1st OLC)
56th Dental Detachment	1 Feb 68 - 1 Nov 69
57th Medical Detachment	Feb 69 - Dec 69
67th Medical Group	1 Apr 69 - 28 Feb 70 (1st OLC)
85th Evacuation Hospital	1 Aug 68 - 31 Jul 69 (2d OLC)
95th Evacuation Hospital	26 Mar 68 - 31 Jan 70 (1st OLC)
176th Vet Detachment	1 May 69 - 31 Oct 69
219th Medical Detachment	23 May 68 - 30 Nov 69
245th Medical Detachment	27 Mar 68 - 15 Aug 69
311th Field Hospital	Oct 68 - Jul 69
936th Vet Detachment	1 Aug 69 - 30 Apr 70

UNIT AWARDS APPROVED

MERITORIOUS UNIT CITATIONS

12th Evacuation Hospital	1 Sep 68 - 31 Aug 69
HHD, 43d Medical Group	1 Jun 66 - 29 Jan 70
HHD, 55th Medical Group	11 Mar 68 - 15 Jun 69
172d Preventive Medicine Unit	1 Aug 68 - 1 Jun 69
522d Vet Professional Svcs	27 Mar 68 - 27 Sep 69
93d Evacuation Hospital	1 May 69 - 30 Nov 69

TAB A4

INDIVIDUAL AWARDS

	ARCOM w/"V"	AM w/"V"	ARCOM(Ach)	BSM PH	BS"V"	BSM(Ach)	SM	DFC	LM	SS	BSM	DCS	MH
Jul 69	242	414	5	148	1459	2							0
Aug 69	109	3	0	49	1531	6							0
Sep 69	213	260	0	98	1346	3							0
Oct 69	125	979	0	116	962	3							0
Nov 69	222	1299	0	120	1221	0							0
Dec 69	172	0	0	131	905	11							0
Jan 70	199	336	0	102	1104	4							0
Feb 70	161	21	0	132	967	5							0
Mar 70	278	752	27	224	1228	2	2	24	5	4	0	0	0
Apr 70	319	497	18	259	1785	5	3	6	5	0	0	0	0
May 70	266	617	13	280	1995	7	0	9	6	1	0	0	0
Jun 70	309	224	7	331	1249	0	3	18	11	5	0	1	0
Jul 70	316	224	9	336	1177	0	0	15	7	0	0	0	0
Aug 70	147	650	16	173	866	5	0	5	2	0	0	0	0
Sep 70	169	426	42	179	712	0	0	5	1	0	0	0	0
TOTAL	3247	6702	132	2678	18507	53	40	82	37	10	0	1	0

TAB B  
AVIATION STATISTICS  
1969

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
No. Times Hit by Hostile Fire	23	33	30	22	46	22	23	24	24	24	18	20	309
No. Hoist Missions (Patients)	176	145	227	183	225	192	137	156	197	252	215	361	2516
No. Times Hit by Hostile Fire (Hoist Mission)	3	2	3	5	6	2	2	4	5	2	4	1	39
No. of Crew Killed	4	5	4	0	4	0	0	0	0	0	2	0	19
No. of Crew Wounded	8	19	8	8	14	7	4	8	13	7	3	4	103
No. Patients Killed	3	0	0	0	0	0	0	0	0	0	0	0	3
No. Patients Wounded	0	1	1	1	2	3	0	0	0	0	1	2	11
No. Aircraft Combat Losses	1	3	11	3	6	3	2	6	2	6	1	1	45
Total No. Missions Flown	8505	7423	10139	9006	9810	9097	8229	8516	8150	8324	7891	9022	104112
Total Flight Hours	6764	5860	7587	6307	7026	6673	6193	6730	6154	6298	6171	6889	78652
No. of Patients Evacuated:													
US Patients	6332	6182	9275	6806	8420	7536	6195	6915	5410	5198	5598	5452	79319
FMAF	410	408	571	548	734	486	619	535	526	614	379	460	6290
ARVN	4806	4431	5567	4476	5492	5065	3856	5000	4623	4804	5010	4780	57910
RVN Civilian	3641	4054	5194	4610	5229	4593	4334	4610	4151	3648	4092	4186	52342
Other	1050	615	1236	982	690	951	927	661	621	774	886	975	10368
TOTAL	16239	15690	21843	17422	20565	18631	15931	17721	15331	15038	15965	15853	206229
Average No. of A/C On Hand	116	116	116	116	116	116	116	116	116	116	116	116	116
Average % A/C Availability	74.9%	71.4%	68.5%	71.8%	71.2%	69.0%	74.3%	79.0%	80.0%	76.0%	74.0%	68.0%	72.0%

*Tab B*

TAB B  
AVIATION STATISTICS  
1970

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
No. Times Hit by Hostile Fire	35	21	27	40	52	41	10	25	29	22			
No. Hoist Missions (Patients)	355	171	313	299	219	171	203	188	158				
No. Times Hit by Hostile Fire (Helicopter Missions)	1	5	6	4	6	4	0	4	2				
No. of Crew Killed	0	0	0	8*	5	2	1	0	5				
No. of Crew Wounded	15	9	4	13	24	16	9	5	15				
No. of Patients Killed	1	1	0	3	0	1	0	1	0				
No. of Patients Wounded	0	1	3	5	1	1	0	1	1				
No. Aircraft Combat Losses	3	1	1	7	6	4	0	1	2				
Total No. Missions Flown	9750	9382	8789	9937	10203	7389	7913	7776	7504				
Total Flight Hours	7268	7374	7624	8090	8344	6777	6892	6758	6353				
No. Patients Evacuated:													
US Patients	5164	5125	4789	4937	6661	5217	4705	4476	3820				
USAF	412	478	643	524	681	447	554	418	445				
ARVN	5551	5058	5407	7547	8532	6474	4852	5239	5225				
RVN Civilian	4095	4183	4067	4674	4947	4068	3373	3475	3035				
Other	637	885	790	1406	1232	655	636	457	423				
TOTAL	15865	15724	15696	19088	22053	16861	14120	14055	12948				
Average No. of A/C On Hand	116	116	116	116	116	116	116	116	116				
Average % A/C Availability	73%	67%	74%	66%	69%	68%	74%	73%	76%				

\* 1 Missing at sea A/C crash

HEADQUARTERS, UNITED STATES ARMY, VIETNAM  
APO San Francisco 96375

REGULATION  
NUMBER 40-10

Medical Services  
AEROMEDICAL EVACUATION

1. PURPOSE: To establish procedures and provide guidance for the utilization of USARV aeromedical evacuation resources.

2. DEFINITIONS: a. Army aeromedical evacuation. That part of the combat zone medical evacuation function which uses Army Medical Service (AMEDS) air ambulances for patient evacuation to and between medical treatment facilities and provides in-flight medical treatment and/or surveillance.

b. Call Signs. Pronounceable words which identify a communication facility, a command, an activity or a unit; used primarily for establishing and maintaining communications. The following call signs are used for aeromedical evacuation in Vietnam:

(1) DUSTOFF. Call sign of air ambulance helicopters of the US Army Medical Command (Vietnam)

(2) MEDEVAC. Call sign of air ambulance helicopters of the 1st Cavalry Division (AM).

(3) EAGLE DUSTOFF. Call sign of air ambulance helicopters of the 101st Airborne Division (AM).

c. Categories of Precedence. Those categories of urgent, priority, and routine in which patients are classified in order to determine precedence of evacuation.

d. Free World Military Assistance Forces (FVMA). Those allied military forces from countries other than the Republic of Vietnam that are in support of the Republic of Vietnam in its counterinsurgency effort.

3. GENERAL. a. Combat zone aeromedical evacuation operations, under all conditions, are conducted exclusively under the operational control of the responsible surgeon or medical unit commander.

b. The aeromedical asset of the Army-level air ambulance units are employed in a support role as determined by the CG, US Army Medical Command, (Vietnam). Air Ambulances are located according to operational requirements and troop density. Air ambulance resources are shifted as necessary to provide responsive air ambulance support.

c. Army-level air ambulance coverage for support of preplanned tactical

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\*This regulation supersedes USARV Reg 40-10, 3 Apr 69

operations is requested through command or medical channels to the appropriate Field Force Vietnam (FFV)/XXIV Corps Surgeon. The FFV/XXIV Corps Surgeon forwards the request through the supporting medical group commander to the supporting Medical Battalion Commander who commits available aircraft to best meet the total support requirements.

(1) Field siting of air ambulances in support of planned tactical operations is accomplished as required for US and FWMAF only. When requests for field siting air ambulances are approved, the major supported unit will be responsible for providing or arranging for the following:

- (a) Necessary aircraft revetments and refueling.
- (b) Adequate crew quarters in the immediate vicinity of the air ambulance parking area.
- (c) Adequate mess facilities in the near vicinity of air ambulance parking area.
- (d) Ground transportation as needed.

(e) A continuously operated communications center, located in the near vicinity of the air ambulance parking area, to assist in the receipt of Dustoff mission requests, dispatch and control of Dustoff aircraft and to provide ground to air radio communications,

(2) Direct coordination between the surgeon of the supported forces and the supporting air ambulance unit is authorized to insure that adequate and responsive air ambulance coverage is provided.

d. Commanders of airmobile divisions will prescribe policies and procedures for employing air ambulances organic to those divisions. For conformity such policies and procedures should follow those prescribed in para 4 and 5, below.

4. POLICY: a. Air ambulance units provide aeromedical evacuation for the following categories of personnel in order of priority indicated below:

- (1) US military and FWMAF personnel.
- (2) Citizens of the United States employed by the US Government and private citizens of the United States.
- (3) Members of the Armed Forces of RVN (RVNAF).
- (4) Regional Force/Popular Force personnel (RF/PF).
- (5) Prisoners of war and detainee patients.
- (6) Patients referred to US medical facilities under the auspices of the Civilian War Casualty Program.

b. Air ambulances are utilized for the following missions:

- (1) Aeromedical evacuation of selected patients.
- (2) Emergency movement of medical personnel, supplies and equipment.
- (3) Uninterrupted delivery of whole blood, biologicals and medical supplies.

c. Categories of precedence.

(1) Within the priorities outlined in paragraph 4a, above, and based on the conditions of the patient, the following precedence for evacuation is prescribed:

(a) URGENT. Emergency cases which must be evacuated within two hours in order to save life or limb. Examples of cases which may be included under this category are gunshot wounds (GSW), fragmentation wounds of the chest, head, neck, abdomen, or thigh; fracture of thigh; broken neck or back; heat injury if passing out or breathing stops; burns covering more than 20 percent of the body; and crushing injuries of the body or major extremities. The following conditions ARE NOT urgent category patients: malaria, psychiatric, pregnancy, and fevers of undetermined origin (FUO).

(b) Priority. Patients requiring prompt medical care. This precedence is used when the patient must be evacuated within four hours or his medical condition will deteriorate to such a degree that he will become an urgent case. Priority evacuation requested during the four hours preceding first light normally will be evacuated at first light. Examples of cases which may be included under this category are GSW, fragmentation wounds or fractures of the extremities, heat casualties with cramps and dizziness, crushing injuries to fingers or toes and burns covering 10 to 20 percent of the body. The following conditions ARE NOT priority category patients: malaria, psychiatric, pregnancy, most FOU's, and fractures of the fingers or toes.

(c) Routine. Patients requiring evacuation but whose condition is not expected to deteriorate significantly. Patients in this category will be evacuated within 24 hours. Examples of conditions included under this category ARE malaria, psychiatric, minor fractures of the fingers and toes and most FUO's. The following cases ARE NOT included in this or any other category: pregnancy and Vietnamese civilian non-battle illness. Routine evacuations are prohibited at night.

(d) Tactical Urgent. It is sometimes necessary to clear patients from an area of operations because of the tactical situation. When such situations develop, aeromedical evacuations are requested by using the precedence codes in para 4c(1), above, giving the total number of patients and normal category of precedence to be cleared from the area followed by a statement that tactical urgency dictates the mission. Commanders will not use this procedure for the purpose of clearing priority and routine patients from an area of operations when the tactical situation does not require immediate evacuation. Armed escort is required for all missions of tactical urgency. It is the respons-

ibility of the commander requesting aeromedical evacuation to request the armed escort.

(2) Misclassification.

(a) When professional medical personnel establish a category of precedence for a patient evacuation, commanders will not upgrade such category of precedence.

(b) In instances where the above categories of precedence are grossly and/or intentionally misrepresented, commanders will be apprised through command channels. Reports of misclassification by air ambulance unit commanders or other qualified medical personnel who become aware of such misclassification will be submitted using USARV Form \_\_\_\_\_ (See Appendix IV).

d. Deceased personnel. Responsibility for the evacuation of deceased personnel does not fall within the purview of aeromedical evacuation. When it is necessary to airlift deceased personnel from an area of operations because of the tactical situation, any available aircraft may be requested. Generally, requests for air ambulances to transport deceased personnel will be denied except in conjunction with patient evacuation. The decision to transport deceased personnel is at the discretion of the aircraft commander (AC). This decision will be based upon the AC's analysis of the tactical situation, patient priorities, aircraft capacities, and the overall medical mission.

5. Procedures.

a. Requests.

(1) General.

(a) Requests for aeromedical evacuation of US and FWMAF personnel may be made directly to the nearest DUSTOFF unit by telephone or radio. Requests for other than US and FWMAF will be made as prescribed in para 5a(3) through (5) below.

(b) When requesting aeromedical evacuation for US or FWMAF military personnel by telephone, a precedence of MEDICAL IMMEDIATE will be used for urgent category evacuation requests.

(c) Requests for aeromedical evacuation of US or FWMAF, directly to a DUSTOFF unit by radio, will utilize the established DUSTOFF frequencies and call signs for locations as indicated in Appendix I.

(d) All aeromedical evacuation requests will contain complete information, as applicable, on USARV Form 117R and will comply with local SO1 and SSI instructions.

(e) Non-medical aircraft may be used for emergency movement of patients when time does not permit arrangement for an air ambulance. When the desti-

nation of the patients is a US facility, the aircraft commander should contact the destination hospital and give the condition of the patient. (Call signs and frequencies are listed in Appendix I) This is essential so that the hospital can prepare to meet the needs of the patient.

(2) US and FWMAF. The decision to request an aeromedical evacuation mission is the responsibility of the senior Armed Forces member of the respective force at the location of the patient. When medical personnel are available their advice will be sought and weighed. When requesting an aeromedical evacuation for FWMAF personnel, an English speaking person will be at the pickup site. If this is not possible, an interpreter will be provided to accompany the aeromedical evacuation helicopter. The requester will provide the interpreter and designate the place of pick-up.

(3) RVNAF. Request for evacuating members of RVNAF will be directed through the Military Region (MR) Tactical Operations Center (TOC) to the Vietnamese Direct Air Support Center (DASC) for referral to VNAF. If the mission is assigned to and accepted by VNAF, it will not be referred later to, or accepted by, DUSTOFF.

(a) Routine and priority category missions will not be referred to DUSTOFF. Urgent category missions may be referred to DUSTOFF only when VNAF has all of its medical evacuation support helicopters fully committed to medical evacuation missions and has a backlog of urgent category medical evacuation missions that will exceed two (2) hours. When urgent missions are referred to DUSTOFF, the MR TOC must furnish DUSTOFF with the mission number, reason for VNAF non-acceptance and the rank and name of the VNAF duty officer contacted.

(b) When urgent missions are to be performed by DUSTOFF and members of the US Armed Forces are not located at the pickup site, and interpreter will be provided to accompany the DUSTOFF helicopter. The DUSTOFF aircraft commander may request a member of the ARVN tactical commander's staff who is thoroughly familiar with the current tactical situation to accompany the Dustoff mission. The MR TOC will furnish or arrange for the interpreter and/or accompanying tactical commander's staff member.

(c) Urgent missions to be performed by DUSTOFF identified either as hoist missions or insecure pickup sites will be accompanied by armed helicopter escort. The DUSTOFF aircraft commander may request armed helicopter escort whenever he believes it is necessary to successful mission completion. The MR TOC is responsible for providing and coordinating such armed helicopter escort.

(4) RF/PF. Requests for aeromedical evacuation of RP/PF personnel must have the approval of the province chief and will be processed under the same procedures as RVNAF (para 5a(3) above).

(5) Vietnamese Civilian War Casualties.

(a) Aeromedical evacuation requests for all categories of Vietnamese civilian war casualties wounded or injured as a result of US or FWMAF military

action will be processed as prescribed in para 5a(2) above by the US or FWMAF unit operating in that area. If no US or FWMAF unit is operating in the area of injury, the evacuation request should be forwarded through VNAF or Province channels to the MR TOC. After verification that the casualties resulted from US or FWMAF action, the TOC will forward the request directly to the nearest DUSTOFF unit. Requirements for armed escort and/or interpreters are the same as prescribed in para 5a(3) above. When the patient destination is other than a US facility, the evacuation request will specify the preferred destination facility.

(b) Requests for aeromedical evacuation of Vietnamese civilian war casualties not resulting from US or FWMAF military action will be processed under the criteria prescribed in para 5a(3) above.

(6) PW or Detainees.

(a) Requests for aeromedical evacuation of PW or detainee personnel injured or wounded as a result of US or FWMAF military action will be processed as prescribed in para 5a(2) above.

(b) Requests for aeromedical evacuation of PW or detainee personnel by other than US or FWMAF units will be processed under the criteria prescribed in para 5a(3) above.

(7) War Dogs.

(a) Requests for aeromedical evacuation of military war dogs from US or FWMAF units will be processed as prescribed in para 5a(2) above. Under no circumstances will the category of urgent be used when making requests. Generally the category will be no higher than routine. Evacuation of dogs will be flown only during daylight hours. For evacuation, the animal will be caged or under positive physical restraint, muzzled and under the direct control of the dog handler.

(b) Requests for aeromedical evacuation of military war dogs from other than US or FWMAF units will not be accepted by DUSTOFF.

b. Responsibilities. When requesting aeromedical evacuation, personnel at the site are responsible for:

(i) Insuring that the enemy situation offers a reasonable opportunity for successful evacuation and employing security to provide a reasonably secure landing zone (defined as one in which personnel standing upright can complete the loading of patients into an air ambulance without being exposed to hostile fire).

(2) Moving the patient to the safest location possible for aircraft approach and departure.

(3) Establishing and marking a landing zone of sufficient size for the pickup of patients except where hoist operations are necessary (see Appendix II).

(4) Providing by radio necessary information pertaining to area security restrictions, friendly artillery, etc., when the air ambulance arrives near the pickup site. The evacuation will not be attempted if radio communications cannot be established (unless the aircraft commander knows the area to be secure).

(5) Marking the friendly limits in the event armed helicopter escort is used.

(6) Requesting armed helicopter escort when the landing zone is considered insecure (defined as the probability that the evacuation helicopter will sustain damage from direct or indirect fire in the landing zone or on approach to or departure therefrom).

c. Hoist operations. Air ambulance hoist evacuation utilizes a helicopter mounted device to extract patients vertically by winching when no suitable landing area is available.

(1) Hoist evacuations will be requested and attempted only when a landing zone is not reasonably available. Landing zones, or areas that can be easily prepared by demolition or cutting devices, will be used in preference to hoist operations when such areas are available in the near vicinity of the patient.

(2) Because of the high danger associated with hoist operations, normally only urgent category patients will be evacuated by hoist. During the hours of darkness, requests will not be submitted for hoist evacuation of priority or routine patients.

(3) Patients will be ready for evacuation and physically located at the extraction site prior to arrival of the air ambulance.

(4) Because of hoist mechanical limitations and severe aircraft vulnerability, hoist evacuations should not be requested when the number of patients exceeds 4. Larger numbers of patients will normally require that a landing zone be prepared.

(5) Armed helicopter escort is required for all hoist evacuations. Area illumination is required for all night hoist evacuations. The requestor is responsible for providing and/or requesting armed helicopter escort and area illumination as required.

(6) The amount of equipment hoisted with the patient will be strictly controlled. In particular, heavy packs, ammunition and/or other unnecessary equipment will not be hoisted.

d. Armed Helicopter Escort.

(1) Armed helicopter escort is required under the following conditions:

(a) Hoist evacuation mission.

(b) Insecure evacuation sites.

(c) Tactical Urgent missions.

(d) At other times when, in the opinion of the DUSTOFF aircraft commander, armed helicopter escort is necessary for successful mission completion.

(2) When armed helicopter escort is required, it is imperative that this request be transmitted in conjunction with the evacuation request. This will minimize the many instances where the evacuation is delayed while DUSTOFF aircraft wait for armed helicopter escort to arrive at the evacuation site.

(3) When armed helicopter escort is required for US or FWMAF aeromedical evacuation missions, the commander of the requesting unit will request such escort as prescribed in local command regulations. If a requesting unit is unable to communicate the request for armed escort through established channels, the unit may request DUSTOFF to obtain such escort.

(4) When armed helicopter escort is required for other than US or FWMAF aeromedical evacuation missions, the Military Region TOC will request and arrange for such escort.

#### 6. Weather Considerations.

a. The weather minimums as specified in AR 95-2 will be adhered to whenever possible and in all cases involving evacuation missions for patients with a category of less than urgent.

b. When-ever weather conditions are below those specified in AR 95-2, urgent category missions will be attempted only when there is a high probability that the mission can be accomplished safely. The decision to attempt an urgent category mission under such weather conditions will be a command decision made only by the respective area DUSTOFF commander or his designated representative. This decision can be made only-after careful consideration has been given to weather and tactical conditions, crew capability, and mission urgency.

Appendix I

FREQUENCIES FOR MEDICAL FACILITIES AND CONTROL UNITS

Military Region One

<u>Location</u>	<u>Unit</u>	<u>Freq</u>	<u>Call Sign</u>
Quang Tri	18th Surg Hosp	45.70	DMZ DUSTOFF
Phu Bai	85th Evac Hosp	46.90	Plasma Hotel
	571st Med Det	45.70	Phu Bai DUSTOFF
	237th Med Det	45.70	Phu Bai DUSTOFF
Da Nang	67th Med Gp	46.90	Single Parent
	95th Evac Hosp	46.90	Single Parent Hotel
	236th Med Det	46.90	Da Nang DUSTOFF
Chu Lai	27th Surg Hosp	45.70	King Kong
	91st Evac Hosp	45.70	Rambler Two-eight
	54th Med Det	46.90	Chu Lai DUSTOFF
	68th Med Det	46.90	Chu Lai DUSTOFF
	566th Amb Co	45.70	Retractor
Field Sites	Hawk Hill	46.90	Charger DUSTOFF
	Duc Pho	46.90	Doctor DUSTOFF

Military Region Two

<u>Location</u>	<u>Unit</u>	<u>Freq</u>	<u>Call Sign</u>
An Son	498th Med Co	46.90	Lane DUSTOFF
Qui Nhon	67th Evac Hosp	46.90	Bandage Three
Pleiku	DUSTOFF	46.90	Pleiku DUSTOFF
Field Sites	LZ English	46.90	English DUSTOFF
	LZ Uplift	46.90	Uplift DUSTOFF

Military Region Three

<u>Location</u>	<u>Unit</u>	<u>Freq</u>	<u>Call Sign</u>
Tuy Hoa	283d Med Det	46.90	Tuy Hoa DUSTOFF
Phan Rang	247th Med Det	46.90	Phan Rang DUSTOFF
Long Binh	45th Med Co	45.70	Long Binh DUSTOFF
	24th Evac Hosp	62.05	Queen Tonic
	68th Med Gp	62.05	Wide Minnow
	93d Evac Hosp	62.05	Twenty Ducks
Saigon	3rd Fld Hosp	62.05	Villa Five
Field Sites	Phan Thiet	46.90	Phan Thiet DUSTOFF
	Xuan Loc	46.90	Xuan Loc DUSTOFF

Military Region Four

<u>Location</u>	<u>Unit</u>	<u>Freq</u>	<u>Call Sign</u>
Binh Thuy	3rd Surg Hosp	62.05	Astro Three
	57th Med Det	46.90	Delta DUSTOFF
	82nd Med Det	46.90	Delta DUSTOFF

## Appendix II

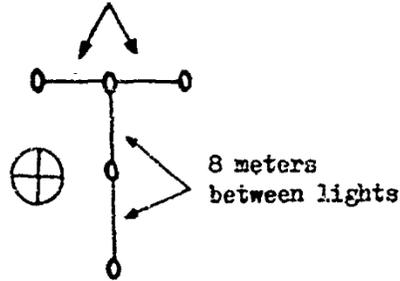
### LANDING ZONE REQUIREMENTS

1. The landing zone should be a level cleared area at least 30 meters in diameter. The presence of shrubs, brush, stumps, rocks, holes, soft surfaces, etc., is a definite hazard to helicopters and should be identified to the aircraft commander.
2. Under combat conditions the landing Zone should be secure from hostile fire. Known or suspected enemy locations should be identified. Effective small arms fire range is 300 meters. If a man can stand safely at the landing site, the area is usually secure enough for DUSTOFF to land.
3. Landing zones are effectively marked with smoke grenades. Several different colors should be available to facilitate accurate identification of landing areas. As a back-up for the colored smoke a guide should be provided to direct the helicopter to the exact landing point.
4. Night operations in unprepared landing areas can be extremely hazardous because of unmarked obstructions. Two types of lighting systems are shown at Annex A. Alternate means of lighting include strobe lights, ground flares and fires.
5. Hoist missions may be performed only when no suitable landing area is available. Because of cable length hoist extractions cannot be accomplished in areas where tree or obstacle height exceeds 250 feet.

ANNEX A

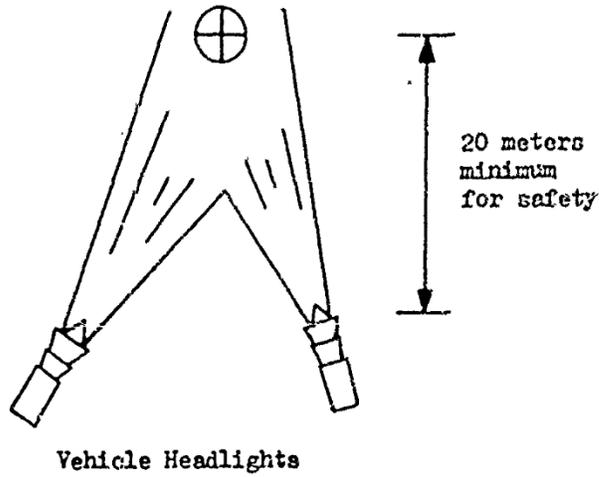
LIGHTING SYSTEMS

5 meters between lights



(Helicopter will land to left of toe)

Landing  
Direction



35

APPENDIX III

USARV Reg No 40-10

PATIENT EVACUATION REQUEST FORM		
(Requester must have ALL the information before calling for an air ambulance.)		
1. REQUESTER (Name, Rank):		
2. COORDINATES OF PICK-UP SITES:		
3. PATIENT DATA:		
A. PATIENT PRIORITY (Guideline Below):		
URGENT:	PRIORITY:	ROUTINE:
B. NUMBER OF PATIENTS:		
LITTER:	AMBULATORY:	
C. TYPE OF INJURY OR ILLNESS (Example: Heat exhaustion, GSW thigh):		
D. NATIONALITY OF PATIENTS:		
4. PICK-UP INFORMATION:		
A. RADIO FREQ AND CALL SIGN OF THE UNIT AT PICK-UP SITE:		
B. LZ IDENTIFYING MARKINGS:		
C. TERRAIN AND WEATHER CONDITIONS: (If Applicable):		
D. TACTICAL SECURITY: (If recently in contact, direction from which the contact came):		
E. HOIST REQUIREMENTS/SPECIAL EQUIPMENT YES: NO: EQUIPMENT:		
F. ENGLISH SPEAKING PERSONNEL AT LZ YES: NO:		
G. HOW WILL LZ BE MARKED (smoke, lights):		
URGENCY DESIGNATORS		
CATEGORY	NO	YES
URGENT	MALARIA PSYCHIATRIC PREGNANCY FUO VN CIV NON BATTLE ILLNESS	GSW OR FRAG WOUNDS OF CHEST, HEAD, NECK, ABDOMEN OR THIGH; FRACTURE OF THIGH, BROKEN NECK OR BACK; HEAT INJURY IF PASSING OUT OR BREATHING STOPS; BURNS COVERING 20% OR MORE OF THE BODY; CRUSHING INJURY OF BODY OR MAJOR EXTREMITIES.
PRIORITY	MALARIA PSYCHIATRIC PREGNANCY MOST FUO FRACTURES OF FINGERS OR TOES VN CIV NON BATTLE ILLNESS	GSW, FRAGMENTATION OR FRACTURES OF THE EXTREMITIES; HEAT CASUALTIES WITH CRAMPS AND DIZZINESS; CRUSHING INJURIES TO FINGERS OR TOES; BURNS COVERING 10% TO 20% OF THE BODY.
ROUTINE	PREGNANCY VN CIV NON BATTLE ILLNESS	MALARIA; PSYCHIATRIC; MINOR FRACTURES OF THE FINGERS AND TOES; MOST FUO.
5. <u>NO! CALL FOR THE AIR AMBULANCE</u>		
REMARKS:		

MISCLASSIFICATION OF PATIENTS FOR AEROMEDICAL EVACUATION

1. UNIT REPORTING \_\_\_\_\_ DATE & TIME \_\_\_\_\_
2. REQUESTING UNIT \_\_\_\_\_ UNIT CALL SIGN \_\_\_\_\_
3. MISSION REQUEST INFORMATION:
  - a. PATIENT CLASSIFICATION \_\_\_\_\_ DIAGNOSIS \_\_\_\_\_
  - b. NATIONALITY AND NUMBER:  
US \_\_\_\_\_ ARVN \_\_\_\_\_ RF/PP \_\_\_\_\_ CIV \_\_\_\_\_ POW \_\_\_\_\_ OTHER \_\_\_\_\_
  - c. COORDINATES: \_\_\_\_\_ TIME OF PICKUP: \_\_\_\_\_
  - d. TACTICAL SITUATION: (SECURE) (INSECURE) HOIST: (YES) (NO)
  - e. GUNBIRDS REQUESTED: (YES) (NO) CALL SIGN: \_\_\_\_\_
  - f. US ON GROUND: (YES) (NO) INTERPRETER USED: (YES) (NO)
4. ASSESSMENT OF MISSION BY DUSTOFF CREW:
  - a. CLASSIFICATION AS ASSESSED BY (DUSTOFF MEDIC) (MC) \_\_\_\_\_
  - b. DAMAGE SUSTAINED TO AIRCRAFT OR CREW: \_\_\_\_\_  
\_\_\_\_\_
  - c. WEATHER: \_\_\_\_\_
  - d. TACTICAL SITUATION (comments): \_\_\_\_\_  
\_\_\_\_\_
  - e. AIRCRAFT COMMANDERS SYNOPSIS OF MISSION: \_\_\_\_\_  
\_\_\_\_\_
5. ACTION TAKEN TO PREVENT FUTURE RE-OCCURENCE AND NAMES OF PEOPLE CONTACTED:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
6. REMARKS: \_\_\_\_\_  
\_\_\_\_\_

TAB D  
MATERIEL PROGRAM

1. SUPPLY PERFORMANCE

a. The customer demand satisfaction rate (initial fill rate) by the 32d Medical Depot for stocked standard items was 87% in July 1969. In March 1970 the rate increased to 92% and has remained over 92% for seven consecutive months.

b. The customer demand satisfaction rate for stocked nonstandard items has not been as good as for standard items. The rate was approximately 68% in July 1969. It is now 84%; however, the rate for nonstandard items fluctuates considerably on a monthly basis. This fluctuation is primarily due to a longer and somewhat irregular pipeline from Okinawa and CONUS.

c. This high level of medical supply performance resulted in providing the physicians with the needed items of medical supplies/equipment to provide outstanding medical care and treatment. This improvement took place during a period in which the depot inventory was reduced from \$16.3 million to \$7.2 million.

2. EXCESS PROGRAM

a. Based upon plans for the phasedown of operations in Vietnam, the matter of excess medical materiel was elevated to a level of high priority and major emphasis. Efforts were directed command-wise toward (1) prevention of excess through accurate and timely computations of requisitioning objectives for the command, and (2) timely identification and disposition of excess.

b. The excess program turned out to be a very active one with the results being a large reduction in the depot inventory with sizeable shipments being made to Okinawa and to RVNAF. In July 1969 the 32d Medical Depot had an inventory of \$16.3 million. By the end of September 1970 their inventory had been reduced to \$7.2 million. This reduction was accomplished primarily by shipments to RVNAF and to the medical depot, Ryukyu Islands as indicated below:

### 3. SHIPMENTS OF EXCESS MEDICAL MATERIEL BY THE 32D MEDICAL DEPOT

DATE	RVNAF	AID	OKINAWA
Jul 69	\$ 94,648	\$13,555	\$ 326,718
Aug 69	60,524		497,270
Sep 69	4,254		393,072
Oct 69	77,452		382,662
Nov 69	279,040	7,600	2,117,470
Dec 69	223,991		387,345
Jan 70	45,984		706,963
Feb 70	7,246		664,616
Mar 70	241,863		1,032,850
Apr 70	12,990		643,941
May 70	12,476		778,972
Jun 70	25,210		499,647
Jul 70	8,736		776,348
Aug 70	11,649		910,262
Sep 70	-----	-----	119,997
<b>TOTALS</b>	<b>\$1,106,063</b>	<b>\$21,155</b>	<b>\$10,238,133</b>

a. There is approximately a million dollars' worth of potential excess in the depot system now. The amounts of additional excess to be generated will depend largely upon whether our hospitals are turned over to the Vietnamese with all the equipment or whether the equipment is returned to our depot system.

b. In addition to the excess shipments mentioned above, we have also returned five MUST hospitals directly to CONUS.

c. The policy of allowing only a 4-1/2 month permissive overstockage is questionable. As an example, command stocks in excess of the Command Requisitioning Objective plus the authorized permissive overstockage of 4-1/2 months are turned over to the ARVN or retrograded to Okinawa. This means that in 5-1/2 months the same stocks retrograded to Okinawa are needed in Vietnam and must be requisitioned, using USARV out-of-country funds. Thus out-of-country funds and transportation and handling costs can be saved by authorizing a permissive overstockage of from 9 to 12 months. The costs to retain stocks already in country is

rather insignificant compared to the costs of shipping the stocks to Okinawa and returning the same stocks to Vietnam in a period of approximately 5-1/2 months.

#### 4. MEDICAL DEPOT REALIGNMENT

As a result of phasedown of operations in Vietnam, plans were promulgated in January 1970 to reduce the number of advance medical depots. In June 1970 the advance depots in Phu Bai and Chu Lai were closed and an advance depot was established in Da Nang. Plans are being formulated now for the closing of another advance depot within the next three months.

#### 5. MEDICAL MAINTENANCE

The medical maintenance program in Vietnam has not been as good as desired. Item identification, irregular and unpredictable demands, and a long order and ship time for repair parts complicate the problems of keeping our items of medical equipment operational. In addition, a shortage of medical equipment repairmen developed. In early October 1970 the 32d Medical Depot was authorized 26 35Gs but only had 13 available. This shortage of medical equipment repairmen plus the age of much of the equipment in use will probably create major maintenance problems in the year ahead.

## TAB E

### MEDICAL LABORATORY ACTIVITIES

#### I. INFECTIOUS DISEASES/SEROLOGY DEPARTMENT

a. A common, problem in this area has been the difficulty of obtaining an adequate convalescent serum specimen. (This is defined as a sample taken seven days or more after onset of illness.) The reason is apparently due to the relocation of the patient during the first week. Even with the cooperation of preventive medicine officers, this problem is often not solved. The magnitude of this is reflected in these figures: a positive serologic diagnosis is rendered in 20% of all FUO cases submitted, but this increases to 50% when counting only those cases for which acute and adequate convalescent sera are received.

b. A major problem in this area is the long delay in the delivery of nonstandard equipment and reagents. This frequently amounts to a year's wait and many critically needed items for this facility are in this category. Thus initiation of serologic testing for influenza, adenovirus, Eaton agent causing primary atypical pneumonia and the FTA-ABS syphilis serologic test are all pending arrival of ordered reagents. Meanwhile, labs in CONUS, Japan and Bangkok have provided supplies to assist us with this problem.

#### 2. PATHOLOGY DEPARTMENT

a. The major problem in this area in the past has been timely delivery of reports. It has taken up to six weeks for a report to get from Long Binh to Cu Chi and investigation inevitably reveals that the "courier system" is faulty, as obviously it is. This situation has been vastly improved through institution of three major changes in the system. Contributing laboratories have assisted by making their shipments two to three times weekly rather than once or twice or when the box gets full. Secondly, clinical material coming to the base laboratory as well as reports being returned to hospitals are no longer manifested on cargo planes but are placed on passenger planes which are always met at the airport. This system seems to work. The third change simply involves more frequent use of the telephone for more significant lesions.

b. The lack of photomicroscopy capability is unfortunate not only for the pathologists but for the veterinarians and parasitologists as well. Our people deserve the opportunity to graphically report their experiences in this part of the world when they have the enthusiasm to do so. Accordingly, we will shortly be requesting purchase of necessary equipment.

### 3. VETERINARY DEPARTMENT

a. Rabies continues to be a potential human health hazard to the US military population. Despite numerous exposures, however, there have been no cases thus far in 1970. The native dogs remain the primary reservoir.

b. In-country fabricated dairy products tested for microbiological compliance continue to fall within acceptable standards with the occasional exception of cottage [cheese]. Chemical food testing capability is now being developed in the Department. This entails testing for fats and total solids in certain dairy products. The first samples were performed the week of 12-17 October and duplicate samples sent to the 406th [Medical General Laboratory, in Japan] for comparison.

c. Several challenges have been seen in the field of animal disease. Tropical canine pancytopenia was the cause of death of 119 war dogs and a contributing reason for euthanasia of 41 more in 1969. In 1970 the rates are near one-fourth of the 1969 rates. Thanks to veterinarians in country and to the veterinary division of WRAIR, the etiology, pathology, clinical pathology and some of the pathogenesis and prevention are known. Effective control and treatment are still unknown.

d. Another disease peculiar to war dogs in Vietnam is "red tongue." This condition has been reported in 4 to 5% of the war dogs in country at one time. Investigations are underway to elucidate cause, treatment, and so forth.

e. This department also complains of the lack of photomicroscopy capability. A paper for publication is already prepared on canine melioidosis, and work will start soon on a paper on the red tongue problem. Photomicrographs are essential for the first paper and would be very helpful for the second.

### 4. PARASITOLOGY DEPARTMENT

The only notable problem in this area is the occasional misdiagnosis of malaria. For example, for every 1,000 slides forwarded for

confirmation, about 25 will be found erroneous. The most common mistake is diagnosing vivax when in fact it is a mixed vivax-falciparum infestation. When the banana-shaped, falciparum gametocyte is viewed on end, it resembles the vivax gamete, The frequency of incorrect diagnoses seems related to the periods of influx of new laboratory personnel. To meet this problem, the Parasitology Department continues to provide an intensive 6-day course for all pathologists, appropriate laboratory officers and selected enlisted technicians from all laboratories.

a. After a lapse of several months, there is now a newly appointed USARV Blood Program Officer, and he has already made several trips within RVN for discussions with hospital physicians. Other such trips are planned in the near future, and the objective is to maintain our operating procedures and policies as near the standards of the American Association of Blood Banks as the tactical situation will permit.

b. Partly as a result of the above liaison visits and partly also as a result of discussions with individuals in CONUS and in country who are interested in our blood program, we have become convinced that the feasibility of establishing a blood donor center in RVN must be carefully studied. For example, in August 807 units of blood were drawn in RVN and only occasionally were these donors located in reception centers. Stateside, such blood is considered unacceptable because of the presumed risk of hepatitis, malaria, and so forth. The idea is to establish a center at or near a reception station and have fresh blood available daily. A detailed study of this project is now being prepared.

## 6. CHEMISTRY DEPARTMENT

a. All toxicological testing is now performed in country. This was made possible by acquisition of a Beckman DK-24 Recording Spectrophotometer and the expanded use of thin-layer chromatography. This capability has resulted in a significant reduction in the time necessary to complete forensic cases.

b. The capability now exists to perform the following procedures which were previously forwarded to the 406th Medical Laboratory: Bound Thyroxine by Column, 5HIAA, Carotene, SGPT, CPK, Protein and Hemoglobin Electrophoresis, VMA, Copper, Ceruloplasmin, Iron and Magnesium.

c. There are presently two notable problems in the Chemistry Department. (1) there is considerable difficulty obtaining supplies. Several of the above procedures must currently be forwarded to Japan due to lack of reagents, (2) inoperative central air-conditioning resulting in increased repair of heat sensitive equipment. It has been possible to move the densitometer and the Beckman spectrophotometer to a room with a window air-conditioner. However, the desiccant in the gas-liquid machine is still adversely affected by the 90 to 100% humidity and all enzyme procedures cause some concern.

d. To dispose of this matter at this point, it should be added that this has also been a problem in the Histopathology Section where it was necessary to acquire a paraffin with a high melting point. This was accomplished, but it happens that this type paraffin has a high content of impurities which readily damage microtome blades. It is not possible to do color photography at existing room temperatures and there are problems also with the cryostat. After discussions with PA&E, FFMF, LB Depot and ICCV, it still remains very uncertain just what the status of ordered spare parts is. The breakdown occurred 17 July.

## 7. SUPPLY AND SERVICES:

a. It is apparent from the foregoing that resupply and spare parts are our chief problems. The major problem concerns repair parts for the IL Blood Gas Apparatus, IL Flame Photometer and Coulter Counter, a prescribed load list was submitted to the 3dd Medical Depot at Cam Ranh and was accepted. A density equipment report was also submitted. The 32d Medical Depot will stock repair parts based on these two reports. Demands for repair parts will be made on the depot to further establish the level of stockage of repair parts. At present, the depot cannot fill, from on-hand stockage the requisitions submitted by this organization. This problem must be solved to facilitate the accomplishment of the 9th Medical Laboratory's mission.

b. Many nonstandard items are used by the 9th Medical Laboratory. Some difficulty has been encountered in obtaining these within a reasonable time frame. Recurring requisitions are being made in order that stockage levels can be established by the 32d Medical Depot. The methodologies and procedures used by all hospital laboratories in Vietnam are being evaluated and recommendations, where possible, will be made to reduce the number of nonstandard items required by -them.

## TAB F

### DRUG ABUSE

1. There has been a significant increase in the number of personnel using hard (narcotic) and dangerous (amphetamines and barbiturates) drugs in the past six months. Hospital and dispensary visits due to overdose/withdrawal symptoms and drug-related deaths have also increased. Implementation of amnesty programs throughout USARV has uncovered a significant increase in the number of known marijuana, hard and dangerous drug users.
2. Attempts to resolve drug problems include greater publicity through newspaper, radio and television concerning the seriousness of drug abuse. Psychiatric teams are providing increased guidance to commanders and becoming more involved in active treatment and counseling of drug abuses. More meaningful and reliable drug statistical reporting methods have been developed.

TAB G

DENTAL ACTIVITIES

1. CONTINUING PROBLEM AREAS

a. Shortage of dental officers. We expect to be at least 24 officers short of the authorized manning level for the rest of CY 71.

b. We will have an 80% overage in prosthetic laboratory specialists (MOS 42D) through the 3d quarter FY 71.

2. PROGRESS AREAS

a. There is an increased emphasis on coordination of DENCAP activities with civic affairs personnel and Ministry of Health officials.

b. The emphasis of DENCAP activities was shifted toward preventive dentistry measures and the training of local health personnel in simple, basic dental procedures.

c. Screening programs at in-country replacement training centers were established to detect and eliminate potential dental emergencies before the individual goes to forward areas.

d. A preventive dentistry clinic at Camp Alpha of the 178th Replacement Company, Tan Son Nhut, was built and is now in operation.

## TAB H

### OPTOMETRY

#### 1. COMMAND-WIDE SHORTAGE OF OPTOMETRIC OPHTHALMOLOGICAL BULBS

a. During the past year medical facilities and units throughout RVN have experienced difficulties in obtaining optometric/ophthalmological instrument bulbs. Most of these bulbs are not available through the medical supply system but must be ordered through local direct support units.

b. Action taken: High usage bulbs have been identified and those items for which stockage levels have been computed and inventory is on hand at the various support commands have been determined through coordination with ICCV. Monthly usage data has been requested from USARV and USA MEDCOM facilities. This data will be utilized to furnish ICCV with an estimate of initial issue and recurring demand requirements. Using clinics/units have been encouraged to begin submitting frequent requisitions for small quantities through normal supply channels with necessary follow-up action. Pending this development of substantiated demand data which should initiate or increase depot stockage objectives, special procurement action will be effected through medical channels in order to satisfy the short term need. These bulbs will be distributed through medical maintenance channels.

c. Solution: The supply officers supporting using activities should be instructed to include bulbs in their Prescribed Load List (PLL) under the provisions of Section VI, AR 735-35. The provisions of para 6-6e permits units to require DSU stockage of those bulbs regardless of demand.

#### 2. SPECTACLE DELIVERY DELAYS

a. Lack of secure ground transportation in most areas of RVN has required increased use of in-country mail service for transmission of spectacle requests to the laboratories and movement of fabricated spectacles to the requesting facility/unit. Spectacle delivery times have ranged from 1 to 21 days for requests processed through advance medical depots and from 7 to 56 days for spectacles fabricated by the base depot. Since most spectacles are fabricated and shipped by the optical laboratories within 48 hours, the major portion of delivery delays occurs in transit.

b. Action taken.

(1) Improved use of available ground and air (courier) transportation in some areas has reduced delivery times by 50%.

(2) Extension of sunglass fabrication to the 1st and 3d Advance Depots by mid-December will enable these facilities to fabricate over 90% of the non-divisional spectacle requirements. Consequently, time/distance factors related to spectacle deliveries will be reduced resulting in more efficient and responsive optometric support. A sunglass fabricating capability at the 3d Advance Depot, located in MR I, will enable the two combat divisions in this military region to receive their sunglass support from this facility instead of from the base depot. Consequently, only 10% of their spectacle requirements will be processed through the base depot.

(3) Solution: A full single vision clear and fabricating capability should be provided to all division optometry sections and to all advance medical depots. This decentralized optical support would provide more responsive and continuous optometric services to the individual soldier since 90% of all in-country spectacles requirements would normally be fabricated by these facilities.

3. Evaluation of optometric activities since July 1969 has resulted in the following recommendations based on lessons learned:

a. Medical planning to include base development planning should provide for assignment and allocation of sufficient optometrists and optical laboratory specialists together with their necessary supporting examination and spectacle fabrication equipment during the early phases of tactical operations.

b. The TOE of the medical command and medical brigades should be modified to reflect the authorization of an optometrist (MOS 3340).

c. Command emphasis is required to insure compliance with Item 32 (Spectacles and Hearing Aids), DA Form 613, Check List for Preparation of Replacements For Oversea Movement.

## TAB I

### NURSING ACTIVITIES

1. There was a shortage of nurses from January to August 1970, especially during the Cambodian operation. The critical shortage was anesthetists until September 1970. Due to the closure of the 45th Surgical Hospital and the 8th Field Hospital at Nha Trang, there were adequate nursing staffs at all MEDCOMV hospitals in August 1970.
2. With the programmed closure of more hospitals there could be an overage of nurses in January. Action is being taken to preclude an overage of nurses in the command during January and February 1971.
3. Nurses' quarters are deficient in all the residual hospitals. The latrine facilities are especially inadequate in many hospitals. Due to the lack of construction funds and the cutback in maintenance funds, these problems continue. At Long Binh Post the situation has been alleviated by the assignment of 10 trailer spaces for nurses of the 24th and 93d Evacuation Hospitals.
4. For months the 90th Replacement Battalion has been short of certain size fatigues and jungle hats to issue to incoming nurses. Through coordination with ACofS, G4, action has been taken to obtain clothing for nurses on a priority basis.
5. Morale of the nurses has been excellent and there have been very few problems with the ANC officers in the command this year.
6. Recommend more study and planning on the use and career field for the enlisted men with MOS 91C. Many 91Cs have requested permission to remain with patient care instead of transferring to the administrative field as 91Z's. At present, to be promoted above E-7 they must leave the patient care field where they are most proficient. The career progression for 91C's should go to E-8 and some 91Cs with two years' college equivalent and field army experience should have warrant officer status. In the current type of warfare and present organization of the battalion, the warrant officer (91C) is capable of doing the work required of a battalion surgeon. The 91Cs who reach the level of warrant officer will have the maturity and the clinical and administrative experience required for a senior medic in a battalion.

7. Recommend that all enlisted medical specialists be rotated between fixed hospitals and field medical assignments early in their careers. Many enlisted medics have been assigned several tours in the field medical service to the detriment of their clinical knowledge and experience. Other enlisted medics have multiple tours in fixed hospitals which leave them with little experience, knowledge or regard for the work in the field medical service. Patients, units, and the enlisted man are hurt when late in his career a medic is assigned as top NCO in a totally strange field.

TAB J

PREVENTIVE MEDICINE

1. ADMINISTRATION/COMMAND AND CONTROL

Preventive medicine units and detachments were removed from control of the 44th Medical Brigade and placed under the three medical groups. Subsequently, the two units and four detachments were placed under the two remaining groups.

2. DISEASE

a. Malaria

(1) Remained a constant problem

(2) Rates increased during and after Cambodia

(3) Malaria discipline down to the lowest unit appeared to slip during the post Cambodia and stand-down periods.

(4) Agranulocytosis and dapsone prophylaxis

b. Hepatitis

c. Diarrhea rise during and after Cambodia. Primary cause was individuals not treating water in the field.

d. Encephalitis in MR III

(1) Noted in summer 1969

(2) Studies and better control in spring, summer, fall 1970

(3) Fairly certain cause is Japanese B Encephalitis virus

3. ENVIRONMENTAL ENGINEERING

a. Radiation protection surveys of diagnostic medical and dental X-ray facilities by USARPAC Environmental Health Engineering Service.

b. Establishment of environmental health engineering service at 9th Medical Laboratory - in process

c. Beginning of sewage lagoon studies

d. Upgrade program for water supply facilities including arrangements for 406th Medical Laboratory, Japan, to carry out complete chemical analysis.

#### 4. ENTOMOLOGY

a. Aerial spray program

(1) Arrival of prototype rigs in country without components for ultra-low volume application

(2) Getting parts and adequate numbers of rigs

(3) Development of present program of spraying FSB and small Compounds

b. Retrograde cargo program

(1) Cargo not properly processed for return to US with delays of ships Stateside while proper actions taken

(2) DOD/USPHS/USDA agreement

(3) USPHS/USDA personnel arrive in Vietnam and begin training

(4) Constant tightening of Military Quarantine Inspection (MQI) program to include certification of both cargo and ships leaving military ports as meeting USPHS/USDA standards

## TAB K

### VETERINARY ACTIVITIES

#### 1. SUBSISTENCE INSPECTION

a. Perishable. The quality and quantity of subsistence for American forces in Vietnam remained excellent and makes us the best fed combat force in history. At some Class I supply points refrigeration equipment cannot be maintained at required temperatures. At times some items are overstocked, crowding the already marginal depot freezer storage facilities and resulting in spoilage and condemnation.

b. Nonperishable. USARV depots and Class I points have reduced stock levels of nonperishable subsistence making the routine surveillance inspections more realistic and worthwhile. A major problem has been insect infestation of cereal grain products with over 4 million pounds condemned in 1969; distressed stocks are now on hand at the Qui Nhon and Da Nang depots. On request from USARV a team of fumigation experts from the Armed Forces Pest Control Board spent 30 days' TDY in Vietnam during the summer of 1970 training personnel at each depot in proper fumigation procedures, using aluminum phosphide. Hopefully USARV can implement this strongly recommended program immediately, such action would effectively reduce the losses such as those experienced in the past.

c. Baker products: Bakery facilities, both commercial and Army owned, have been -substandard with sanitary practices ranging from unsatisfactory to fair. The quality of bread from commercial sources has been poor. Efforts to correct the insanitary [sic] practices by requiring better facilities, more education and constant supervision are being implemented. A study to determine the feasibility of placing resident US Army food inspectors in commercial bakeries is currently underway. The US Armed Forces should consider construction of several Army owned, contractor operated bakeries.

d. The five Army owned, contractor operated dairy plants continue to provide excellent dairy products to the US Armed Forces. Distribution of ice cream is a problem in several areas, especially to the IV Military Region. The 9th Medical Laboratory has finally received the equipment for the required chemical testing of dairy products.

## 2. ANIMAL SERVICE

### a. Military Dogs

(1) Medical problems. The major medical problems continue to be tropical canine ancytopenia (TCP) and acute glossitis (red tongue) in military dogs. The incidence of TCP is lower than in FY 69, however, until more effective control measures are found and implemented, this disease will remain a major problem. Red tongue has spread throughout the Republic of South Vietnam in military scout dogs. Epidemiologic studies are being pursued in country, and two research laboratories--SEATO in Bangkok, Thailand and NAMRU-2 in Taipei, Formosa—have agreed to assist in the study of this condition. Morbidity rates have been near 100% in some individual platoons, making these platoons noneffective for periods of up to two weeks.

(2) The German shepherd VS other breeds. It is obvious that the German shepherd is not the ideal military dog for tropical climates, especially Vietnam. Tropical diseases and heat prostration are the major medical reasons the breed is not ideal. The size of the breed is a major disadvantage when the handler is a small Vietnamese soldier. Research, development and test programs are needed to develop or determine the best suited breed for SE Asia. The native dog appears to be resistant to problem diseases in Vietnam. Crossbreeding should be considered to produce a better military dog for use in SE Asia. Breeding programs could be initiated by the Vietnamese Armed Forces at little cost. In fact, some of the US abandoned dog facilities would be ideal for breeding and testing programs.

b. Pets and mascots. Rabies continues to be endemic in the dog population of Vietnam. Constant vigilance by all Medical Corps officers, preventive medicine personnel, and military veterinarians has been required to prevent human cases. At times the cooperation of provost marshals and commanders has been less than adequate in the control of pets and mascots.

## TAB L

### PLANS AND OPERATIONS

#### 1. REDUCTION OF MEDICAL RECORDS BACKLOG

In the past four months the backlog of outstanding individual medical records has been reduced from 5,345 to 586. The primary impetus behind the reduction derived from command emphasis on constant monitoring of and information to medical treatment facilities.

#### 2. REDUCTION OF AVERAGE TIME NECESSARY TO COMPLETE CONGRESSIONAL, PRESIDETIAL, AND SPECIAL MEDICAL INQUIRIES.

The techniques and procedures used in answering inquiries have been revamped, resulting in greater accuracy and timeliness. However, the average time necessary to complete an inquiry is approximately 21 days. Causes of delay are [word unreadable] transmittal and communications problems, haphazard attitudes toward accuracy and completeness, unnecessary correspondence among command levels, and problems bringing men in from the field for evaluation.

#### 3. REDUCTION OF OUTSTANDING LINE OF-DUTY DETERMINATIONS

An effective system has been initiated to reduce the number of outstanding LODs (Line of Duty), accomplishing a reduction of 700 out of 3,000 LODs within the past two months since its instigation. This aids DA in decisions concerning retirements and disability benefits.

#### 4. REDEPLOYMENT

Redeployment began in June of 1969 and since that time four increments have been completed as of 15 October 1970. Total withdrawals to date include 3 hospitals with 1,652 operating beds, 33 company- and detachment-sized units for a total of 2,341 spaces. A list of units redeployed or inactivated since July 1969 is attached (TAB K1) As a result of redeployments, the total operating bed level has reduced from 4,700 in mid-1969 to a current level (15 October 1970) of 3,048.

#### 5. ORGANIZATION AND CONSOLIDATION OF USAMEDCOMV

On 1 March 1970 the USAMEDCOMV was organized as a result of consolidating the 44th Medical Brigade with the USARV Surgeon's Office. The

medical command organization eliminated duplication of effort, reduced manpower requirements by 17%, and provided a headquarters that would be more responsive to drawdown requirements.

## 6. SURGEON'S CONFERENCES

During the period June 1969 to December 1970 three surgeon's conferences were held. These semi-annual conferences were held in August 1969, March 1970, and August 1970.

## 7. EVACUATION BATTALION CONCEPT

a. The concept of a medical battalion composed entirely of helicopter ambulance and ground ambulance units was developed. This battalion would have the sole responsibility of combat evacuation, both air and ground, within its area of operation. The value of this concept lies in the flexibility provided to the battalion commander to shift any or all of his evacuation assets to meet the need as the tactical situation development.

b. To implement this concept, the 61st Medical Battalion was organized at Qui Nhon in January 1970 and assigned a mix of air ambulance company, air ambulance detachments, ground ambulance companies, and ground ambulance detachments. After observing this battalion for three months, the 58th Medical Battalion was organized at Long Binh under similar lines.

c. This concept has provided a better utilization of evacuation assets, improved response, improved maintenance and better command and control. Direct command, control and supervision is provided by a senior experienced Medical Service Corps aviator with extensive experience in medical evacuation, both air and ground.

TAB L1

LIST OF UNITS REDEPLOYED OR INACTIVATED SINCE JULY 1969

<u>UNIT DESIGNATION</u>	<u>REDEPLOYED INACTIVATED</u>
650th Medical Detachment TM KJ	15 July 1969
305th Medical Detachment TM KB	1 August 1969
312th Evacuation Hospital	1 August 1969
313th Medical Detachment TM KA	1 August 1969
378th Medical Detachment TM KE	1 August 1969
472d Medical Detachment TM RB	1 August 1969
889th Medical Detachment TM KA	1 August 1969
311th Field Hospital	7 August 1969
316th Medical Detachment TM NC	13 August 1969
74th Field Hospital	13 August 1969
482d Medical Detachment TM GD	12 September 1969
22d Surgical Hospital	18 October 1969
29th Evacuation Hospital	22 October 1969
520th Medical Company (CLR)	26 October 1969
45th Medical Detachment TM KB	30 October 1969
202d Medical Detachment TM MA	1 November 1969
541st Medical Detachment TM MA	3 November 1969
240th Medical Detachment TM KF	7 November 1969
245th Medical Detachment TM JB	13 November 1969
74th Medical Battalion HHD	15 November 1969
36th Evacuation Hospital	25 November 1969
1st Medical Company (AMB)	4 February 1970
1st Medical Detachment (Mobile Lab)	6 February 1970
359th Vet Detachment (IE)	6 February 1970
43d Medical Group	7 February 1970
760th Vet Detachment (JB)	9 February 1970
463d Medical Detachment (KH)	14 February 1970
67th Medical Detachment (KF)	16 February 1970
219th Dental Detachment (K J)	16 February 1970
551st Medical Detachment (KH)	16 February 1970
74th Medical Detachment (Mobile Lab)	18 February 1970
241st Medical Detachment (MB)	18 February 1970
764th Vet Detachment (IE)	18 February 1970
257th Dental Detachment (K J)	20 February 1970
945th Medical Detachment (KA)	20 February 1970

210th Medical Detachment (MC)		28 February 1970
2d Surgical Hospital		10 March 1970
*44th Medical Brigade	NLT	15 April 1970
658th Medical Company (AC)		25 June 1970
188th Medical Detachment (PA)		25 June 1970
542d Medical Company (CLR)		25 June 1970
563d Medical Company (CLR)		25 June 1970
667th Medical Company (AC)		25 June 1970
55th Medical Group		25 June 1970
7th Surgical Hospital		10 July 1970
507th Medical Detachment (PC)		10 July 1970
545th Medical Detachment (FC)		10 July 1970
666th Medical Detachment (GA)		10 July 1970
51st Medical Company (ABM)		31 July 1970
75th Vet Detachment (JA)		31 July 1970
561st Medical Company (AMB)		31 July 1970
17th Field Hospital		1 August 1970
504th Vet Detachment (IE)		15 August 1970
45th Surgical Hospital		15 August 1970

\*9- space drawdown

## TAB M

### DIETETIC ACTIVITIES

1. Future authorized assignment for three dietitians in RVN will be one at the 3d Field Hospital, one as staff dietitian at the 67th Medical Group and the third at the 68th Medical Group as staff dietitian with the additional assignment of dietetic consultant to the USARV Surgeon.
2. During the twelve-month period ending 30 September 1970 food service units of the medical command fed 3,958,828 rations. Of this number 1,012,972 (47.6%) were served to patients.
3. The USARV Dietary Consultant assisted in devising a more acceptable ration for the Thai Army. MACV approved the ration change on 9 January 1970 and the ration change was implemented 1 April 1970.
4. Emphasis has been placed on training programs for all food service personnel. A course in food sanitation sponsored by the training section of the Saigon Civilian Personnel Office has been completed by all Vietnamese employees in MEDCOM units.
5. Procuring hospital subsistence items continues to be a problem. In the near future the Long Binh Army Depot will order special hospital subsistence for all of Vietnam. Due to the small quantities consumed, it is more feasible for one depot to procure and ship the quantities needed to other depots. This method should alleviate the problem.
6. The staff dietitian and food advisor of each medical group make monthly visits to all mess units to assist in the improvement of all facets of food service.

DEPARTMENT OF THE ARMY  
HEADQUARTERS, 67TH MEDICAL GROUP  
APO San Francisco 96349

AVBJ GC-O

27 October 1970

SUBJECT: Feeder Report to Commanding General's End of Tour Report

Commanding General  
US Army Medical Command, Vietnam (Prov)  
APO SF 96384

1. Organization and Mission:

a. Mission: The mission of the 67th Medical Group is to provide medical service to United States Army, Vietnam, personnel, other Free World Military Assistance Forces and other authorized personnel located in MR1 and northern MR2. Hospitalization, medical and surgical care, is also provided to Vietnamese civilians who are injured as a result of hostile action.

b. The Group is organized as indicated in Inclosure 1. Dispensaries have been attached to the supporting hospitals to facilitate control. This provides a senior medical officer, the hospital commander, to monitor the activities of administrative and professional services of all Group medical treatment facilities in his geographical area. Similarly, evacuation units, ground and air, have been grouped in certain locations to improve the span of control through the 61st Medical Battalion. (See inclosure 2 for greater detail)

c. During the period, elements of the 67th Medical Group provided medical support to the following units in MR1 and Northern MR2.

4th Infantry Division  
101st Airborne Division (Airmobile)  
Americal Division

1st Brigade, 5th Infantry Division (Mech)  
173d Airborne Brigade  
1st Marine Division

1st ARVN Division  
2d ARVN Division

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24th ARVN Division  
27th- ARVN Division

ROK Tiger Division

d. Prior to 15 January 1970.

(1) Prior to 15 January 1970, the 67th Medical Group's area of operation was confined to MR1. At that time the Group provided command and control for 19 subordinate units.

(2) On 19 December 1969, the 18th Surgical Hospital ceased to operate as a MUST hospital and moved into a fixed installation which had been formerly occupied by the 3d Marine Medical Battalion near Quang Tri. At that time it assumed the additional responsibility for operating a 40 bed children's hospital.

e. 15 January 1970 and later.

(1) On 15 January 1970, the 43d Medical Group was inactivated and the 67th Medical Group assumed control of 17 of its units and the responsibility for medical service in northern MR2. At this time, there were eight hospitals with 1623 operating beds in the Group.

(2) As the US Marines and US Navy operations were phased down in MR1, the 67th Medical Group assumed a greater share of the overall medical support. The NSA [Naval Support Activity] Hospital in Da Nang was phased down and closed on 25 May 1970. At this time the 95th Evacuation assumed responsibility for POW care in MR1, ambulance support for the Da Nang area, and became a Neuropsychiatric treatment center with the attachment of the 98th Medical Detachment (KO). Also on 1 July 70 the 172d Preventive Medicine Unit assumed responsibility for the Military Quarantine Inspection Program for retrograde cargo generated in the Da Nang area.

(3) The 67th Medical Group Headquarters moved from the 95th Evacuation Hospital compound to Camp Baxter (formerly NSA Hospital complex) on 20 July 1970. The Medical Regulating/Communication elements were relocated to Camp Baxter in September 1970, after completion and refurbishing of the new accommodations.

## 2. S-1 Activities:

a. Replacement Personnel. All personnel being assigned to any subordinate unit, are physically processed through the 67th Medical Group headquarters. Selected personnel are given detailed briefings and the major staff sections provide their incoming counterparts with in-depth briefings. Incoming personnel are also processed through Team C, 222d

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Personnel Services Company, and then sent on to their respective units. This form of reception permits individual personnel assessment and better enables the individual to accomplish his mission after his arrival in his assigned unit. While this procedure, in effect, gives the group the additional mission of functioning as a Replacement Company the salutary results make the efforts worthwhile.

b. Rehabilitation Transfers. The information required of a transferring unit when rehabilitation transfers are requested has been standardized. Thus, the receiving unit is completely apprised of the status and problems encountered in handling the transferee. Finally, the individual is fully informed of the exact reason for his transfer.

c. Audit Guidelines. Specific guidelines formats, and procedures have been standardized in the control of unit funds throughout the Group. This standardization not only assists in auditing these funds, but assists the unit in maintaining an adequately controlled unit fund.

d. Other Sundry Funds Format. The format for the maintenance of records of other sundry funds has been standardized. As above, the audit of these funds is simplified and the maintenance of proper records is facilitated.

### 3. S-2/3 Activities:

a. Communications. Communications continues to be a problem throughout the group. Telephonic communications are complete, but very difficult to utilize on many occasions. Total radio communications throughout the Group is impossible. In-country mail service has been and continues to be a problem. Frequent staff visits and the use of both a formal and informal helicopter and other courier service has done much to reduce the magnitude of this problem.

b. OJT Anesthesiology Training. An ongoing OJT Anesthesiology Training program is in being at the 95th Evacuation Hospital. Such a program does much to compensate for a shortage of trained anesthesiologists. Upon completion of the program, it has been found that these physicians function well under the supervision of a trained anesthesiologist.

c. Physical Security. A continuing program to upgrade the subordinate units ability to protect itself is in being. Through inspections, technical visits and command emphasis physical security throughout the Group has continually improved.

## SUBJECT Feeder Report to Commanding General's End of Tour Report

d. Security. Periodic staff visits and inspections has done much to improve all aspects of security. Document control has been tightened, and many unnecessary documents have been destroyed. Each unit is inspected a minimum of once each quarter, and is physically assisted in correcting deficiencies if such assistance is indicated. There has been no compromise of classified defense security information in this group.

e. Emergency Evacuation, 95th Evacuation Hospital. Twice during the month of October, 1970, it has been necessary to completely evacuate all patients from the 95th Evacuation Hospital because of threatened inundation by an elevated tide as a result of a typhoon. These in-country evacuations were completed within a matter of five to six hours with minimum discomfort to the patients. These evacuations have proven the effectiveness of the medical regulating element in the Group as well as the ability of a hospital to quickly react to unexpected requirements.

f. Hospital Facilities. Problems continue to exist in accurately forecasting facility requirements in an operation of this nature. The 85th Evacuation Hospital is an excellent example of the results of being unable to have accurate long range forecasts. It is presently in a substandard facility at best. However, based on information available at the time, the need for a new facility did not exist. However, subsequent events have proven how desirable, a more acceptable facility have been.

#### 4. Medical Regulating:

a. Combined MRO Function. In May 1969, a combined Army/Navy/Marine Medical Regulating Facility was established at the 67th Medical Group Medical Regulating/Communications Center. This regulating facility was staffed jointly by the Navy medical regulating section, Third Marine Amphibious Force (III MAF) and the 67th Medical Group medical regulating section. The Navy regulating staff, comprised of one officer, one NCO and 5 EM, was responsible for coordination the evacuation for Navy and Marine medical activities within Military Region 1. In conjunction with the phase-down of facilities in the Da Nang area and the transition of command and control of MR1 from III MAF to XXIV Corps, the Navy medical regulating section phased out on 10 April 1970. The 67th Medical Group Regulating Officer was tasked with the responsibility of medical regulating for Navy and Marine medical facilities in MR1.

b. Statistical Analysis. A statistical analysis of medical regulating and hospital workload data during the period June 1969 through September 1970 is attached as inclosures 3-6.

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5. Evacuation: Evacuation of patients and associated matters are contained in Inclosure 2.

6. S-4 Activities:

a. Problems:

(1) Shortage of Medical Equipment Repairman, MOS 35G. Medical Equipment Repairmen were short in both the quantity and quality required. It has been very difficult to keep the hospitals of the 67th Medical Group staffed with the short course man they are authorized. Little maintenance assistance was received from the supporting advance depots of the 32d Medical Depot as they had the same staffing problem. In addition to the difficulties indicated above, the 35G20 short course graduate authorized, is not sufficient in skill level to adequately support a large Evacuation Hospital with the complex equipment found here in RVN. Chances to authorization were prohibited due to the moratorium on MTOE changes during most of the period. The result has been an unsatisfactory medical maintenance program. With the lifting of the moratorium on MTOE changes, adequate authorization may be obtained in the near future.

(2) Inexperience of Medical Supply Officers, MOS 4490. The average experience of the Chief of Supply and Services Division of the hospitals of the 67th Medical Group at the present time is 20 months' active federal service. Most of these officers have less than 6 months' supply experience when they enter RVN. Although their performance has been outstanding considering their limited experience, certain problems do exist in our hospitals that would not occur if the Supply Officer had more experience. Considerable amounts of supervision were required to combat these deficiencies. Consequently, no real significant problem has occurred to date.

(3) Engineer Facilities Maintenance. With the cutback in the Current Operating Budget, the already marginal facilities support for the hospitals and other units of the Group can be expected to deteriorate even further. The principal problem areas are: 1. Air Conditioning 2. Maintenance of Power Plants, and 3. Adequate Water Supply. The failure of any or all of these could render a medical treatment facility inoperable for patient care in a combat situation. Close coordination has been made with the district engineer and the local PA and E and Philco Ford contractors [contracted to provide facilities maintenance in the I CTZ]. However little success has been achieved. Assurance that hospitals and other medical treatment facilities will have first priority has been given. However, this is a constant problem and does have a definite effect on the quality of patient care the treatment facilities are capable of rendering.

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b. Accomplishments:

(1) Increased initial fill rates and decreased "O" balances. In the spring of 1970, and early summer the initial fill rates and "O" balances in the hospitals were not properly emphasized. Many items were improperly managed, and the young Medical Supply Officers more or less lived from hand to mouth "putting out fires" on problem items as an emergency arose. In July 1970, increased emphasis was placed on the training of Medical Supply Officers in the management of these items and a special effort was made to increase the support provided the medical treatment facility by their respective medical supply sections. By close coordination with the commanders of the supporting advance depots, the average initial fill rates for the group has risen some 3 to 4 percent and the number of "C" balance items has significantly decreased. Hospitals of the Group have been supporting their medical treatment facilities with an average 94 percent initial fill in recent weeks. Medical Supply Officers of the group are now becoming managers rather than firemen.

(2) The Group Medical Supply and Maintenance Conference was held on 11-12 September 1970 in Da Nang. This conference permitted the Supply Officers of this Group to meet and discuss common problems as well as hear the comments of Senior Medical Supply Personnel in the command. This conference was extremely successful and plans have been made to repeat the conference about three times each year.

7. Food Service:

a. Problems:

(1) Change in Class I Support. The Army assumed responsibility for Class I support in MR1 on 1 July 1970. This change precipitated numerous subsistence problems such as shortages and substitutions. These problems are being slowly resolved. However, several problems continue to arise.

(2) Distribution of Class I Supplies. Medical facilities in distant areas, such as Phu Bai and Quang Tri, have not received sufficient quantities of fresh fruits and Vegetables. The prime reason for this shortage has been the lack of a sufficient number of Sea Land Vans. A new company was to assume responsibility for this distribution on 1 November 1970. Resolution of this problem is anticipated at that time.

SUBJECT: Feeder Report to Commanding General's End of Tour Report

(3) Maintenance of Kitchen Equipment. The maintenance of kitchen equipment has been a tremendous problem during the past several months. Repair or replacement of parts have not been available. Consequently, much kitchen equipment has been inoperable. Some messes have shown improvement. However, this is primarily due to aggressive self-help programs. The problem should be magnified during the coming month because of a reduced level of contractual support.

(4) Individual Serve Items. A shortage of individual serve items existed until recently. Hospital Command interest in this matter and close coordination with the supporting Class I supply points resulted in improvement in supply of these items.

b. Accomplishments.

(1) Dining Hall Improvements. A concentrated effort has been made to upgrade the appearance and efficiency of the dining facilities throughout the group. As a result, significant improvement has been achieved in both areas.

(2) A continuing program to improve the quality of ward feeding has produced excellent results. Efforts have been successful in increasing the variety of food available to both ambulatory and bed patients. Improved methods of delivering food to the wards, more carefully serving of individual trays, quickening of serving lines and increased variety of food have all contributed to palatability of food and hence better nourishment of patients.

(3) Training Aids, Vietnamese: English - Vietnamese operators instructions for all garrison mess equipment being used in the messes were published and distributed. Additionally, standard hospital diets were similarly translated and distributed. Both have been integrated into an instructional program for Local Vietnamese National Kitchen Police and Tray Service Attendants. This effort should pay large dividends in the future. Food Sanitation Courses for all Vietnamese mess personnel were completed in June 1970 and are currently in use.

8. At the conclusion, the 67th Medical Group is in the process of reducing their activities throughout their zone of responsibility

SUBJECT: Feeder Report to Commanding General's End of Tour Report

as warranted to support the drawdown program. The only difficulty envisioned at this time is providing complete continuity of medical care during this period of withdrawal and contraction.

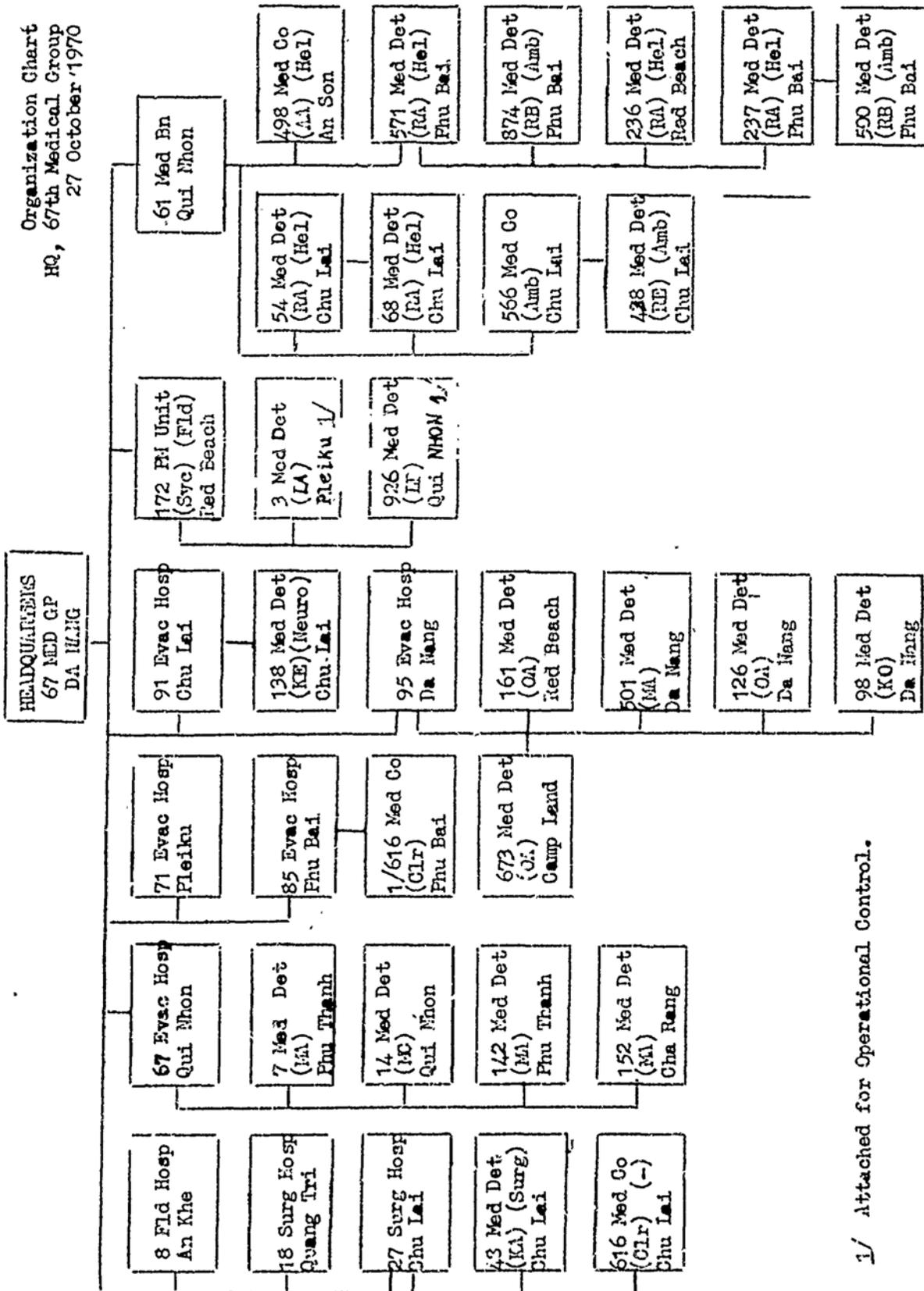
A handwritten signature in black ink that reads "Ralph R. Chapman". The signature is written in a cursive, flowing style.

6 Incl

1. Organizational Chart
2. 61st Med Bn Feeder Report to  
CG's End of Tour Report
3. Hospital Admission Statistics
4. Dispositions to Duty Statistics
5. Patient Evacuation Statistics
6. Hospital Death Statistics

RALPH R. CHAPMAN  
COL, MC  
Commanding

Organization Chart  
 HQ, 67th Medical Group  
 27 October 1970



1/ Attached for Operational Control.

DEPARTMENT OF THE ARMY  
HEADQUARTERS, 61ST MEDICAL BATTALION  
APO San Francisco 96238

AVBJ-GC-MB-CO

22 October 1970

SUBJECT: Feeder Report to Commanding General's End of Tour Report

TO: COMMANDING OFFICER  
67th Medical Group  
APO San Francisco 96349

1. Organization and Mission.

a. During the period 1 July 1969 through 10 February 1970 the 61st Medical Battalion functioned as a TOE doctrinal type organization, performing the missions of both surface evacuation and patient treatment. The battalion remained under the command of the 43rd Medical Group until group inactivation on 15 January 1970, at which time the battalion was assigned to the 68th Medical Group.

(1) As of 1 July 1969, the battalion had command and control responsibility for one Medical Company (Clearing), one Medical Company (Ambulance), three General Dispensaries (MB), one Dispensary (MA), and one Medical Detachment (OA), in support of II CTZ (Corps Tactical Zone) units (see Inclosure 1, Organizational Chart). The battalion HHD remained located at Cam Ranh Bay, and the battalion remained under the command of a Medical Corps Lieutenant Colonel.

(2) During January 1970, one General Dispensary (MB) was deactivated, and all remaining dispensaries including the Medical Detachment (OA) were attached to the 6th Convalescent Center. By 10 February 1970, both medical companies came under the direct control of the 68th Medical Group.

b. Beginning 11 February 1970, the battalion underwent significant changes in both mission and organizational structure. The battalion was relieved of patient treatment responsibilities, the HHD was relocated to Qu Nhon, and the battalion assumed the mission of air and ground evacuation for the northern half of RVN. With this mission, the 61st Medical Battalion became the first battalion organized for the sole purpose of medical evacuation in a combat zone.

(1) The battalion was given command and control responsibility for six Medical Detachments (RA), two Medical Detachments (RB), one Medical Detachment (RE), two Medical Companies (Ambulance), and one Medical Company (Air Ambulance) all located in the northern half of RVN (see Inclosure 2, Organizational Chart). The battalion evacuation resources totaled 61 UH-1H air ambulance helicopters, 87  $\frac{3}{4}$  ton ambulances (one ambulance company MTOE authorized 39 ambulances), and 3 bus

SUBJECT: Feeder Report to Commanding General's End of Tour Report

ambulances. Detachment groups consisting of either air or air and surface ambulance units were formed to improve span of control and ease of management. A rated Army Aviator MSC Lieutenant Colonel with a previous Vietnam flight tour was given this command. Furthermore, the battalion Executive Officer and S3 positions were filled by aviation rated MSC officers.

(2) On 26 February 1970, the battalion became operational with the following primary missions as directed by the 67th Medical Group:

(a) Provide command, control and administrative supervision of attached US Army Medical Units located within I CTZ and II CTZ North.

(b) Provide aeromedical and surface ambulance evacuation of US and specified categories of FWMAF (Free World Military Assistance Forces) RVNAF (Republic of Vietnam Armed Forces), CWCP (Civilian War Casualty Program), MEDCAP (Medical Civil Action Program), and PW patients in I CTZ and II CTZ North.

(c) Provide air and surface ambulance movement of medical personnel, supplies, equipment, and whole blood as needed in support of the 67th Medical Group mission.

(3) In addition to the above formalized missions, additional tasks were directed. Due to the lower than desired aircraft availability and CMMI readiness results within the evacuation units prior to the new battalion organization, improvement in these major areas became specified tasks. Implied tasks included evaluation and improvement as needed, of air and surface evacuation efficiency, more standardization of medical evacuation and aviation safety procedures, and reduction of responsibilities of hospitals to provide local ground ambulance support.

(4) During the summer and fall of 1970, one Medical Company (Ambulance) was deactivated, and one Medical Detachment (RA) was relocated and reassigned to the 68th Medical Group.

2. Operations (relates to new organization and mission).

a. Medical Evacuation.

(1) Air and surface evacuation procedures were rapidly evaluated. Unnecessary surface ambulance site coverages were eliminated and excessive surface ambulance support was reduced. In instances where surface ambulance evacuations over questionably secure routes were identified, air ambulances were utilized for these evacuations. Reorganization allowed re-attachment of surface ambulance detachments from hospitals to battalion supervision and control. In some instances, scheduled evacuation of routine category patients by air ambulance was instituted.

(2) Air ambulances were shifted frequently to augment areas of heavy casualty density and reinforce capabilities of the air ambulance unit in that area. This was notably accomplished in support of the Dak Seang siege, the Cambodian operation, and certain periods of DMZ area operations. The ability of a medical

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battalion with the area of coverage and air ambulance resources of the 61st, to rapidly shift air ambulances hundreds of miles if necessary, remains as the greatest operational benefit of such an organization. This is particularly true in a limited ground LOC environment such as Vietnam.

(3) The battalion evacuated an average of 7,700 patients monthly by air ambulance, of which 65% were Vietnamese military or civilian personnel, and one percent PW or detained personnel. Monthly surface ambulance evacuation averaged 4,300 patients, of which 35% were Vietnamese Military or civilian personnel. An average of 30% of aircraft sustained combat damage monthly while performing medical evacuations. An average of 2% of battalion aircraft were totally destroyed due to combat damage monthly. Surface ambulances sustained negligible combat damage.

b. Aviation operations.

(1) Standardized aviation safety procedures were instituted or strengthened shortly after battalion reorganization. Included were enforced mandatory use of seat belts by passengers and ambulatory patients, maximum use of restraining straps for litter patients, and mandatory use of water survival vests or wings for all crewmembers and patients/passengers involved in coastal or over water flights. For certain units operating in areas of frequent over water flight, use of the above water survival equipment became mandatory for all flights, coastal or otherwise. The use of chest protection armor became mandatory for all crewmembers on all flights, including medical evacuation, administrative, medical courier, and test flights. Improved flight following procedures for battalion aircraft were instituted where needed.

(2) A comprehensive aviation safety regulation was developed and published, to include aviation safety surveys and guidance on special safety matters. A lack of sufficient numbers of second tour aviators has not allowed use of a fulltime battalion safety officer, however a position for one has been included in the MTOE presently being submitted. Further, an aviation safety element within the S3 section is needed, complete with clerical personnel and filing and desk space, for a medical battalion organized with air ambulance units. Weekly aviation safety meetings for both aviators and enlisted flight personnel, with submission of safety meeting minutes were instituted.

(3) Aviator training programs were and continue to be evaluated. Increased hood flying, to include twice the amount of hooded flight time and practice instrument-type approaches required by USARV, was established. Although renewal of instrument flight qualification cards for single engine aircraft in Vietnam is waivable under several conditions, the battalion instituted a required removal policy. Aviator shortages did not allow use of a rated aviation officer as the assistant S3 until September. The assistant S3 serves also as the battalion aviation training officer and the battalion Standardization Instructor Pilot (SIP), and performs frequent visits to subordinate air ambulance units.

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This individual should be an instrument Flight Examiner as well. Use of an assistant S3 in this fashion provides invaluable information and advice on professional unit aviation operational and training status to the battalion commander.

c. Aircraft maintenance. This area was evaluated shortly after battalion reorganization.

(1) Organizational maintenance procedures, to include far better scheduling of aircraft for Periodic inspection and time-change component parts replacement, was accomplished. The significant shortage of aircraft maintenance personnel was alleviated; however, it required several months of intensive efforts. Command liaison visits were accomplished personally by the battalion commander with Direct Support Aircraft Maintenance Battalions. Improvement in DS maintenance turnaround time for air ambulances was noted on the part of those DS units where down time appeared. excessive. Strengthening of unit procedures pertaining to requisitioning of critical and NORS (EDP) parts also reflected improvement.

(2) The need existed for a battalion aircraft maintenance section to closely monitor the total aircraft maintenance picture, accomplish frequent assistance and inspection visits, and advise the battalion commander when command attention or liaison was required. Sufficient aircraft supervisory personnel were not available to allow establishment of this section until October. It consisted initially of a commissioned MSC aircraft maintenance officer and an enlisted aircraft technical inspector. A maintenance NCO will be added. Furthermore, the officer and NCO positions have been requested on the latest MTOE, and are the minimal required for a medical battalion with air ambulance units.

d. S3/S2 activities.

(1) The S3/S2 section has required considerable modification. The requirements for an aviation safety and training element, aviation records end reports element, and aviation statistics and data element have been identified. In addition to normal medical battalion S3 functions, this section has had a major role in monitoring of aviation operations and coordinating aeromedical support for major tactical operations. Furthermore, the S3 section has also been responsible for:

(a) Coordinating replacement of damaged or destroyed aircraft, and coordinating repair of special equipment such as rescue hoists and jungle penetrator devices.

(b) Processing combat damage and aircraft accident or incident reports, and maintaining complete data on hostile fire and restricted flight areas.

(c) Coordinating movement of medical personnel on battalion or other aircraft and accomplishing most movement manifesting for the Medical Group and its major units.

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(2) In addition to normal medical battalion S2 functions, the requirements of coordinating the procurement of special aircraft communications equipment, and monitoring aircraft and unit facility modification to accept this equipment has been accomplished.

(3) An aviation rated assistant S3, a flight operations qualified assistant operations NCO, and additional clerical personnel including a flight operations specialist, have been included in the latest battalion headquarters MTOE request.

e. S1/Personnel activities. In addition to normal medical battalion personnel and administrative activities, a significant increase in records, reports and personnel actions have been observed. The many air ambulance detachments, although not company size, generate the same type of unit administrative reports and personnel actions. Flight status, air crew member badge, and awards requests are significant. The S1 section has been modified to include an assistant S1 and additional administrative and clerical personnel. These personnel additions have been included in the latest MTOE request. The need for an aviation rated S1 or assistant S1 is still being evaluated.

f. S4/Supply activities. In addition to normal medical battalion S4 functions, the additional functions of assisting in the procurement of individual flight clothing and equipment and individual crew and patient/passenger survival equipment has been of great benefit to the aviation units. The battalion S4 section has also been of considerable benefit in conducting frequent assistance visits, identifying and solving unit level supply problems, and assisting in procurement of supplies needed. Notable improvement in weapons and protective mask maintenance, and ammunition storage procedures has been obtained.

g. Vehicle Maintenance activities. Vehicle maintenance procedures were evaluated shortly after battalion reorganization. Major revamping of maintenance procedures and vigorous command emphasis was required and applied. A daily vehicle technical inspection program was instituted, as was a PLL and TAAMs clerk training program. A complete maintenance regulation was developed, to include user and organizational level technical inspection criteria and stringent motor stables requirements. A battalion vehicle maintenance section was established early in battalion reorganization and a full time maintenance officer and NCO were employed. Frequent assistance visits and inspections have been performed and commanders have become far more vehicle maintenance conscious than before. It must be noted that even though a shortage of wheeled vehicle mechanics has consistently existed under present TOE authorizations, the TOE authorizations for vehicle mechanics are grossly short of those required. A wheeled vehicle maintenance warrant officer and maintenance NCO have been included in the latest MTOE request.

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h. Commander/Executive Officer activities. The need for an aviation rated MSC commander appears to be a definite requirement for a battalion organized for ground and air medical evacuation. Frequent and continual command visits are a necessity. Although the battalion was reorganized with an aviation rated Executive Officer, the battalion functions better with a non-aviation rated Executive Officer. The present incumbent is not aviation rated and remains primarily at the headquarters to supervise the many staff and administrative functions. The function of the Executive Officer is relatively minimal in professional aviation matters, and the S3 section has been expanded to contain several aviation rated officers, as noted earlier, to compensate for this. Command and staff liaison and the inevitable movement of plain paperwork would have been enhanced by a battalion headquarters location more proximal to the group headquarters. This may not be the case in a more conventional geographical disposition of units however. The attitude of personnel within this battalion is one of personnel regarding themselves primarily as evacuation experts, while considering hospital personnel as treatment experts.

3. Results so far. After approximately nine full months of operation in a battalion ground and air medical evacuation concept, the following major results appear cogent:

- a. An approximate fifteen (15) percent increase in overall aircraft availability.
- b. An approximate fifteen (15) percent improvement in overall CMMI readiness scoring.
- c. An improvement and economy in surface and air ambulance resource efficiency. In particular, approximately the same number of patients are evacuated by surface ambulances with one less ambulance company.
- d. Far more standardized aviation safety and operational evacuation procedures have been accomplished.
- e. The need for hospitals to be responsible to provide their own local surface ambulance support has been significantly reduced.
- f. Shifting of air ambulance resources are accomplished much more efficiently than before.

4. Major Recommendations.

- a. That a medical battalion designed for surface and air ambulance medical evacuation functions be considered by CDC for employment in the Field Army and COMZ.

SUBJECT: Feeder Report to Commanding General's End of Tour Report

b. That consideration be given to employment of a Medical Group designed solely to command and control Field Army surface and air ambulance medical evacuation battalions/resources.

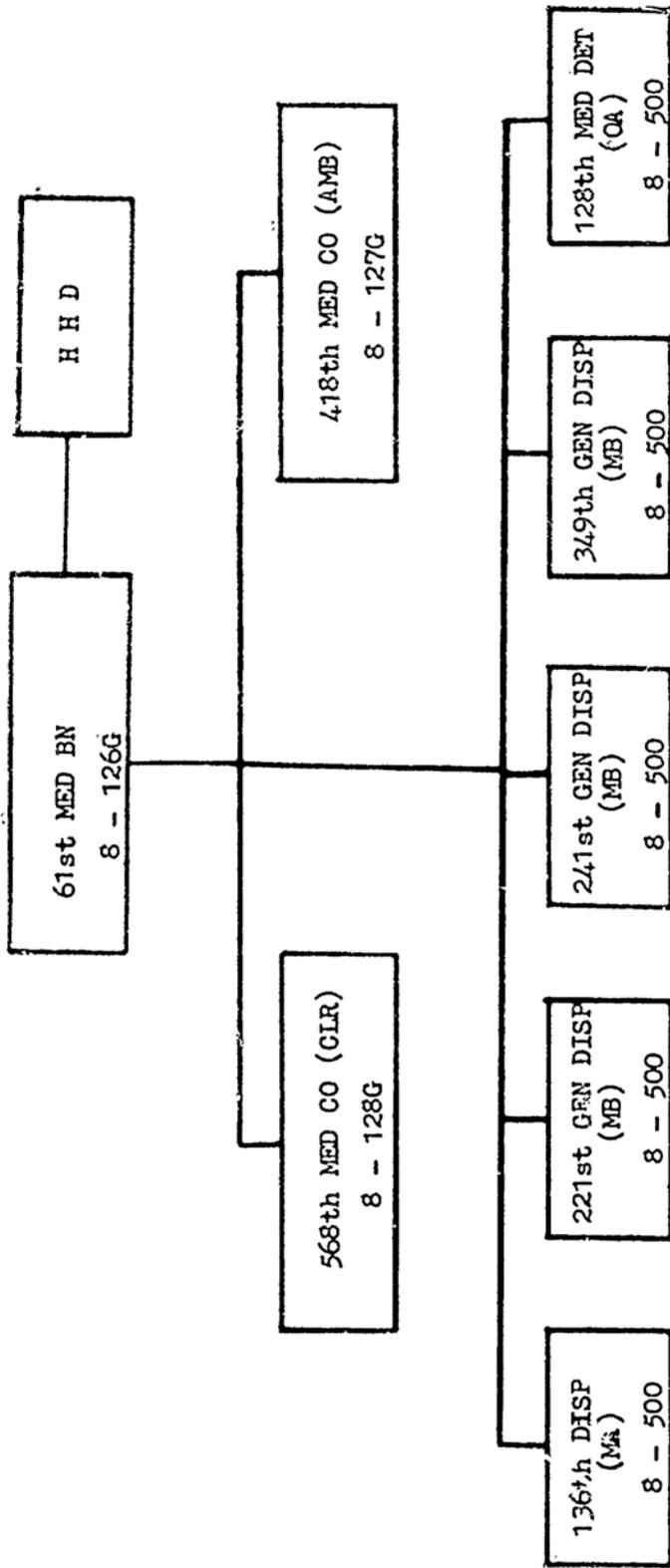
c. That approval of the MTOE for this battalion be favorably considered, to allow additional evaluation in a combat environment.

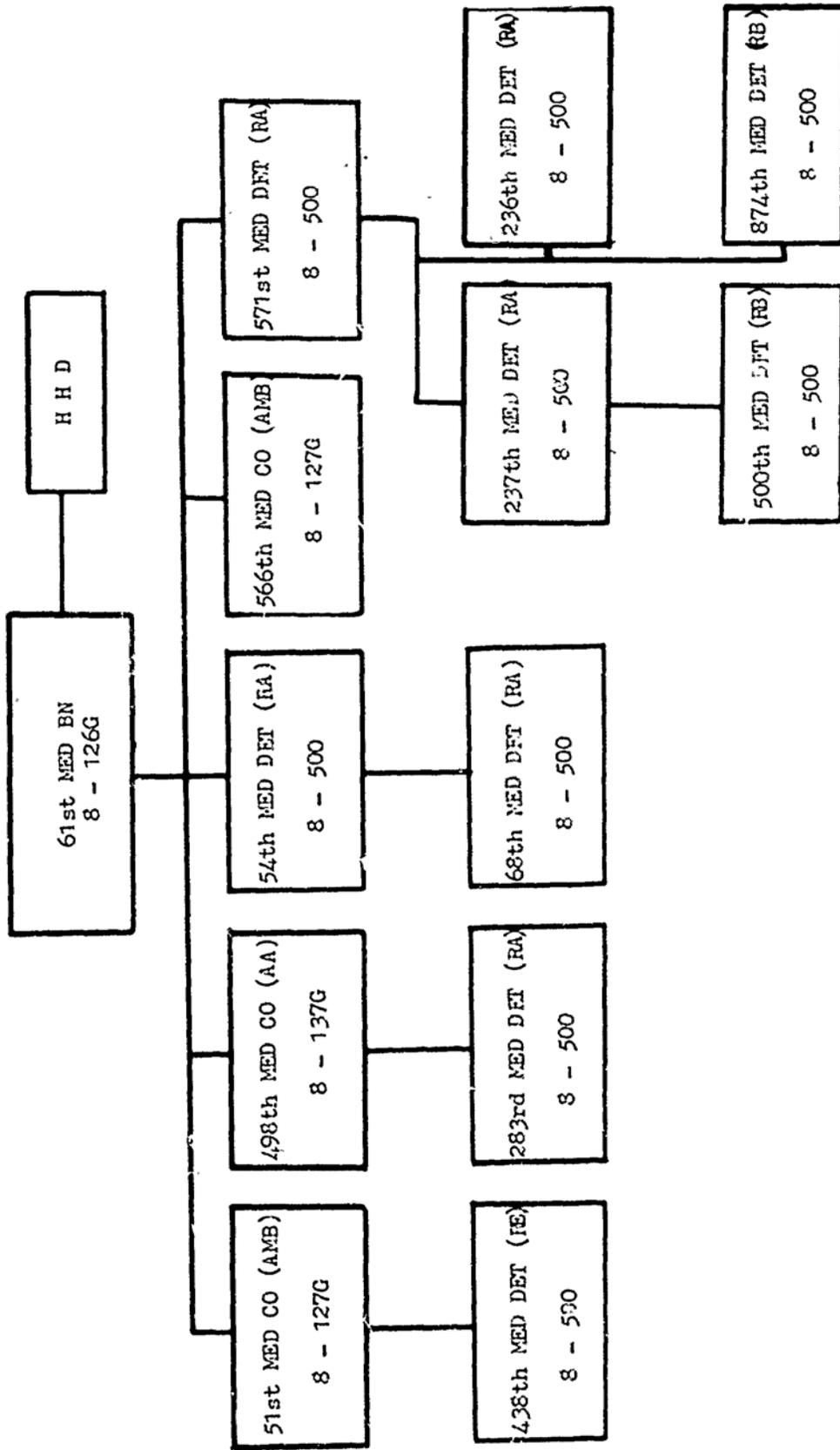
d. That the need for wheeled vehicle mechanics be re-evaluated by CDC.



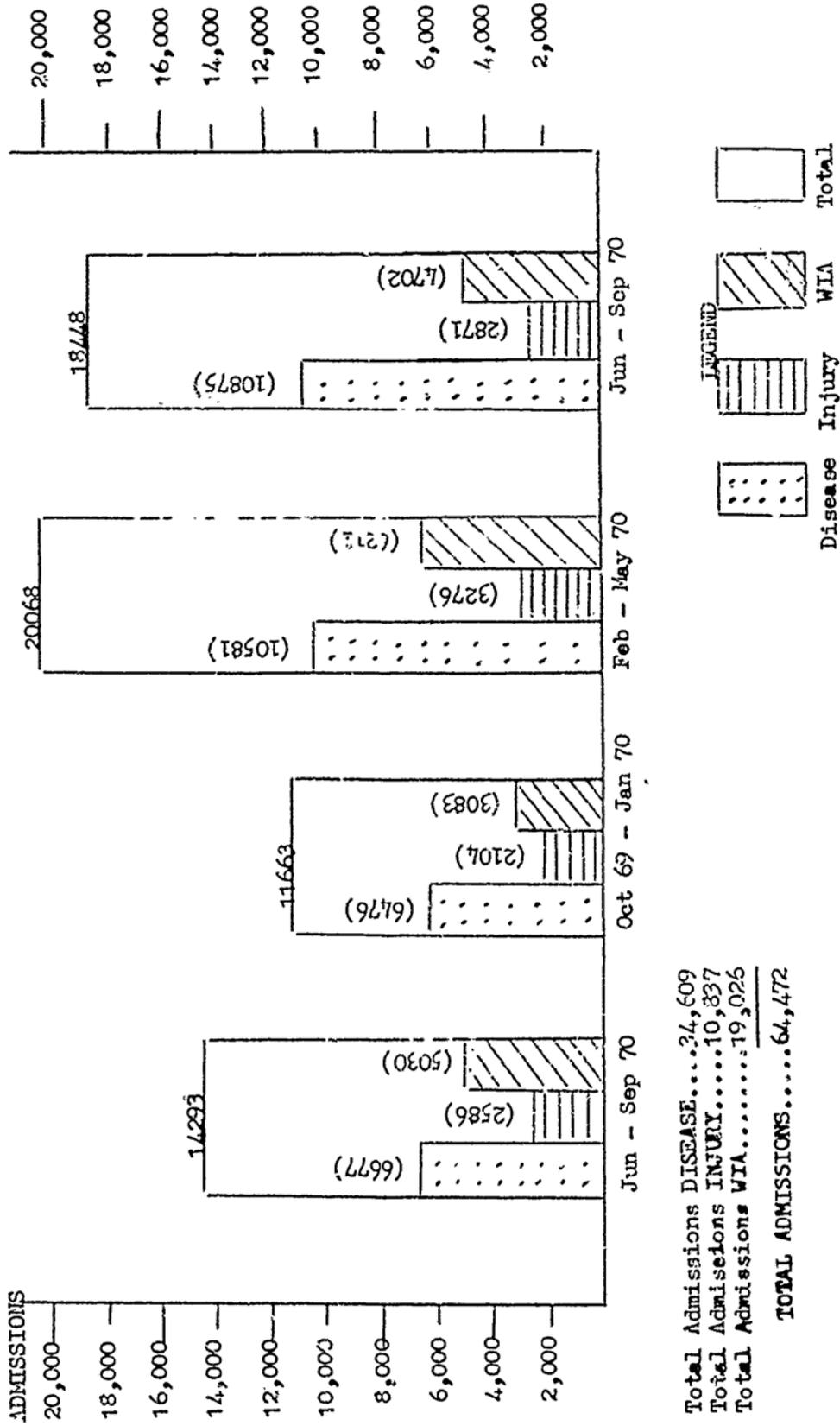
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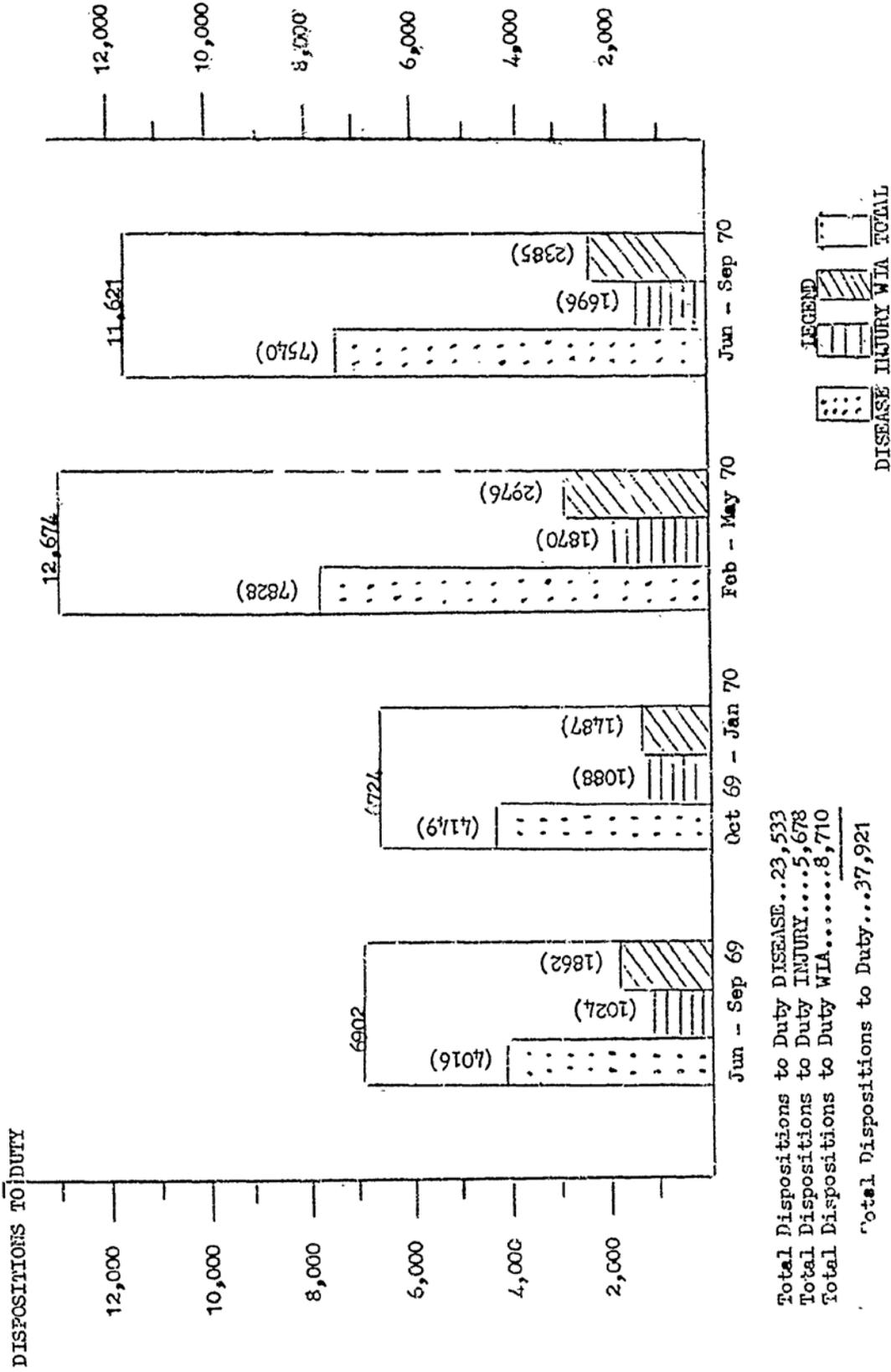




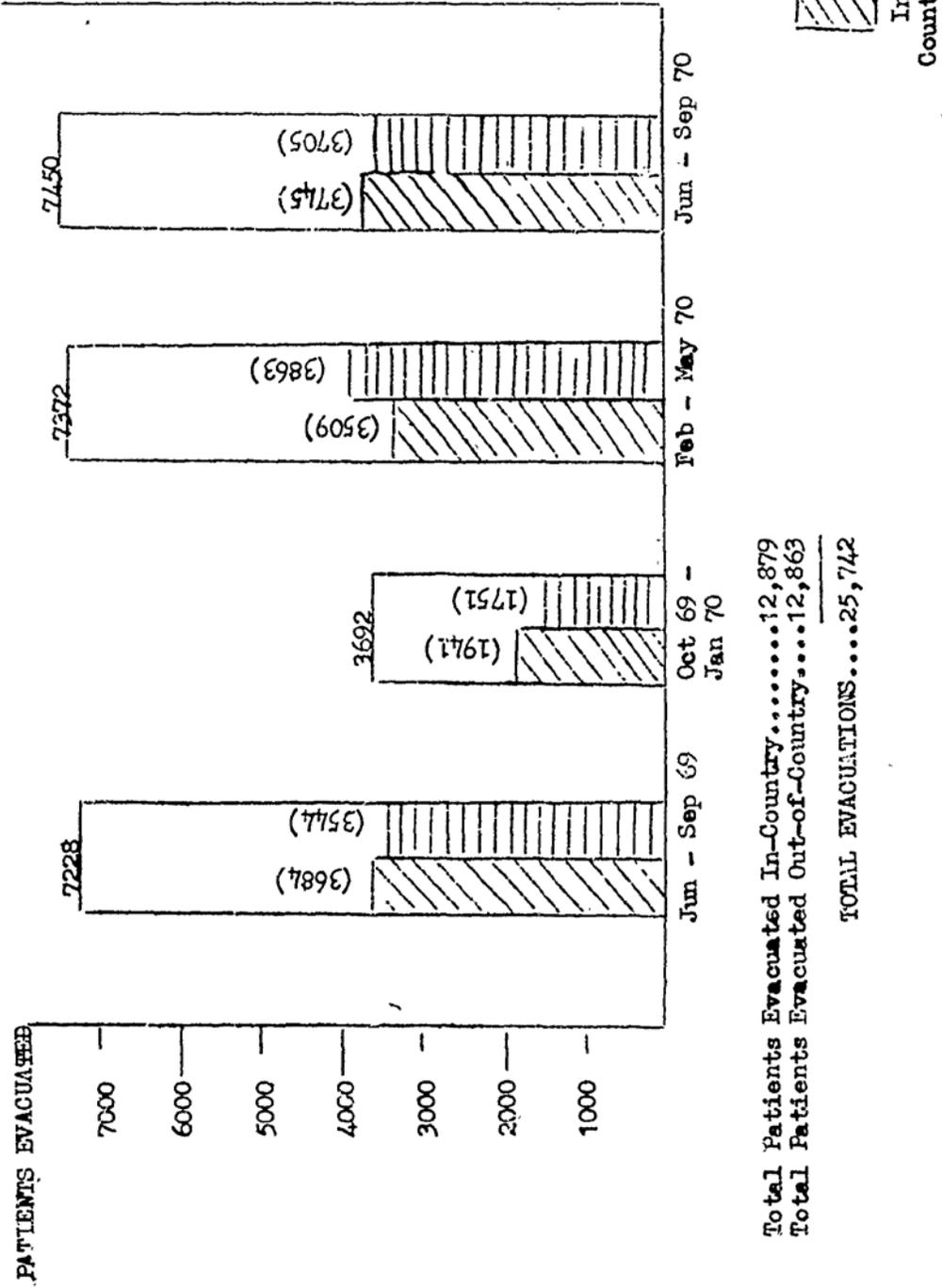
HOSPITAL ADMISSION STATISTICS, JUNE 1969 - SEPTEMBER 1970



DISPOSITIONS TO DUTY STATISTICS, JUNE 1969 - SEPTEMBER 1970



PATIENT EVACUATION STATISTICS, JUNE 1969 - SEPTEMBER 1970

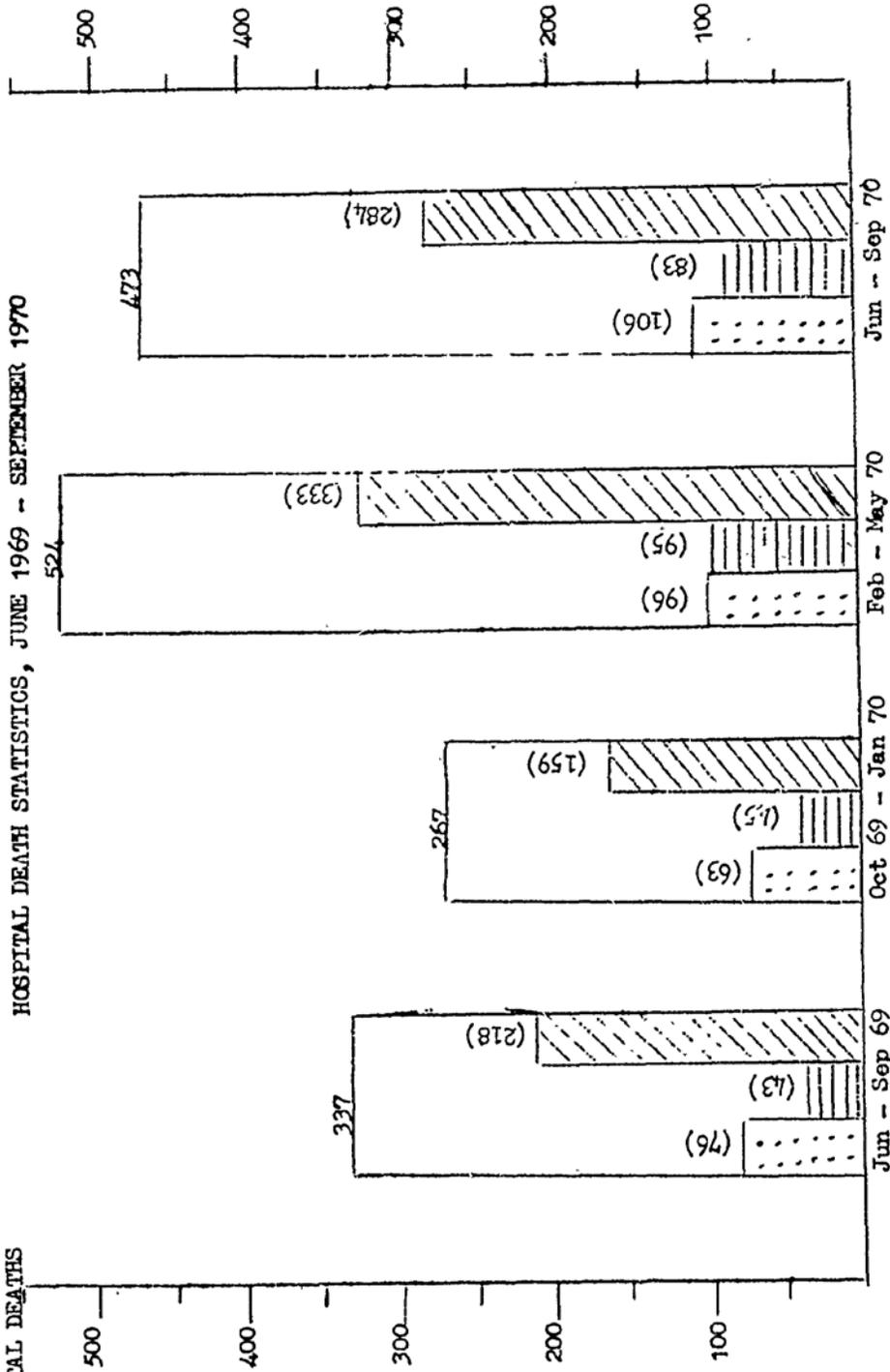


Total Patients Evacuated In-Country.....12,879  
 Total Patients Evacuated Out-of-Country.....12,863

TOTAL EVACUATIONS.....25,742

HOSPITAL DEATHS

HOSPITAL DEATH STATISTICS, JUNE 1969 - SEPTEMBER 1970



LEGEND  
 Disease Injury WIA Total

Total Hospital Deaths DISEASE...341  
 Total Hospital Deaths INJURY...266  
 Total Hospital Deaths WIA.....994  
**TOTAL HOSPITAL DEATHS...1601**

DEPARTMENT OF THE ARMY  
HEADQUARTERS, 68TH MEDICAL GROUP  
APO 96491

AVBJ GD-PO

31 October 1970

SUBJECT: End of Tour Feeder Report (BG Thomas)

Commanding General  
USAMEDCOMV (P)  
ATTN: ACofS, P & O, MAJ Walker  
APO SF 96384

1. General: The undersigned assumed command of the 68th Medical Group on 4 August 1970. This is an evaluation from that date through 15 October 1970.

2. Organization and Mission: The 68th Medical Group was responsible for providing field Army level medical service in the II Military Region South, III and IV Military Regions. It consisted of 50 attached units.

3. Activities and Related Areas of Interest:

a. Personnel

(1) The General Medical Officer (3100) strength was reduced significantly in late September through 15 October 1970 due to a rotational hump that was beyond the capability of the 68th Medical Group to correct. The enlisted personnel picture was excellent during this period with the exceptions of 76Y40, 67N40 and 67W2F.

(2) Medical Maintenance Technicians (35G): With the input of more sophisticated equipment into 68th Medical Group Hospitals, it is desirable to have higher skill level support. The ACofS USAMEDCOMV (P) has initiated action to alleviate this problem.

(3) Supply Officers: Considering the fact that hospitals within 68th Medical Group are operating more sophisticated "station type" facilities, the lack of experienced general medical supply officers reduces the medical supply branches' capability to respond to patient care needs. This deficiency cannot be alleviated by OJT for medical supply officers.

b. Supply:

(1) The Commander's Critical Item List (CCIL) continues to be an

31 October 1970

effective tool for expediting receipt of equipment and parts that have been backordered for unreasonable periods of time. All unit commanders have been encouraged to make maximum utilization of CCIL.

(2) Revetments around patient care areas are rapidly deteriorating. Hospital Commanders have submitted work order requests to replace or repair these revetments. Should work order requests be disapproved some repair work can be accomplished by daily hire and unit personnel.

(3) This headquarters has been receiving vehicular maintenance personnel with the required MOS, but without school training or experience. These untrained personnel are utilized to the best advantage and administered OJT by the higher skilled non-commissioned officers.

(4) The lack of organizational support maintenance for remotely located units is being resolved by publication of a General Order at MEDCOM or USARV level attaching the medical unit to a LSA, tactical, or other medical unit for organization maintenance.

c. Food Service:

(1) The need for Tray service attendants in hospitals was recognized with the publication of USARV Regulation 30-9. It authorized 1.5 tray service attendants per food cart used on the wards to feed patients. All units in 68th Medical Group have requested the additional personnel alots [sic].

(2) The Sanitation Course conducted by Civilian Personnel office to the LVNs in food service was a success and has helped to maintain high sanitary standards in our mess facilities. All units scheduled received the classes and KPs passing the examination were presented certificates.

(3) During the period 4 Aug to 15 Oct 1970, units in the Group served approximately 187,868 rations to non-patients. Patients in the dining hall were served 55,174 rations. Approximately 65,652 rations were served on the wards to regular diet patients. In addition, 9,423 rations were served as modified diets.

d. Special Training:

The Group S-2/3 Section, in an effort to reduce CMMI failures, improve security, improve communications and generally upgrade the maintenance of equipment, has arranged for and is currently conducting refresher training for key personnel in subordinate units in the following areas: PLL, Tactical Vehicles, TAAMS, Small Arms, Generators, Communications, Field Sanitation, and Counter Sapper. These classes began in September and will be completed by mid-November. They will be recycled quarterly.

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#### 4. Subordinate Units/Areas of Interest

a. The CIDG hospital located at 3rd Surgical Hospital will close on 15 November 1970. On November 1970, ARVN will move into 4 wards and set up a hospital for 80 to 100 patients. The 3rd Surgical Hospital will support the ARVN hospital with linen, X-ray, and laboratory facilities and rations.

b. The 3rd Field Hospital is not receiving combat casualties. It has been designated the in-country hospital for clean elective surgery and such patients are being so regulated. BG Thomas dedicated the, first 300 MA X-Ray Apparatus, in-country, at the 3rd Field Hospital on 12 Oct 70.

c. The 8th Field Hospital compound (Nha Trang) was formally turned over to ARVN on 8 September 1970. Maximum distribution of equipment, not deadlocked by MACV, was made to MEDCOM units. Assistance rendered by 32nd Medical Depot facilitated the transfer action.

d. The 12th Evacuation Hospital was reduced from 315 beds to 250 beds in the month of September.

e. The POW wards at 24th Evacuation Hospital has been phased out to provide the hospital an expansion capability of 600 beds. Conversion target date is 30 Nov 70.

f. Following its formal closing on 1 August, the 45th Surgical Hospital turned in its last vehicle on 15 Oct 70. The delay from final close-out (15 Aug 70) was due to the lack of experienced mechanics and rigid ordnance turn-in procedures. Assistance was rendered by 58th Medical Battalion Consolidated Motor Pool.

g. The 1/50th Clearing Platoon is due to operate the facility at Tuy Hoa until mid-December and then return to Long Binh.

#### h. 58th Medical Battalion:

(1) Bogus Missions have continued to be a problem area and are of two general types. One is flagrant overclassification of patient's category; the other is an insecure site being reported as secure. The Aircraft Commander normally attempts to correct the situation on the spot, by explaining the existing problems to the U.S. personnel or Controlling Agency at the pick-up site. It is understood that the security of a pick-up site can change quickly, hence the main concern is with overclassification of patient category. The 58th Medical Battalion has instituted a formal Bogus Mission report that will gather statistical information as well as report the name, grade and unit of individuals calling in bogus missions. In addition, it is anticipated that approval of the proposed revision of USARV Regulation 40-10 will stop a large majority of bogus missions in the requesting stage.

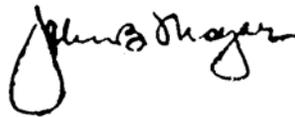
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(2) Lack of fire support during approach for landing into an insecure area has been a subject of concern. Aeromedical evacuation helicopters of the 58th Medical Battalion have been instructed to ascertain whether or not the gunships have permission to provide suppressive fire or not comply with rules of engagement prior to initiating an approach for landing. If the gunships do not have this permission, the mission is withheld until the Dust Off can be afforded a reasonable chance of accomplishing the mission safely.

i. The 136th Medical Detachment (MB) was reactivated 1 Oct 70 at Camp Frenzell Jones. Equipment for this dispensary was acquired by USARV approved lateral transfer from the 199th.

j. A detailed study is being made to determine the feasibility of consolidating or realigning primary medical support in the Saigon area. This study includes the USAHAC, 218th and 229th Dispensaries. The study and recommendations will be forwarded to Commanding General, U.S. Army Medical Command Vietnam (Prov) on or about 1 November 1970.

k. Due to command emphasis on the part of BG Thomas, the project for renovation of the new 345th Medical Detachment is underway. A team of 20 engineer personnel are being sent to Vung Tau to commence work on 2 November 1970.



JOHN B. MOYAR  
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Commanding