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Chief's Corner

Welcome to the summer 2017 issue of the *AMEDD Historian*! As usual, I'm very proud of the authors who made contributions to this issue. Without their dedication and passion to preserve the past, we could not bring you these interesting articles on AMEDD history. I once read "The profession of arms is ancient and honorable," and being an AMEDD soldier is part of that tradition with its glory and honor. Through the *Historian* we hope to bring you their stories. We have some new authors with LTC (Ret) Steven Clay writing about Colonel Charles E. Tegtmeier, Jessica Pellegrini with her article on the history of the Military Blood Program, Navy LT Erik Kumetz is remembering Army surgeon Gordon Seagrave, and LTC Eric D. Lombardini writes about MAJ Elwood Nye, VC.

We still continue to look forward to receiving your donations of documents and other three dimensional artifacts, so please keep them coming – contact information is on the last page.

We have added a new outlet for AMEDD history through an iTunes podcast. Our staff recorded our own COL Betsy Vane, Nurse Corps Historian, presenting a lecture on nurses in World War I. After posting the lecture to iTunes, the podcast (continued on page 28)

Merritte Weber Ireland

Sanders Marble, senior historian

The longest-serving Surgeon General since the Civil War, Merritte W. Ireland took the reins right at the end of WWI, immediately had to demobilize, but made sure that even as the AMEDD shrank it focused on the future rather than returning to the status quo.

Born in 1867 in rural Indiana, the son of a physician, Ireland skipped college and went straight to the Detroit College of Medicine, graduating after a normal three-year course. However, he felt himself inadequately prepared and took two internships (when even one was unusual) studying another year at Jefferson Medical College, one of the leading schools in the US. In 1891 he joined the Army Medical Corps, and had five years' service with troops in various small posts. The 1898 Spanish-American war and the subsequent insurgency in the Philippines (1899-1902) brought him a variety of responsible positions, in which he shone. He went to Cuba assigned to the main support hospital (he helped make it a success despite being an ad hoc unit), but also went into action where he was recommended for promotion for bravery under fire. Afterwards, he was sent to Long Island as executive officer of the Army's highest-profile hospital, the temporary Camp Wickoff which treated the troops evacuated from Cuba



MG Ireland shortly before retirement.

with malaria, yellow fever, and typhoid. These were America's heroes, they were on the doorstep of New York City (and its aggressive newspapers), and the hospital was thrown together from green timber with patients arriving before the buildings were ready. There were bad headlines, but the hospital commander, William Forwood, would himself be Surgeon General (briefly – he was promoted for seniority despite only having three months to serve before compulsory retirement) and he and Ireland quickly brought order from chaos and avoided an even worse public relations problem. From Long Island he went to the Philippines, with months of field service and several commendations for bravery (but no medals; the only medal the Army had was the Medal of Honor) followed by service as head of medical supply for the whole force in the Philippines, with additional non-medical administrative duties for the military government. He was still a captain.

In 1902, he returned to the US and was promptly brought to the Surgeon General's Office by the new incumbent, Robert O'Reilly. O'Reilly was breaking the precedent of having senior officers as his immediate staff (and the SGO was only three or four additional officers) and brought in promising junior officers so they would learn the administrative and policy aspects of the AMEDD. Ireland shone. For the next ten years he was involved with personnel (officers and enlisted), supplies, establishing a reserve, and mandatory vaccination of the Army, among other issues. A law required rotation between Washington offices and the field, and in 1912 he went back to the Philippines as a lieutenant colonel and brigade surgeon. That was an uneventful tour, and he returned to the US in 1915, heading to Fort Sam Houston. He was sanitary inspector of the Southern Department, a geographical region, then division surgeon of the temporary cavalry division based at Fort Sam, then Southern Department surgeon. Revolutions and civil war in Mexico meant the Southern Division was the most active in the Army, and Ireland provided medical support for BG John Pershing's Punitive Expedition into Mexico and also for Regular and National Guard mobilizations along the border.

When the US entered WWI, Pershing was selected as the commander of the American Expeditionary Force, and requested Ireland as his Surgeon, but was told to take COL Alfred Bradley, senior to Ireland and already a medical observer in London; Ireland would be the deputy. However, Bradley was often unwell (he would be medically retired in April 1918) and Ireland was the driving force in the AEF Surgeon's Office. Ireland was involved with every aspect of medical care, medical readiness, and medical support, and his excellent work made him a natural choice for Surgeon General when the incumbent had to retire for age in 1918. Ireland was so obviously the natural choice that various medical officers senior to him recommended him to Pershing as the next Surgeon General. On 30 October 1918 he was sworn in while still recovering from the influenza, which had struck as a pandemic at the end of the war.

With the fighting ending on 11 November, Surgeon General Ireland had no war to support, but had to demobilize the AMEDD while providing medical care to the wounded (most of whom had recently been wounded and would be hospitalized for several months) and making sure that all out-processing soldiers had medical exams that would prevent future false claims against the government. This was before there was a Veterans Administration to provide long-term care, and Army hospitals would have the patients until well into 1920.

Ireland laid out three goals for the AMEDD:

- 1) select and prepare troops for withstanding the rigors of war
- 2) preserve health of the troops
- 3) treat the wounded for return to duty or discharge.

These were deceptively simple, with many steps needed to bring them about. Ireland had lived through three hasty mobilizations, the Spanish-American War, the Punitive Expedition, and WWI. He had seen many temporary, even emergency, developments in the AEF that were worthwhile and he began to build new organizations in the AMEDD. Throughout his tenure money was tight (at one point he was personally



MAJ Ireland about the time he went to the Surgeon General's Office.

approving each civilian hiring) and within those constraints he had to balance readiness now against future capabilities. Ireland was confirmed as Surgeon General in 1918, reappointed in 1922 when GEN Pershing was Chief of Staff, and reappointed in 1926 and 1930 by successive Chiefs of Staff who had seen less of him in WWI than they had seen his efficient stewardship of the AMEDD after the war.

Ireland got funds for several new general hospitals (which he started naming for famous medical officers), Fitzsimons in Denver, William Beaumont at Ft Bliss, Sternberg in the Philippines, Tripler in Hawaii, and new facilities at Letterman (San Francisco) and Walter Reed. He had the School of Aviation Medicine made permanent so the Army could take proper care of its fliers. He built an Army Medical Center out of teaching and research organizations and the Walter Reed General Hospital; it was the nation's first research-oriented medical center and also a clinical teaching center. While the Army needed medical generalists who could be the lone doctor assigned to some remote post, he allowed a few doctors to become specialists; typically they traveled around hospitals rather than patients being moved. He made sure the AMEDD got some VA patients to extend the variety of patients and their conditions for teaching purposes; for similar reasons he got more beneficiaries accepted. Taking VA patients, some years 30% of total patients, also helped the AMEDD justify force structure, and paid for those new hospitals.

Personnel was a major concern, and he focused on officers. He maintained strong links with the civilian medical profession, as a President of the American College of Surgeons and a governor of the American College of Physicians amid other organizations. For him the medical profession was a source of reservists for patient care, and he regularly corresponded with medical school deans and wrote articles for medical journals, encouraging medical (and dental and veterinary) ROTC programs. He arranged paid internships at Army hospitals for promising medical graduates, an effective recruiting tool. (He also preserved an Army School of Nursing, even though it had a horrible retention rate.) He revamped the SGO staff to include dental and veterinary officers to provide better coordination and direction for those corps, and expanded the SGO from the tiny personal staff to a whopping 33 officers, plus civilian employees. Nurse recruiting was largely outsourced to the American Red Cross, but he got nurses more pay, relative rank, retirement benefits – and he got more nurses and moved them to smaller hospitals, raising the standard of care there. Ireland got a Medical Administrative Corps formed to relieve doctors of some administrative work, as Sanitary Corps officers replaced doctors in some laboratory and other professional work. However, the 'Enlisted Force of the Medical Department' was abolished, ending the experiment that started in 1887 with the Hospital Corps being handled separately from the line Army, although men could still enlist specifically for the AMEDD. There were always fewer personnel than needed, but that was true across the Army, and Ireland's two biggest personnel problems were few doctors for the many small posts, and too few cadre to keep the Army Reserve and National Guard units trained.

He got a Medical Field Service School established so that Army doctors could get military training as officers – and he later established an advanced course for field-grade officers, and an NCO course. An Equipment Laboratory was established to develop field equipment and adapt civilian material where possible. They began at the front lines with the first-aid packet (SEE STORY) and worked their way back, echelon by echelon. The AMEDD worked with the Army's developing mobilization plans to not only know how many hospitals it would need, and when in the process, but also how much of what equipment was needed. These might sound like obvious steps now, but this was the first time the US had seriously tackled the problems. He re-established the Army Medical Bulletin, and shifted it from an occasional publication to a regular one, providing a reliable distribution route for AMEDD information. To support his arguments for AMEDD force structure he had studies done on casualty rates in WWI; with data he could justify both field medical units and TDA hospitals for long-term recovery. He did not neglect the 'Army' part of 'Army medicine' and arranged for medical officers to attend the Infantry School; Command and General Staff School; Army War College; and the Army Industrial College, as well as arranging for some training with industry. He also got AMEDD officers on the CGSS, AWC, and AIC faculty. Ireland expected the Regular Army doctors to be wartime senior staff and commanders of medical units (reservists would provide most of the patient care) so he deliberately put more emphasis on Army education for RA officers than clinical development. There were a few cours-

es in summers for reservists, but most could only take correspondence courses.

Ireland knew the importance of the AMEDD in military operations, but paradoxically his increasing the infrastructure – general hospitals, a medical center, the MFSS – reduced the number of personnel immediately available for the field. Certainly Congress had cut military funding (and the Army Air Corps siphoned off even more) but in 1926 Ireland had to admit that his AMEDD was not as ready for war as the AMEDD of 1917. The start of the Great Depression in 1929 further tightened the AMEDD budget, but there was no threat on the horizon. On 31 May, 1931 Merritte Ireland reached the mandatory retirement age, leaving an AMEDD with short-term problems but with the long-term infrastructure to expand for WWII.

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Colonel Charles E. Tegtmeyer, MC: Physician, Leader, Trainer

LTC (Ret) Steven Clay, President 16th Infantry Regiment Association

American military history books are replete with tales of hero soldiers who braved enemy fire and accomplished amazing things in the heat of battle. Most of those stories are about frontline infantrymen, or tankers, or even artillerymen. Only once in while does one read about the other heroes who are not combat arms soldiers, but who take the same risks, and who die and are wounded in the same numbers, as their warrior counterparts. These soldiers, of course, are the medics of the US Army Medical Department.

Medics do not fight the battles. Yet they are always there, dutifully saving lives and conserving the fighting strength of our units under the same horrendous conditions under which the lowly grunts do their dangerous work. It takes a special kind of leader to train and mold such men into a team capable of accomplishing the mission when utter chaos prevails. Such a leader was Colonel Charles E. Tegtmeyer, purportedly the most decorated Medical Corps officer in World War II, perhaps for all of US history to this point.

Tegtmeyer, known as "Charlie" to his friends, received his medical degree in 1935 from Columbia University. Shortly afterward, he was commissioned as a first lieutenant in Medical Corps Reserve and called to active duty in November 1940. He was initially assigned to the 26th Infantry Regiment, 1st Infantry Division, at Plattsburgh Barracks, NY, as a battalion surgeon. He would serve with the 'Big Red One' throughout the war, later commanding an ambulance company and Collecting Company B, 1st Medical Battalion, through operations in Algeria, Tunisia, and Sicily. Following the Sicilian Campaign in July 1943, he became the Regimental Surgeon for the 16th Infantry Regiment. In that position, he landed at Omaha Beach on D-Day, 6 June 1944, in the second wave of the 16th Infantry's assault.

From the beginning of his active duty service, both medical and combat arms leaders realized that Tegtmeyer was not a typical doctor. He was a very versatile leader and trainer who frequently took on very unmedical duties. For example, in North Africa and later in Europe, his regimental commanders would have him occasionally lead the headquarters advanced party forward, a duty normally assigned to the regimental XO, operations officer, or headquarters company commander. It was an unusual assignment for a doctor to say the least and showed the high level of confi-



MAJ 'Charlie' Tegtmeyer.

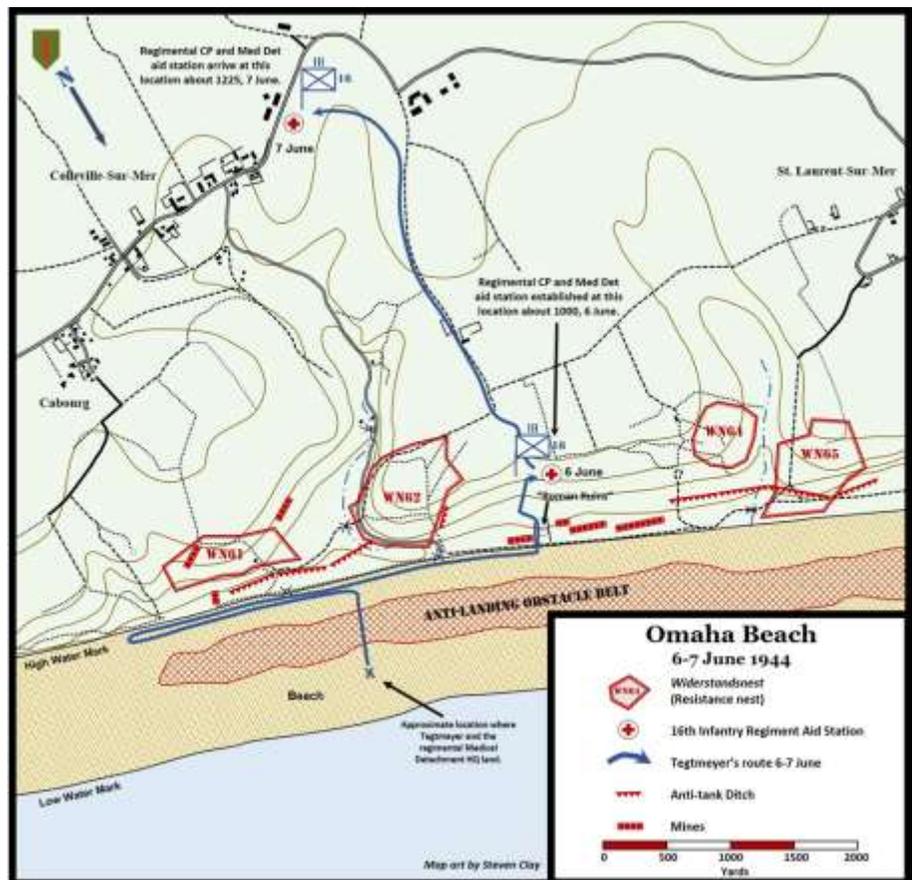
dence in him by his leaders.

As a Reservist and not a professional soldier, Tegtmeier, realized he was initially lacking in basic military knowledge so he constantly strove to learn the “big picture” of military operations to better gauge how his units’ operations fit into the overall mission. He also looked for better ways to prepare his men for the wide variety of duties they would have to perform under combat conditions. This was especially true when preparing his men for the landings at Omaha Beach.

In August 1943 at the end of the fighting in Sicily, Tegtmeier was promoted to major and assigned to command the Medical Detachment of the 16th Infantry Regiment. After arriving with the 1st Infantry Division in England in November 1943, he learned that his regiment would be one of the two units chosen to lead the assault onto Omaha Beach. All leaders of the 1st Infantry Division knew that this amphibious assault would be different and far more difficult than those previously experienced at Arzew in North Africa and Gela, Sicily. After the briefings he and other leaders received on the German defenses, Charlie knew that he and his men much work to do. As with the rest of the 16th Infantry, Charlie quickly instituted a training program to prepare his troops for what they knew was to be a grueling and dangerous mission at the outset.

After a brief respite to settle his men into their new billets near Beaminster, Dorsetshire, in southern England, Tegtmeier soon had his troops conducting myriad small group classes on the various medical skills each would need for the anticipated work on the beach. Tegtmeier had these blocks of instruction conducted not only to train the new replacements in the unit, but also to provide his more experienced soldiers with the latest emergency medical techniques then available. In addition, as part of an infantry unit, Charlie required his troops to participate in the same physical conditioning exercises, to include such events as road marches and obstacle courses, which were undertaken to prepare the larger regiment. The regiment’s medical detachment also fully participated in the regiment’s two major landing exercises in February and May 1944. Like everybody else, the medics had to learn how to waterproof their vehicles for the landings, how to wear and operate the life belts they would wear for the landings, and how to properly descend into the landing craft without falling or breaking a leg. Not only did the men of the medical detachment perform almost all the same training as their infantry brothers, they still had to carry on their daily mission as well -- the routine medical care -- for the men of the regiment. By June, all preparations were complete. Tegtmeier had done everything he could to make sure that all components of the 16th Infantry Regiment’s medical detachment were ready for the big show.

In the cold morning darkness of 6 June 1944, Tegtmeier and the regimental surgeon’s section clambered down the cargo nets draped over the sides of the USS *Samuel P. Chase* and carefully dropped into an LCM landing craft bobbing on the 10-foot swells below. Elsewhere, on the USS *Henrico*, the battalions’ aid stations and company medics were doing likewise. Before



The 16th Infantry’s section of Omaha Beach. Courtesy of the author.

long, the craft were making its way south toward Omaha Beach while dawn broke over the scene. As Tegtmeier's LCM approached the shore, machine gun bullets began whizzing by and a metallic tattoo rattled out as bullets struck the landing craft. Suddenly, the boat stopped and Tegtmeier and his men began the long wade to shore.

Exhausted by the time they reached the beach, the men of the surgeon's section fell to the ground behind the low wall of shale rocks built up on that part of the beach. Thus far, Tegtmeier and his men were fortunate. They had landed at Easy Red right in front of the E-3 draw, the most dangerous place on the beach that day – but had miraculously experienced no casualties coming in. Along the shale, scores of other men lay dead and dying as others huddled behind the rocks trying to avoid the voluminous small arms and shellfire being directed their way. Once they had caught their breath, Tegtmeier and his detachment first sergeant, Staff Sergeant Herbert Goldberg, began to direct their men to search out the wounded and provide first aid. It was hardly necessary, many of the medics had immediately gone to work saving lives.

This scene was repeated all over the beach that day. The platoon medics, and the men of battalion medical sections as well, were heroically providing first aid to the wounded and dying troops without orders. They were well-trained and instinctively knew what to do. Many of them risked their lives by dashing into the water repeatedly to pull wounded men to safety before they drowned or were struck again by fire. One such man, Staff Sergeant Arnold R. Lambert, was severely injured when a landing craft dropped its ramp on him as he was pulling a wounded man to shore. It was Lambert's fourth or fifth trip into the water that morning to save lives. Other regimental medics frequently performed similar feats of valor.

Some of the other units on the beach had no medics. Some units had no medics organically attached. Others, such as the Engineer Special Brigade, had inexperienced medics and apparently were not well trained. As a result, they were largely ineffective and many refused to brave the intense fire in order to carry out their jobs. In addition, the LCI bringing the regiment's medical support unit, A Company, 1st Medical Battalion, was severely shot up by the German defenders as it approached the shore. The company sustained a tremendous number of casualties—the



16th Infantry Regiment medics on Omaha Beach.

company commander was later able to gather only 12 men of his command to perform medical work. This further reduced the number of effective caregivers on the beach and added to the load on Tegtmeier's men.

Tegtmeier and his surgeon's section had landed right next to COL George A. Taylor, the regimental commander, and the regimental headquarters section. Spotting Tegtmeier and 1LT Lawrence Deery, the regimental chaplain, lying near him, Taylor stood up and directed them to follow him along with Tegtmeier's medics. Over the next hour or so, Taylor and this group worked east all the way across the mouth of the E-3 draw and back again under the most concentrated rain of fire on the beach. One by one

Tegtmeyer’s men stopped to render assistance to wounded men while Chaplain Deery comforted the dying.

After about an hour, the group moved west once again across the most dangerous stretch of the beach. On reaching the “Roman Ruins,” Colonel Taylor learned that an assault team from the regiment had cleared a path to the bluffs. Tegtmeyer directed Goldberg to take those few men remaining from the surgeon’s section (the rest were still giving aid at various points on the beach) and establish an aid station about two-thirds the way up the bluff, out of direct fire and relatively safe from indirect fire. Tegtmeyer remained behind briefly to police up other medics and wounded, then made his way to the bluff. There, Tegtmeyer and his section began gathering the large numbers of wounded men on the beach to provide first aid and coordinate with the Navy to have the men evacuated. Eventually, they would collect over 80 wounded men at the site.

In the afternoon, an auxiliary surgical team arrived at Tegtmeyer’s aid station/collecting point, but for some reason they came ashore without any medical equipment. Tegtmeyer tried to get the commander to have his men help bring the wounded from the beaches to the protection of the bluffs, but the officer refused. The 16th Infantry’s aid men would have to do it on their own. Frustrated, Tegtmeyer ordered the team to move off the trail and dig in, but otherwise stay out of everybody else’s way.

By late afternoon, the direct fire on the beach had slackened to almost nothing, but indirect fire was still a problem. Nevertheless, Tegtmeyer directed Goldberg to organize a litter relay to move the most critically wounded down to the Roman Ruins. There, the wounded were supposed to be transferred to US Navy personnel who would load them on empty landing craft for transport back to hospital ships. The walking wounded also went with this group. Eventually, all but ten of the wounded men were moved down to the ruins, but the Navy medical transfer team was nowhere in sight.

As dusk was falling, two German bombers snuck through air defenses and dropped several bombs aimed at landing craft on the beach. One bomb struck an ammunition boat beached near the Roman Ruins, which began exploding furiously and burned and popped from bursting shells for three hours. Due to the proximity of the burning craft and the fact that the Navy had failed to appear, Tegtmeyer’s men were forced to remove all the wounded men back to the bluff for safety. As a result, three of the wounded died that night.

The following morning, the naval medical liaison officer finally arrived at Tegtmeyer’s position on the bluffs. He apologized that he was not able to evacuate the wounded from the beach the previous day because the coxswain of his craft would not stay long enough to load the wounded. The man simply refused to halt the craft and wait to be loaded. Tegtmeyer was not happy about it, but he acknowledged that his men had experienced similar issues with other coxswains the day before. Nevertheless, by 1000, between Tegtmeyer’s men and the Navy team, all remaining wounded from the beach under the

16th Infantry’s care had been loaded and were on their way to a hospital ship. Tegtmeyer then ordered his men to pack up and they headed inland where the sounds of battle clearly sounded around Colleville-sur-Mer. They had more work to do.

On 7 June 1944, Tegtmeyer and the 16th Infantry Medical Detachment still had a long way to go in this war and

General Eisenhower awarded the DSC to MAJ Tegtmeyer (left) and Technician 4th Grade Stanley Appleby, who had waded into the surf to pull wounded soldiers to safety.



both would perform superbly until the end when they reached Falkenau, Czechoslovakia, in May 1945. D-Day, however, was their shining moment. For their heroic actions and effective medical care on that dreadful beach, Tegtmeier and two of his men were later awarded the Distinguished Service Cross. No less than 20 men of the detachment received the Silver Star for valor (2 posthumously) and 55 earned the Bronze Star (6 posthumously). The Medical Detachment as a whole was also awarded the Presidential Unit Citation for its performance on Omaha Beach that day as well. In addition to his Distinguished Service Cross, Tegtmeier received a Bronze Star for training his medical detachment. Without that training, they would not have been ready for the extreme challenge they faced. All of this came at a cost, however. The detachment suffered seven men killed in action and another 26 were wounded from a unit consisting of about 100 officers and men for a casualty rate of over 30 percent.

This short version of what these men accomplished on D-Day is wholly inadequate. So much more could and should be written about the tales of unvarnished bravery performed these doctors, dentists, medics, litter bearers, and other aidmen under amazingly difficult conditions that day. It must suffice to say here that these men were clearly heroes and saved the lives of many men who might have otherwise perished from their wounds or drowning. The fact that they were so effective at performing their mission was in large part due to the leadership and training of the commander, Major Charles E. Tegtmeier.

Sources

This is based on Charles E. Tegtmeier (ed. by Steven Clay and Sanders Marble). [A Doctor's War: The Memoir of Charles E. Tegtmeier, Combat Surgeon in the 1st Infantry Division](#). Cantigny, IL: First Division Museum at Cantigny, 2015, with additional research in 16th Infantry Regiment association files.

All images from the Army Signal Corps.

From Internment Camp to Battlefield Valor: CPT Robert S. Kinoshita

Robert L. Ampula, Administrative Officer, U.S. Army Medical Department Regiment

The bravery and valor displayed by Japanese Americans during WWII are well documented and most people are aware of the heroic deeds of the 442d Regimental Combat Team and 100th Infantry Battalion. Made up almost entirely of Japanese Americans (Nisei), many of whom volunteered for service from internment camps, they are quite likely the most decorated American units to date. A review of Asian and Pacific Island Distinguished Service Cross recipients in 1996 determined that 21 should be upgraded to the Medal of Honor. Another Medal of Honor was included for the AMEDD's James K. Okubo under a special provision. The Nisei were also assigned elsewhere, and their valor seemed to follow wherever they were assigned. One notable example was Captain Robert S. Kinoshita.

Robert was born in the territory of Hawaii in 1906 of Japanese parents from Hiroshima, Japan. From a young age he had an ambition to become an Army officer and in high school he joined the U.S. Army Junior Reserve Officer Training Corps (JROTC). Upon graduation from high school he began his college classes at the University of Hawaii. One of his other ambitions was to become a doctor, and the University of Hawaii had a cooperative program with the University of Nebraska instead of a medical school. Robert moved to the mainland to attend the University of Nebraska's medical school and advanced R.O.T.C. While still in school, he earned an Army commission as a Second Lieutenant, Infantry Reserve in 1929. In 1934 he completed his second ambition and graduated from medical school and was commissioned as a First Lieutenant in the Medical Corps. He moved to Oregon and went to work at a hospital where he met a Caucasian nursing student who would become his future wife. When they decided to marry, they had to travel to another state because Oregon would not allow interracial marriages.

Robert was called to active duty in 1936 to work as a camp surgeon for the Civilian Conservation Corps (CCC), a part of President Roosevelt's *New Deal* Program. By 1941, Dr. Robert Kinoshita was a captain

with the Army and district surgeon in the CCC, in charge of multiple camps. He had one son and his wife was pregnant with their second child. When the Japanese bombed Pearl Harbor, Robert was ordered to active duty, in part because of his exemplary service in the CCC. He received orders for Fort Omaha, NE, but soon thereafter President Franklin D. Roosevelt issued Executive Order No. 9066 on February 19, 1942. This started the relocation of approximately 120,000 Japanese Americans from the west coast into internment camps located in the interior of the United States. Robert's orders were cancelled and the War Relocation Authority told Dr. Kinoshita that he and his 6-year old son had to enter a camp, but his wife would not be allowed since she was Caucasian. In addition he was told that when the family's new baby was born, it would have to go into the camp as well. His wife was told that she could only enter if she signed a legal release form which stated that she would not sue the US Government and that she would follow the same rules and restrictions as placed on the other internees.

The family was moved to Wyoming's Heart Mountain Relocation Center where he worked as a doctor and surgeon in the camp's hospital. He continued to volunteer for active duty but was continually denied. After repeated letters to various Congressmen and Army friends, he was finally ordered back to active duty as a Captain in March of 1943. He then left the camp without his family and reported to Carlisle Barracks and attended numerous courses. He again wrote to his friends in Washington when he heard the Army was activating a Nisei fighting unit that was training at Camp Shelby, MS. He was ordered to the 442d as Executive Officer, but on arrival he was assigned as the Medical Detachment Plans and Training Officer and Sanitary Inspector. Part of his job was to train the medics of the 442d. He was able to find a small house and his wife and children joined him at Camp Shelby. Once the 442d was ordered to overseas duty, CPT Kinoshita had to find a home for his wife and children for the duration of the war. Fortunately, a captain and his wife that he befriended while in the CCC offered to house his family at Camp McCoy, WI. Just before the 442d shipped out, it was determined that the 442d had a surplus of medical officers. CPT Kinoshita and three other doctors were ordered to other units that were short of doctors; Kinoshita was ordered to 7th Armored Division as the Battalion Surgeon, ultimately assigned to the 38th Armored Infantry Battalion. After additional training at Fort Benning GA he joined the division in England.

The division landed in France on 13 August 1944 as part of the Third Army, and on 16 August CPT Kinoshita was already performing above and beyond the call of duty. That day the unit engaged the Germans in the vicinity of Leves, France. The Germans offered stiff resistance and caused many casualties. When he heard about the casualties, CPT Kinoshita moved through the streets while under heavy fire with complete disregard for his own personal safety. He quickly collected, treated and evacuated them while still under heavy fire. He was wounded as the battle reached its peak, but he never wavered from his mission. For his actions, CPT Kinoshita earned a Silver Star.

A few weeks later on 11 September near Metz, France he learned of wounded men in an isolated platoon. He quickly volunteered to lead men to treat and evacuate the wounded. He skillfully led the way through perilous terrain and, once arrived, treated the wounded and prepared them for evacuation. Later that same day he was told of wounded men that were exposed to enemy fire. He found that the men were in an open field in front of a strongly fortified enemy position. Once again, thinking only of the wounded, he went forward completely exposed to the enemy and waving a Red Cross flag. Through this act of bravery, he managed to rescue all of the men. For this deed he earned a Bronze Star for heroism.

Six days later, while waiting in his jeep to advance, mortar and 88mm shells began to fall on the column of vehicles. A tank directly in front of CPT Kinoshita was hit and a moment later a shell landed near his jeep and both he and his driver were wounded by shrapnel. Once again he ignored his own wounds and carried his driver to a ditch on the side of the road. He protected the driver with his own body while treating him, and then had him evacuated. He directed his medical detachment to return to the town of Lorry-les-Metz to set up an emergency aid station while he remained to assist the wounded. CPT Kinoshita crawled through the mud to the other side of the road to treat a severely wounded soldier. He then climbed up on the tank to extract the wounded while under intense fire from the enemy. He treated many other wounded under the incessant fire, including a patient he carried through the mud to have him evacuated. All of these actions were per-

formed in spite of his own wounds. Only after all the wounded had been treated did he allow his wounds to be treated. He then moved back to the emergency aid station and continued tending to the wounded. These actions would lead to the award of his second Silver Star. (Although Kinoshita earned a second Bronze Star for heroism, no details have been found.)

Before Captain Robert S. Kinoshita reported for active duty he wrote an article titled "I Am Proud to Serve" for the *Heart Mountain Sentinel* published on 6 March 1943. Although he was addressing the camp's inhabitants, his article still has meaning today regardless of one's ethnic background:

My commission as an officer of the United States Army bears a phrase which says the President, reposing special trust and confidence in the patriotism, valor, fidelity and abilities of the applicant appoints him to the position. I am gratified that I have been given an opportunity to actively carry out that trust placed upon me at a time when my nation is in danger. We evacuees have been through a great deal in the past year. We have shared the pain of evacuation, and the trials of readjustment in this strange place. Now we are given the chance to prove the loyalty that we have declared so often. It is a challenge to our faith and patriotism. Some of you may be embittered by your experiences, but I do not feel that way. Since the declaration of war I have offered my services innumerable times, even as a buck private, and I feel that my efforts are now at last rewarded. I consider this my opportunity to prove that I am worthy of my American heritage. I am proud to serve my country and I would be ashamed of myself, and my people, if we could not meet this challenge. I want my children to be proud of me as a soldier of my country, and when the war is over, I will want to be able to stand before any man and tell him that I too helped to bring victory to America. I have faith in the future of the United States. I am proud that I will be associated with hundreds and thousands of other Nisei in this great crusade for the freedom and liberty of the common man, and I invite others who have not made up their minds, to join us in our battle. This great nation has given us life. It is the least we can do in her time of need to offer ourselves in her service. Robert S. Kinoshita

It is certain that Robert's sons were proud of him as a soldier and that he helped bring victory to America. It is also certain that Robert and his fellow Nisei earned great credibility and proved their love of country and selfless service. Robert S. Kinoshita left the Army in 1946 with the rank of major. He opened his own private practice and retired in 1976. Robert passed away on January 2, 2001 at the age of 94. His wife of 60 years died 5 days later.

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Crossing the bridge: The AMEDD's transition to branch immaterial commands.

Lewis Barger, historian

As you may know, we recently attacked military medicine's last sacred cow of discrimination – and perhaps the most sacred of all – by drastically limiting the number of command and high-level staff jobs that are monopolized by any one AMEDD officer corps... We are a better AMEDD for having crossed this bridge.

-LTG Ronald R. Blanck, The Surgeon General, 31 July 1998

At the time of this writing, there are seventeen active component Army Medical Department general officers. Nearly half (eight) were originally branched in the Army Nurse, Dental, Medical Service, or Veterinary Corps and four of those eight are in command, while five of the nine Medical Corps generals are in command. Twenty-five years earlier that would have been inconceivable. In January 1992 there were nineteen active duty general officers in the AMEDD. Over two-thirds were physicians. The Chief of the Dental Corps was by law a major general and the dentists also had two additional brigadier generals. The Army Nurse and Medical Service Corps were each authorized a brigadier general who served as their respective corps chiefs. The remaining general officers were all Medical Corps with one exception: Brigadier General Clara Adams-Ender, a nurse, had been selected to serve as Commanding General, Fort Belvoir and Deputy Commanding General, Military District of Washington after her term as Chief of the Army Nurse Corps ended. All AMEDD senior command positions were filled with Medical Corps general officers.

Then, nobody would have been surprised that the overwhelming majority of general officers in the AMEDD were Medical Corps. Before 1901, the only officers in the Medical Department were medical doctors. Between 1901 and 1920 several new corps were added either in unique fields of care (Dental – 1911, Veterinary – 1916), to assist doctors in the provision of care (Army Nurse – 1901), or to take over some ancillary medical functions that did not pertain directly to patient care (Ambulance – 1917, Sanitary – 1917, Medical Administrative – 1920). The Medical Corps remained indisputably in charge of the Medical Department, though. It was not until 1938 that a Dental Corps officer, Brigadier General Leigh Fairbank, became the first non-Medical Corps general officer and in 1947 Congress specified that the chief of the Dental Corps would serve as a major general, at that time equal to the rank of the Surgeon General. The Medical Service Corps was authorized a brigadier general position in 1966, and the Army Nurse Corps in 1970. The Veterinary Corps got a brigadier general in 1942, but lost the authorization in 1990, then got it back in 2004.

Before 1945, Medical Corps officers in the small peacetime Army were expected to form the nucleus of trained regulars around which an expanded AMEDD would be built in times of war. The Medical Department's experience in the Civil War, Spanish-American War, World War I, and World War II all pointed to the necessity of having a competent corps of officers who could assume the leadership of the department at the strategic and operational levels, while volunteer and conscripted doctors were hastily trained in the special requirements of military medicine on campaign and employed largely at division level and below in the field or in hospitals within their medical specialty. As a result, although a peacetime physician might never be required to serve at the operational or strategic level, there was an expectation that they be prepared to do so. This began to change after the end of World War II when the Cold War necessitated maintaining a larger standing Army. While the Army was only about 188,000 strong in 1939 (50,000 larger than it had been a decade earlier) in 1950 there were nearly 600,000 on active duty. With the correspondingly larger Army and Medical Department, the need to ready all Medical Corps officers to assume responsibilities at a scale above their peacetime responsibilities became less urgent. Emphasis on the unique requirements of operational medicine largely fell to those serving in field units, while military medicine practiced in fixed facilities began to focus more on adhering to civilian standards of medical practice.

The end of the Vietnam War brought more changes to the Army and its Medical Department. The end of the draft and the institution of the all-volunteer Army eliminated a principal means for the AMEDD to obtain physicians. To compensate, both the Health Professions Scholarship Program and the Uniformed Services University of the Health Sciences were established in 1972 to bring in new physicians. Physician bonuses were also implemented to increase retention, but economic recession, reduced military budgets, societal problems, and a generally negative view of the military made attracting and retaining physicians very difficult. From 1972 to 1977 the number of Medical Corps officers in the Army dropped from 5,667 to a low of 4,056, at which point the numbers began to gradually increase again.

Increased emphasis was placed on mitigating the anticipated loss of physicians by creating “physician extender” programs. Nurse clinician programs, begun in 1972, expanded the role of nurses and in 1977 nurse clinicians were further divided into nurse practitioners and clinical nurse specialists moving nurses away from their former role of assisting doctors towards practitioners in their own right. The Army had first begun considering training physician assistants (PAs) during Vietnam, and formal training began in 1972 with the first class graduating in August 1973. Although physicians still oversaw these new classes of providers, more and more patients were having primary care contacts with non-physicians. A significant difference between the PAs and nurse clinicians was that PAs were, until the 1990s, warrant officers while nurses held a commission. The practical effect of this was that while PAs were effectively limited to their role of physician extenders, nurses began to build on their increasing healthcare responsibilities by gradually adding administrative and leadership responsibilities to their resume.

The Surgeon General also began issuing an annual letter, “Staffing Authorization and Utilization of Army Medical Department Commissioned Personnel in Active Component TOE Units of U.S. Army Forces Command (FORSCOM),” generally shortened to the MEDO letter. The MEDO letter established the policy in peacetime of removing most doctors (and other healthcare providers) from assignment in FORSCOM Table of Organization and Equipment (TO&E) units so that they could be assigned in the Medical Department’s fixed facility treatment facilities where they could see patients on a day-to-day basis and maintain their clinical skills. Doctors continued to command the garrison hospitals, but Medical Service Corps officers commanded many of the field units with the expectation that a doctor would take command in wartime.

In 1986, in response to problems encountered with providing the right mix of professional officers in a timely manner during Operation Urgent Fury (Grenada, 1983) the Office of The Surgeon General published Army Regulation 601-142, Army Medical Department Professional Officer Filler System (PROFIS). PROFIS was intended to “provide timely fills for personnel vacancies not normally staffed during peacetime” and allow “for communication and coordination between providing commands and gaining commands prior to mobilization.” PROFIS was not limited to Medical Corps officers, but it did include in its rosters those physicians who were slated to take command of patient treatment and medical command and control units when those units deployed, replacing the Medical Service Corps officers who commanded in peacetime.

The Gulf War (1990-1991) revealed flaws in PROFIS. Records had not been updated as frequently as they should have been and some medical personnel who were slated to join TO&E units turned out to be non-deployable – in the first phase of the deployment only 46 percent of the required professional fillers could be assigned to their units in the 72 hours that was the standard for filling all of the positions. Many PROFIS fillers lacked training, or were unfamiliar with the units they were deploying to and the types of equipment they would have to use. Additionally, the subject of who should command the deploying units became an issue as combat commanders took exception to replacing the subordinate commander they knew and trusted with a doctor they did not know shortly before deploying to combat. In one of the best known of these incidents, Colonel Jerome V. Foust, Medical Service Corps, was retained as commander of the 44th Medical Brigade,

one of the most prestigious TO&E medical commands in the active component. In April 1992, a Medical Corps Brigadier General took command of the 44th for the first time since 1976. Several factors were cited to justify this assignment in peacetime: a desire to move the medical brigade from its subordinate status under 1st Corps Support Command back to being directly subordinate to the Corps Commander; an expanded role for the medical brigade as the parent unit for all corps medical assets, including those not stationed at Fort Bragg; and the increasingly important role the XVIIIth Airborne Corps held as the Army's rapid reaction force in the Army's contingency plans. One suspects, though, that even if it was not given as a primary reason for assigning a Medical Corps commander, there were still those in the corps who felt a certain degree of reassurance in the knowledge that should the 44th be called to combat again, it would answer that call under the leadership of a Medical Corps officer.

In September 1992, Alcide M. LaNoue was promoted to Lieutenant General, becoming the 38th Surgeon General of the Army. LaNoue entered office just as the Army was beginning to focus on reducing its size after the end of the Gulf War and the dissolution of the Soviet Union. Additionally, as LaNoue was taking charge, the Medical Department was receiving criticism from a Government Accountability Office (GAO) report and the Defense Advisory Committee on Women in the Service (DACOWITS). The GAO report *Operation Desert Storm: Full Army Medical Capability Not Achieved* found fault with PROFIS, training, supplying and equipping hospitals, and unit status reporting in the Medical Department. Although many in the AMEDD felt unfairly criticized after providing quality patient care, the GAO report found that "had the war started earlier or lasted longer or had the predicted number of casualties occurred [the Army's ability to provide adequate care] would have been questionable."



LTG LaNoue.
Courtesy National Archives

At the same time, DACOWITS was pressing the Army to open more leadership roles to women. In particular, they recommended that the Army Nurse Corps, the single branch with the greatest proportion of women in the Army, as well as the other AMEDD corps, be given the opportunity to command hospitals and other medical units that provided patient care. DACOWITS members noted that both the Navy and Air Force permitted personnel in non-physician branches from their medical services to command hospitals, and urged the AMEDD to evaluate its command selection policies to ensure that officers were not being unfairly excluded from the opportunity to command.

Adding to these calls for reform within the Medical Department, members of both houses of Congress involved with appropriations were expressing concern that the Army had too many physicians in jobs that did not involve direct patient care at the same time the AMEDD was asking for additional specialty pay to attract physicians into the service. The Defense Appropriations Act of 1992 established a requirement for the Department of Defense to identify the skills required to command a healthcare facility and a DoD task force developed criteria for evaluating whether or not an officer was competent to be selected for command. The Army, acting as the DoD Executive Agent, was tasked with developing training to ensure that officers received training that would prepare them for command.

Faced with these calls to remedy the problems identified after the Gulf War, to create more opportunities for women to serve as leaders, to maximize the use of physicians in patient care roles, and to ensure that command selectees had been adequately leader developed to command the Army's healthcare organizations LTG LaNoue proposed opening command up to the best qualified officer. In addition, he wanted to remove the PROFIS commander position from units as an initial step towards correcting the problems identified during

Desert Shield/Desert Storm. LTG LaNoue had already taken the first step towards branch immaterial command in January 1993, when he placed Brigadier General Nancy Adams, an Army Nurse, in command of the Center for Health Promotion and Preventive Medicine (Provisional). Adams, in her oral history, also believed that selecting a woman to command at a senior level would help sell the concept as a means towards creating greater opportunities for women in the Army.

In June 1993 LaNoue briefed the Chief of Staff of the Army, General Gordon Sullivan. Sullivan asked LaNoue to study the proposal further, which was formalized in February 1994 by a memo activating the Leader Development Decision Network (LDDN) to study branch immaterial command in the AMEDD. The LDDN was tasked with studying leader development in the AMEDD and making recommendations that would ensure that AMEDD officers were afforded opportunities for formal training, operational assignments, and self-development that would prepare them to command healthcare facilities. The LDDN reported quarterly on its progress until December 1994 when they presented their recommendations to a General Officer Steering Committee. The recommendations included rewriting Army command policy to open most field and garrison medical commands to a competitive, non-branch specific command selection process and developing corps specific development models to ensure officers from all corps were properly prepared to command. Other recommendations included establishing a branch immaterial assignment code to designate branch immaterial positions and reforming command selection board procedures to enable branch immaterial selection. The LDDN did not recommend designating all commands as branch immaterial, dental and veterinary units were reserved for Dental Corps and Veterinary Corps officers, and some specific commands were designated for Medical Service Corps and Medical Corps officers. TO&E Command Designated Position List commands (CDPL, since changed to CSL – Centralized Selection List – generally lieutenant colonel and above commands) that were recommended as branch immaterial commands included Combat Support, Field, and General Hospitals, Area Support Medical Battalions, and Medical Groups. Fixed facility CDPL commands proposed as branch immaterial included MEDDACs, Troop Brigades, the Center & School Training Brigade and Training Battalions, and the commands within the Environmental Hygiene Agency (later Center for Health Promotion and Preventive Medicine, CHPPM).

The Medical Department planned on briefing GEN Sullivan in the first three months of 1995 and beginning implementation later that year, but the Chief of Staff had more pressing matters and the briefing was placed on hold. In the summer of 1995, Sullivan retired and was replaced by General Dennis Reimer, and it would be nearly a year before LTG LaNoue would have the opportunity to bring the plan to him for a decision. In a June 1996 memo, Reimer asked LaNoue to provide him with some additional information before he approved branch immaterial command in the AMEDD. Reimer was not trying to block the initiative. Instead, he was trying to ensure that the Medical Department would be successful in the transition by requiring specificity in the plans for the distribution of non-Medical Corps general officers, the future utilization of corps chiefs, and greater definition in AMEDD plans to leader-develop field grade officers from all corps to prepare them to lead as colonels and general officers. (Incidentally, that year Congress changed the United States Code to say that Surgeons General would be selected from any corps in the AMEDD, not just from the Medical Corps as the law had previously stipulated.)

Once GEN Reimer's concerns were satisfied, he approved the change in policy. A branch immaterial position designator code, 05A, was approved for use on Command Designated Position Lists and the first boards were held which considered officers from outside the Medical Corps for command. Initially, selections were only considered for company grade commands and lower tier commands at the lieutenant colonel and colonel level. The intent was that colonels who demonstrated the ability to successfully command a Medical Activity (hospital) would then be eligible to compete for command of a Tier One facility like a general hospital in a

later board. There was one exception. BG Adams, who had already commanded successfully at CHPPM and William Beaumont Army Medical Center was selected for a second star and command of Tripler Army Medical Center, taking command in March 1998. Adams was the first non-Medical or Dental Corps officer selected for Major General and command, the first to cross the bridge, realizing LTG LaNoue's vision of a Medical Department commanded by the best qualified officers from all the AMEDD corps.

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This painting shows Surgeon General Norman Kirk with his senior staff officers in late 1943 or early 1944. Almost all were Medical Corps officers.

Left to right:

BG Charles C. Hillman MD, Chief, Professional Services Divisions, OTSG;

BG Hugh J. Morgan MD, Chief Consultant in Medicine, OTSG;

BG Raymond Bliss, MD, Chief, Operations Service, OTSG;

COL James R. Hudnall, MC, Chief, Personnel Service, OTSG;

COL (later BG) Edward Reynolds, MAC, Chief, Supply Service, OTSG;

BG Raymond A. Kelsler, DVM, Director, Veterinary Division, OTSG;

MG Norman T. Kirk, MD, The Surgeon General;

MG Robert H. Mills, DDS, Director, Dental Division, OTSG;

MG George F. Lull, MD, Deputy Surgeon General;

BG James S. Simmons, MD, Chief, Preventive Medicine Division, OTSG

Decades of Working Together to Save Lives: A History of the Military Blood Program

Jessica Pellegrini, ASBP Staff Writer

With roots that can be traced back to World War II, the Armed Services Blood Program – the official blood collection, blood component manufacturing and transfusion program for the U.S. military – has a storied history. The program represents all three services and coordinates among the blood programs of the Army, Navy and Air Force as well as the unified commands. It relies upon many components (such as the Service Blood Program Offices, blood donor centers, Blood Product Depots and Blood Support Detachments, among others) to provide blood and blood products to ill or injured service members and their families worldwide – in peacetime and war.

A world at war underscores the need for a military blood collection program

Prior to the founding of the ASBP, the military did not have a unified transfusion program. In peacetime and when wartime needs could not be met blood was purchased from civilian agencies. After the Japanese attack on Pearl Harbor in 1941, the U.S. entered World War II with this same contingency structure in place. However, a world at war caused the delivery of blood to theater to undergo several of the program's leading advances.



Loading blood in refrigerated marmite cans for shipment to the European blood bank by a mobile unit, March 1944.



5th U.S. Army medics administer blood plasma in an open field. Date is unknown, but the picture was taken before the introduction of large plasma bottles.



Technicians taking blood for typing at the 2nd Medical Laboratory, 5th U.S. Army, Carinola area, Italy, May 1944.

According to Army Col. Ronny Fryar, former Army Blood Program director, by 1944, the Army had several hospitals that were able to collect whole blood to help meet their needs in theater as well as military hospitals in the U.S. (such as the Walter Reed General Hospital in Washington, D.C., and the Brooke General Hospital in San Antonio, Texas). Additionally, the American military began to build up its airlift capabilities and the need to transport blood was high on the list of demands. Soon after airlifting blood to forward locations began, it proved to be a key innovation that changed the face of the military blood program. In fact, the military aircraft became the much-needed link to get blood throughout the Pacific and European theaters.

In the Pacific theater, the military airlift became the vital link in getting blood supplies to hotspots throughout the Pacific theater. During the battle for Okinawa alone, nearly 20,000 units of blood were directed through a blood bank in Guam then airlifted into Japan using local air services. Nearly 12,000 Americans died and 60,000 more were wounded trying to Okinawa. Without enough blood in forward areas, provided primarily via military aircraft, it is almost certain that the U.S. would have lost thousands more.

Throughout WWII more than 825,000 units were collected in support of troops fighting around the world. In September 1945, with the end of hostilities in World War II, the military began to downsize. In returning to a peacetime posture, the blood programs were quickly phased out.

Army, Navy and Air Force combine forces to create first tri-service military blood program

It would be nearly a decade after World War II before the military blood program would be officially established as an organization. The ASBP was begun by President Harry Truman in 1952; however, in its current form, the program has been a fully-operational, distinct tri-service agency since 1962.

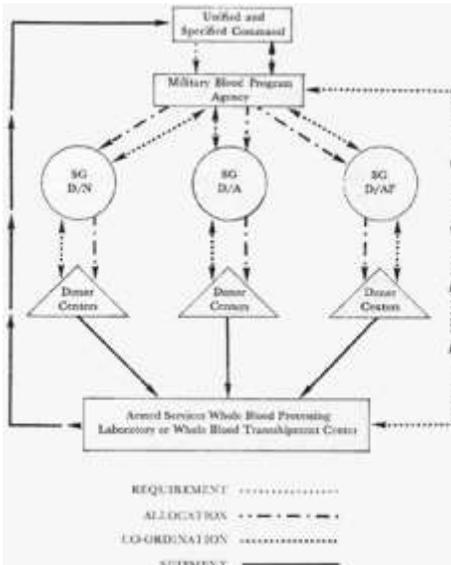
The military's ability to deliver and administer blood to wounded troops continued to advance during the Korean War; however, the conflict also proved that whole blood could not be provided in wartime with maximum efficiency unless supplies, equipment, trained personnel and a detailed plan for its collection, processing and distribution were already in place. The Department of Defense determined that civilian blood programs were not adequately organized to meet wartime requirements of the armed forces and the potential needs of the civil defense program. While civilian programs were well equipped to handle specific local and regional crises, they were not designed to support an ongoing international need. Only a national program, backed by military leadership which remained organized in peacetime, could meet military requirements.

Vietnam War tests a coordinated program across the three services

In its first major wartime engagement, the Military Blood Program collected roughly 1,800,000 units of blood in support of troops in Vietnam. Program officials considered the blood program a phenomenal success. For the first time in U.S. military history, every unit of whole blood used to support the war was voluntarily donated by military personnel, their dependents and civilians employed at military installations. Nearly 1.5 million volunteers gave blood to the Military Blood Program, yet civilian blood agency collections were not adversely impacted by the increased military requirements.



A helicopter helps provide blood support and medical equipment to service members in Vietnam.



Military Blood Program Agency scheme for tri-service collecting-processing of whole blood to ship through the Armed Services Whole Blood Processing Laboratory-East at McGuire Air Force Base, NJ, 1966-1970.

As these accomplishments suggest, the history of the Military Blood Program in Vietnam is one of rapid organizational advancement to meet escalating needs. Prior to April 1965, only Type O-negative blood was sent to Vietnam. Because less than half of the U.S. population has Type O-negative blood, developing a method whereby all types of blood could be used would be necessary to help reduce the potential for blood shortages. The solution was to increase the sophistication of forward medical facilities so that first group A and then all blood types could be transfused safely by the end of 1965.

Initially, almost all blood needs were met by the 406th Medical Laboratory in Japan, with blood donations collected by each of the Services in Okinawa, Japan and Korea. That blood was distributed by the 406th Mobile Medical Laboratory in Saigon to all U.S. and allied forces except the Vietnamese, who had their own system.

By June 1966, though all field medical units were within a 30-minute helicopter flight for blood resupply, the 406th Medical Laboratory could no longer meet blood demand. At this point, a new era began. The ASBP began to draw blood in the continental U.S. to meet the shortfalls in

theater. Blood was sent to the Armed Services Whole Blood Processing Laboratory at McGuire Air Force Base, N.J., for processing before being shipped to medical units in Vietnam.

The advances developed during this period showed that an established military blood program could reduce the burden of using combat troops as donors, supply all blood required through military member donations, distribute all blood types according to the technical level of the transfusing medical unit, anticipate future need, and develop a supply program from the rearward areas in advance of increased demands.

Blood support in the seas

While most combat medics and medical facilities operated on the ground, the Navy's hospital ships *USS Repose* and *USS Sanctuary*, provided medical care from 1966 to 1971. Between them, the ships admitted more than 37,500 patients and treated more than 13,600 battle casualties, many of whom needed blood transfusions. The ships alternated duty so that medical facilities were always nearby for wounded troops. One ship would spend three days off Dong Ha near the Demilitarized Zone between North and South Vietnam, while the other was in Da Nang Harbor. Every three months, one ship would steam to Subic Bay Naval Base in the Philippines for approximately 10 days of maintenance, while the other stayed "on the line" off Dong Ha. These ships were also the first in the Navy to feature crews composed of both men and women.



US Navy personnel load Armed Services Blood Program blood onto the *USNS Comfort* during its relief mission in Haiti.

Today's military blood program continues to save lives

Today, the ASBP operates more than 20 blood donor centers and 81 transfusion centers in the U.S., Europe and Asia. Two Armed Services Whole Blood Processing Laboratories serve as storage and shipping facilities for contingency blood — both liquid and frozen. A network of Blood Transshipment Centers, Expeditionary Blood Transshipment Systems, Blood Product Depots, and Blood Supply Units are in place or on call at all times to ensure support of front-line medical response units anywhere around the globe.

About the Armed Services Blood Program

Since 1962, the Armed Services Blood Program has served as the sole provider of blood for the United States military. As a tri-service organization, the ASBP collects, processes, stores and distributes blood and blood products to Soldiers, Sailors, Airmen, Marines and their families worldwide. As one of four national blood collection organizations trusted to ensure the nation has a safe, potent blood supply, the ASBP works closely with our civilian counterparts by sharing donors on military installations where there are no military blood collection centers and by sharing blood products in times of need to maximize availability of this national treasure. To find out more about the ASBP or to schedule an appointment to donate, please visit www.militaryblood.dod.mil. To interact directly with ASBP staff members, see more photos or get the latest news, follow @militaryblood on Facebook, Twitter, Flickr, YouTube and Pinterest. Find the drop. Donate.

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Dr. Gordon Seagrave: Remembering the Burma Surgeon

LT Erik Kumetz, MD, USN

On 31 August, 1950, Dr. Gordon Seagrave received word from his jail cell of the Burmese government's formal indictment: high treason against the state. To the seasoned Johns Hopkins surgeon, the charge came as no surprise—in fact, he welcomed a trial to clear his name. His support and sympathy for the people of the Shan States, the area of Northern Burma where he began his medical work nearly 28 years prior, had long drawn the ire of southern government officials who were battling armed resistance in the region. However in the United States, the trial of beloved WWII hero, the “Burma Surgeon,” sparked outrage across the country.

Born in Rangoon (now Yangon) in 1897, Seagrave was the son of American missionary parents. Through his Baptist upbringing, he discovered his passion to become a medical missionary at an early age after meeting an eccentric Irish physician-missionary who practiced in Namkham, a village on the border between the Northern Shan States and China. Seagrave soon left Burma (since renamed Myanmar) to pursue his for-



Dr. Gordon Seagrave
Courtesy San Diego Air & Space Museum Library & Archives

mal education in the United States where he earned his M.D. degree from Johns Hopkins University. After completing an internship at Union Memorial Hospital in Baltimore, the young surgeon returned to Burma with his wife, Tiny, and a small collection of worn surgical instruments recovered from a hospital wastebasket.

Seagrave and his family were then sent north by the mission commit-

tee to the hospital of his childhood hero in Namkham. The mountainous terrain was rugged, the medical facility no larger than a small shack. Not to be deterred, Seagrave set about construction of a new hospital, built initially out of cobblestone from a nearby riverbed, which grew to employ 18 nurses, 135 nursing trainees, and two additional doctors as well as serve nearly 6,000 patients a year.

There, the Burma Surgeon specialized in “wastebasket surgery,” a term he coined for performing operations with limited materials he brought from the States. The level of acuity was remarkable: burst appendix, uterine rupture, grapefruit-sized goiter, and trauma following a bear attack to name a few. Practicing on the frontier demanded the need to specialize in all fields of medicine, often by trial-and-error:

The biggest anxiety was in regard to the anaesthetic, for during our previous operations the patient would either be walking off the table in the middle of the operation or would stop breathing because he had too much anaesthetic, and we should be inducing artificial respiration with all our might.

Despite the limited resources, Seagrave performed hundreds of operations, successfully treated innumerable cases of malaria, and opened one of the first government-accredited nursing schools in the region, teaching each class in Burmese, Shan, Karen, and English. (The first foreign exchange students under the U.S. Fulbright Act in 1947 were Burmese nurses associated with Dr. Gordon Seagrave’s training school.)

In 1942 the Japanese pushed into Rangoon, effectively cutting off Allied aid to China from British India; bombing raids intensified in the north. An American general, Joseph “Vinegar Joe” Stilwell, was tasked with command of two divisions of Chinese troops to retake Burma. For Seagrave the decision to assist the war effort was easy: “The desire to serve Burma runs in my blood.” Commissioned as a Major in the U.S. Army Medical Corps, the Burma Surgeon and his nurses set off with Stilwell to meet the Japanese offensive.

Over the coming months, Seagrave set up makeshift surgical sites behind the frontlines. A passage from his autobiography, *Burma Surgeon*, captures the never-ending waves of trauma the medical corps experienced:

April 15th—Between the heat and the bombers we can’t get much sleep in the daytime, and the nights are full of work. Last night at ten-thirty, thirty-five cases arrived, two of them belly cases...I wish I could keep [them] here, but our staff isn’t sufficient. Two more truckloads arrived while we were working, and we did not finish till nine-thirty this morning, when we had one hour of sleep before we had to start washing out last night’s gauze and linen.

Ultimately, reinforced by troops from the capture of Singapore, the Japanese defeated the Allies’ advance. In May 1942, Stilwell ordered the evacuation of his staff and medical team from Burma into Assam, India. The withdrawal took 29 days on foot through the Burmese jungle with the Japanese close on their heels, a feat infamously known as the “Stilwell Walkout.” In India, Seagrave was promoted to the rank of lieutenant colonel and published *Burma Surgeon* earning him international fame. His account of the war became a national bestseller and was widely read



by Allied troops in other theaters.

However, it was also upon ending their grueling march out of the Burmese jungle that Seagrave was greeted by devastating news: the Japanese high command had occupied his hospital at Namkham and were bombed by the U.S. Army Air Corps, destroying the building. His dreams and hard work may have been reduced to rubble, but it would not crush his indomitable spirit. "I told General Stilwell [upon hearing the news]...that we all hoped when new action developed against the Japs he would save out the meanest, nastiest task of all for us." In 1944, Seagrave accompanied the Allied advance back into Burma succeeded in recapturing the country; his account was published as *Burma Surgeon Returns*.

In 1946 after reuniting with his family, Seagrave continued his medical practice in the country as Chief Medical Officer of the Shan States. In the position, he was able to navigate the political instabilities gripping the country until his arrest on August 15, 1950. The charge of high treason centered on an incident at his hospital compound, in which Seagrave supplied Naw Seng, an officer of the Karen National Defense Organization (KNDO), a group still in armed conflict against the government today, with medical equipment and allowed his army to establish defensive positions in the hospital. Seagrave denied the allegations, asserting he told the armed group to leave. The government concluded that the KNDO would not have arrived unless the surgeon had been sympathetic to their cause.

Although the court could not find enough evidence to convict Seagrave of high treason, the justices found him guilty under a different provision in which he assisted another individual guilty of high treason (Naw Seng) and was sentenced to six years in prison. For the United States, the results of the trial were alarming. The *Boston Herald* declared the trial, "a tragic miscarriage of justice." For many Americans, the results legitimized their Cold War fears that Burma was becoming a communist state.

On October 31, 1951, the Supreme Court of Burma found that the surgeon, although unquestionably sympathetic to the Karens, had given aid to Naw Seng in order to protect his staff. Seagrave was allowed to return to Namkham and rebuild his hospital. There he remained until his death in 1965. "Last night I lay awake hours remembering my old ruined dreams...a hospital above denomination where Buddhists and animists could come and receive loving care when sick and learn that peace comes only to men of good will," wrote Seagrave after the war, "It was a beautiful dream—and outside the stars were shining."

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For more on the AMEDD in China-Burma-India, see <http://history.army.mil/html/books/010/10-24/index.html>

New Donations

New to the AMEDD Museum

The AMEDD Museum has been offered several exciting groups recently that expand our ability to tell the story of army medicine.

Among the offers is a life ring from the United States Army Hospital Ship *Frances Slanger*. This life ring has the hand painted ship's mascot, Popeye the Sailor Man, painted in the center. Along with the life ring were several documents that will be preserved in the research collection.

COL Michael Fuenfer, Medical Corps, has been interested in Army Medicine since he was a child. From his childhood collecting he has donated a blue AMEDD patient robe, a 1950s era summer convalescent suit, a 1949 parachutist medical pouch, and a pre-WWII patient pajama top.

COL Claude Perkins, Medical Corps has offered his Desert Camouflage Uniform worn during his deployment to Kuwait and Iraq in 2002-2003. He was assigned to the 856th Combat Support Hospital, a reserve unit based in New York. COL Perkins attended the United States Military Academy and was originally an infantry officer.

New to the ACHH Research Collection

Documents:

Martin Duke, M.D. donated "The Emily Post" newsletters from the U.S. Army Hospital Ship *Emily H.M. Weder*, November 1944 - March 1945.

Ms. Shirley Escobedo donated a small collection of personal papers belonging to MSG Jesus J. Escobedo, who served with the 110th Station Hospital, Vienna, Austria during the 1950s.

The AMEDD Museum transferred a collection of military service records and photographic images belonging to LTC Ross F. Swall to the ACHH Research Collection. The items document Swall's military service from 1940 to 1967.

Four video interviews with personnel from the Critical Care Flight Paramedic Course were added to the AMEDD training collection.

Highlights

Documentation of the Critical Care Flight Paramedic Course will be an ongoing project in collaboration with Fran Trachta, the goal of which is to encourage course participants to contribute archival material they deem relevant for long term, historical preservation.

Books:

3 books

Donors:

Doug Burck

Dora M. Suddeth

BG Robert W. Enzenauer, M.D., Colorado, Army National Guard

Highlights

Hibbs, Ralph Emerson. *Tell MacArthur to Wait*. New York: Carlton Press, 1997.

COL Elwood Nye, V.C.

LTC Eric D. Lombardini, VMD, Commander, Public Health Activity-Fort Carson

The United States military is in a constant state of controlled transformation. Often reactive, ideally proactive, the military responds to the intricate and complex web of threats that our ever-evolving world presents us. Equally, the military undergoes continual metamorphosis as it adopts and reacts to new technologies, new social norms and as we adapt to the dangers and pressures of an increasingly polarized world, the emergence of novel diseases or the spread of maladies into new terrains, increasingly unstable or failed nation states and the extraordinary dissemination of information. This intrinsic ability of our military to transform has always been a fundamental part of the fabric of our institution. The military has been at the forefront of social change, often preceding the nation itself. Occasionally the changes are subtle and their significance may be obscured in the fog of history, leaving only a select few to be nostalgic for a lost past. This is the case for the horse in military service.



Horse and rider with gas mask, World War I.

The United States cavalry underwent a fundamental revolution around the end of the First World War. This would change the very essence of the mounted forces of the United States Army, whose history dates back to the First Troop Philadelphia City Cavalry, established as the Light Horse of the City of Philadelphia to fight the British during the American Revolution. The advent of mechanical transportation and mechanized combat presaged the end of the horse and the end of conventional mounted warfare. During the First World War, trench warfare, artillery fire, and fully automatic guns underscored the vulnerability of horses and markedly decreased their use on the battlefield. Most of the combatants began to change from their dependence on mounted cavalry in this evolution of modern combat.

In addition to the direct use in combat by our troopers, horses and mules had been crucial for the Quartermaster Corps forming the essential transportation on the supply chains; they were used by the Artillery to move guns; by the Medical Department to pull ambulances. For the Veterinary Corps, the horse represented the heart and soul of the mission. Sadly for many, by the end of the war, the horse's predominance in our Nation's struggles faded rapidly into the

background.

In 1917 a cavalry officer by the name of Elwood L. Nye, who had graduated from Colorado State University in 1914, entered the Army Veterinary Corps, where he served for 29 years. He was stationed across the nation, from Schofield Barracks in Hawaii to the cavalry post of Fort Meade, South Dakota, from the Presidio in San Francisco to the United States Military Academy at West Point to name a few. While in Hawaii and South Dakota, he served with the 4th Cavalry.

Nye believed in the horse and cherished the service that these magnificent animals gave to our Nation. He understood the horse as an integral part of the cavalryman, not as a weapon system



MAJ Nye on maneuvers.

or a mode of transportation, but as a partner, as a comrade in arms.

Stationed in South Dakota in 1938, MAJ Nye participated in the last mounted regimental cavalry parade at Fort Meade. The cavalry fort had been established during the Indian wars and was maintained as such through World War II, being home at various times to the 4th, 7th, 8th and 10th Cavalry Regiments as well as the 1st and 25th Infantry. When Nye was assigned there, the transformation of the cavalry was underway, taking into account that modern warfare had made large cavalry units obsolete, but that regiment sized units would still play important roles in the United States Army when embedded in large infantry or armor units. As such, the passing of the oldest branch of the service in its essential form, along with the soul of its tradition and ritual marked the end of an era. Because of his love for the mounted cavalry, COL Nye became a renowned expert in the history of the horse in the United States military, with special focus on the Indian Wars. When a horse cemetery was uncovered at the site of the Battle of the Little Big Horn in Montana, COL Nye was dispatched to study the bones and lend his interpretation to our understanding of the 7th Cavalry and Custer's defeat.

COL Nye, upon his retirement, became a professor of pathology at Colorado State University's School of Veterinary Medicine and he died in 1975. While no longer standing, the original veterinary clinic at Fort Carson was named in his honor, and while not officially designated as such, the current veterinary center at Fort Carson is still associated with his name.

While those of us in the Veterinary Corps, as well as historical elements in the infantry, armored and airborne cavalry, still bear a nostalgic love for the horse in combat, it is unrealistic to fight the necessary and crucial evolution of our military in the adoption of the new. A horse requires forage, gallons upon gallons of water, and while their hearts are strong and their spirits stronger, they are flesh and blood. The horse still serves, although not in the same capacity. Mounted color guards are the stewards of their noble service. Caisson horses add solemn dignity to the procession in which we lay to rest our honored dead. Horses are used in medical research, such as vaccine development or the production of anti-toxin and anti-venom to protect the warfighter, and the Special Forces community still ride based on the mission.

As you travel the country, for duty or for pleasure, I challenge you to revisit our history and pay homage to the contribution of the horse in military service. Visit the F.E. Warren Air Force Base in Cheyenne, Wyoming or the Nebraska State Park of Fort Robinson and you will see the essence of the well-organized, geometrically symmetrical, architectural layout of these converted cavalry posts. Stables line the outer circle of the parade fields, and the plaster horse's head marking the historical veterinary hospitals are still in evidence.

Speak with your veterinary brothers and sisters in arms, as they have been and remain as the caretakers for the health and wellbeing of these and all animals in service, and highlight the crucial bond between Soldiers and horses.

For those of you who will have the privilege to witness the United States Army Mounted Color Guard in action at either Fort Carson or Fort Riley, pay special attention to these Soldiers, whose honorable service represents the dignity, heraldry and the essence of the partnership between cavalryman and their essential equine partners. They are the window into our past and through them, you may be able to imagine the thunder and glory of a cavalry charge.

Sources

Elizabeth A. Lawrence, VMD, PhD. "Twilight of the Cavalry: Colonel E.L. Nye Remembered," paper at the 1988 American Veterinary Historical Society meeting.

Elwood Nye, "Marching with Custer," *Army Veterinary Bulletin* 35/2 (April 1941), 114-140.

Marching Onto the Global Stage-Julia Stimson and the Army Nurse Corps

Paula Ussery, AMEDD Museum

One of the most prominent nursing leaders in the early history of the Army Nurse Corps was Julia Stimson. Described as energetic, passionate, determined and a commanding presence, she was born into a distinguished family oriented to public service. Her father, Reverend Henry A. Stimson, believed his daughters, not only his sons, should be well educated. She graduated from Brearley (Girls) School that had been established to provide young women with an education equal to that received by young men. Vassar admitted her at age sixteen due to her intelligence and academic ability, and she graduated in 1901. Higher education was a rarity for young women at that time with only 2% of American women attending college. After graduation, she struggled to find a career. Her parents objected to her desire to enter medical school. However, the traditional Victorian woman's world of home, church, and family was not a sufficient challenge and she took a course in medical illustration at Cornell University Medical College. She was also awarded a scholarship for graduate study in biology at Columbia University. Her career in nursing began after she was hospitalized for a chronic skin condition in 1903. She entered the New York Hospital Training School in 1904 and in spite of the stress of long hours in class and on the wards and a flare up in her skin condition Julia graduated in 1908.

She began her professional career at an opportune time as nursing was transitioning into a profession that demanded a dedicated education and an advanced skill set. This transition in nursing went hand-in-hand with the scientific revolution occurring in medicine during the late 19th and early 20th Centuries. Stimson's first professional appointment was as Superintendent of Nurses at Harlem Hospital in New York. While there, she introduced the idea of medical social work to the hospital. In 1911, she accepted a position as the head of Medical Social Service at Children's Hospital in St. Louis, MO. There Stimson created a coalition of professional staff, financial supporters, and volunteers that dramatically expanded the department. In four years, social work expanded from four to thirty personnel, the budget increased from \$1,500 to \$10,000 per year. She also battled the general manager of the hospital kept the hospital storerooms locked thereby preventing the nurses from accessing needed supplies, and who ordered her to accept an unqualified candidate.

With America's entry into WWI in April 1917, Stimson began the second part of her career, one that would give her international recognition. In 1916 the American Red Cross began organizing reserve hospitals across the United States. One of these hospitals, Base Hospital 21, was organized from the faculty and staff of Washington University School of Medicine in St. Louis. It was one of the first reserve hospitals mobilized and Julia Stimson was the Chief Nurse.

Stimson's organizational skill was immediately apparent after the unit arrived in France. "Julia is as usual ... running her department in a splendid way. The nurses have a fine spirit and are very happy ... under conditions which are not adapted to women..." wrote one of the Medical Corps officers. Stimson herself was enormously proud of the nurses:

They are working terribly hard, sleeping with helmets over their faces ... washing in the water they had in their hot-water bags because water is so scarce, operating fourteen hours at a stretch ... wearing men's ordnance socks under



Miss Stimson receiving the Distinguished Service Medal from GEN John Pershing, 1918.

their stockings, trying to keep their feet warm in the frosty operating rooms at night, and both seeing and doing such surgical work as they never in their wildest days dreamed of, but all the time unafraid and unconcerned with the whistling, banging shells exploding around them. Oh, they are fine! One need never tell me that women can't do as much, stand as much, and be as brave as men.

Due to her administrative skills, she was appointed Chief Nurse of the American Red Cross in France in April 1918. She began a series of inspection trips of facilities throughout the combat zone. This raised nurses' morale and lent authority to her interventions on behalf of the nurses. Stimson organized a uniform and equipment bureau to supply the deployed nurses with clothing to survive the harsh working and living conditions. Seven months later the Army appointed her Chief Nurse of the American Expeditionary Force, and she became responsible for the 10,000 Army nurses overseas. Her appointment came as the fighting ended and she dealt with a variety of issues relating to the demobilization of the reserve Army Nurses and their return to the United States. She also handled disciplinary problems that occur at the end of hostilities while military personnel are awaiting their return and discharge. For her wartime service, the United States government awarded Stimson the Distinguished Service Medal. Other nations acknowledged her contributions as well. She was awarded the British Royal Red Cross, 1st Class; the French Medaille de la Reconnaissance Francaise; the Medaille d'Honneur de l'Hygiene Publique; and the International Red Cross Florence Nightingale Medal.

In 1919, Stimson was selected to be Superintendent of the Army Nurse Corps and dean of the Army School of Nursing that was created due to the shortage of nurses during World War I. She guided the school for 12 years. It offered women a three-year nursing education, with classes in microbiology, oral hygiene, ophthalmology, chemistry, diet, public sanitation, surgery, anesthesia, dermatology, and orthopedic surgery. It closed in 1931 due to the Great Depression; 937 young women graduated. Among the future leaders of the Army Nurse Corps were graduates Mary G. Phillips, Ruby Bryant, Virginia Henderson, and Mabel Stott.

She wrote a message to each graduating class. In 1928 she wrote of team work:

... I want to impress upon you at the very beginning of your careers the necessity of co-operation, of organization, of pooling resources, whether of information or equipment, not because of the good that will accrue to you ... by so doing, but most important of all, to the public. You cannot be a successful public servant alone. You cannot render to the community the service ... which will bring the greatest good to the greatest number, alone.

She served as Superintendent of the Army Nurse Corps until 1937. During her tenure as Superintendent, Congress authorized Army nurses relative rank, educational benefits, increased baggage allowances, the right to purchase military insurance and the privilege of membership in the (formerly) all male officers' clubs. Stimson procured an increase in pay, a retirement plan based upon the number of years in service, and pensions for nurses disabled due to their service. Julia Stimson received the rank of major, the only female in the Army with that rank.

She retired after twenty years with the Army Nurse Corps, but retirement did not end her service to her country or her profession. She was elected President of the American Nurses' Association in 1938 and she remained President until 1944, retiring at age 63. During WWII she returned to the Army Nurse Corps to recruit nurses for this second global conflict. In 1948, just weeks before her death, she was promoted to the rank of colonel.



Stimson's oak leaves were personally engraved.

The 2017 Spurgeon Neel Award

The Army Medical Department Museum Foundation is pleased to sponsor the 2017 Spurgeon Neel Annual Award competition for the article of 5000 words or less that best exemplifies the history, legacy, and traditions of the Army Medical Department.

Named in honor of Major General (Retired) Spurgeon H. Neel, first Commanding General of Health Services Command (now U.S. Army Medical Command), the award competition is open to all federal employees, military and civilian, as well as non-governmental civilian authors who submit manuscripts for publishing consideration.

The AMEDD Museum Foundation will present a special medallion award and a \$1000 monetary prize to the winner, who will be notified in advance, at a Foundation-sponsored event early in 2018.

All manuscripts must be submitted to the AMEDD Museum Foundation, amedd.foundation@att.net, by 30 September 2017. At the time of submission, a manuscript must be original work and not pending publication in any other periodical. It must conform to the Writing and Submission Guidance of the AMEDD Journal, and must relate to the history, legacy and/or traditions of the Army Medical Department. Manuscripts will be reviewed and evaluated by a six-member committee appointed by the President of the AMEDD Museum Foundation. The winning manuscript will be selected no later than December 2017.

Additional detail concerning the Spurgeon Neel Annual Award may be obtained by contacting Mrs. Sue McMasters at the AMEDD Museum Foundation, 210-226-0265.

was listened to by staff from the Pritzker Military Museum and Library and NPR, and they subsequently contacted us because they wanted the slides to support the audio podcast. So please listen and learn about Army Nurses in World War I.

Our mission is to educate, inspire, and promote esprit de corps in AMEDD soldiers, DA civilians, and the public, by telling the story of Army Medicine. On May 1st, ACHH is changing parent organization from Headquarters MEDCOM to the Army Medical Department Center and School, US Army Health Readiness Center of Excellence. When a young man or woman enters the AMEDD at Fort Sam Houston, they do more than just put on a uniform; they take on the history and legacy of previous AMEDD Soldiers and need to know that history. So I believe this is a good fit for ACHH with our mission, and that we'll reach new AMEDD Soldiers with our history.

If you come to Fort Sam Houston after May 1, 2017 please stop in at the AMEDD Museum and see the new exhibit on Army Medicine in World War I, the staff worked hard on this exhibit and it should be very informative!

Finally, if you want to read back issues of the *AMEDD Historian*, you can find them at <http://history.amedd.army.mil/newsletters.html>. I look forward to your comments and articles for submission. Please send suggestions about how we can make your history newsletter even better!

Bob Driscoll
Chief, ACHH

Did you deploy to Iraq or Afghanistan?

Did your unit write a history of their deployment?

Let us know!



If your unit printed it themselves, we have no idea about the book, and we'd like to get a copy for our research collection.



Writing for *The AMEDD Historian*

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

Photos of historical interest, with an explanatory caption

Photos of artifacts, with an explanation

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

Articles of varying length (500 word minimum), with sources listed if not footnotes/endnotes

Book reviews and news of books about AMEDD history

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

Please contact us about technical specifications.

The opinions expressed in *The AMEDD Historian* are those of the authors, not the Department of Defense or its constituent elements. The bulletin's contents do not necessarily reflect official Army positions and do not supersede information in other official Army publications or Army regulations.

AMEDD Center of History and Heritage

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