The AMEDD Historian

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Contents

Welcome to issue #33 of the AMEDD Historian Newsletter! As with all of our editions (available at https://history.amedd.army.mil/newsletters.html) we aim to provide interesting stories and events from the history of the AMEDD. Some issues are concentrated on conflicts and various themes, while others are focused on biographical material or historical objects.

Our goal is to inform the reader and gain interest in the history of the Army Medical Department. Historical events also provide examples for leaders to note previous trends. We also welcome contributions from our readers and we would like to hear your comments!

In addition to this publication, please visit our websites with attached social media feeds:

History: http://history.amedd.army.mil/

The AMEDD Regiment: http://ameddregiment.amedd.army.mil/

The AMEDD Museum: http://ameddmuseum.amedd.army.mil/index.html
These websites serve as great resources for the history of Army Medicine. Peruse our documents online, exploring valorous awards and medical advances as well as interesting biographical information.

The Medical Field Service School

Lewis Barger, ACHH

The medical department has for some years realized the need for something in the nature of a field service school, a place in which medical department officers could be taught practically and early in their careers the elements of the military side of their work. It was recognized that early teaching of that kind would hasten the officer's adjustment to his new and peculiar work, would save him much embarrassment and many hard knocks that necessarily attend learning merely through mistakes and experience, and would the sooner fit him into his place as a part of the military machine and make him a smoothly functioning part.

– Annual Report of the Surgeon General to the Secretary of War, 1922

One of the lessons learned from the First World War was the necessity of training all officers for field service. The American Expeditionary Force had established an extensive school system in France to ensure company through division officers were trained to perform the tasks expected of them in combat. The need largely stemmed from the rapid expansion of the Army: from an active force of 127,500 in April 1917 to 3.7 million men by November 1918. Men who had never served before were made company, battalion, and regimental officers. Officers who had been serving on active duty or in the National Guard found themselves promoted to greater positions of authority. Training camps in the U.S. prepared units for deployment and schools in France continued and expanded on training begun in the United States.

Before the World War the Army Service Schools at Fort Leavenworth provided advanced training to some, but not all officers. Some officer branches that required technical training had their own schools (Field Artillery School of Application, 1824; School of Cavalry Practice, 1836; Engineer School of Application, 1866) and most officers received their initial tactical training attending the U.S. Military Academy (1802), but it wasn't until 1881 that the Infantry and Cavalry school at Fort Leavenworth opened to provide advanced training in tactics. By 1915 both the number of schools and the types of training at Fort Leavenworth had increased substantially. The collection of schools that made up The Army Service Schools at Fort Leavenworth included: The Army School of the Line; The Army Staff College; The Army Signal School; The Army Field Engineer School; The Field Service School for Medical Officers (including Correspondence Course); and The Special Class for Field Officers.

Special Service Schools authorized by WD GO no. 112, 25 Sep 1919.
The Infantry
The Cavalry
The Field Artillery
The Coast Artillery
The Engineer Corps
The Signal Service
The Air Service
The Tank Corps
The Ordnance Department
The Medical Department
The Motor Transport Corps
Such other special service schools as may be hereafter authorized.

On September 25, 1919 the War Department issued General Order No. 112, Military Education in the Army, which specified a system of instruction in the Army and authorized schools for officers to teach basic and advanced courses. The intent was schools which would ensure officers were properly trained to perform their duties during wartime. An additional consideration was that reserve component officers were being commissioned during peacetime who were not graduates of the military academy. The Militia Act of 1903 had formalized the status of the National Guard and the conditions under which it could be federalized. The National Defense Act of 1916 created the Reserve Officer Training Corps, as well as officer and enlisted reserve corps for the Army. Per General Order no. 112, the new schools would train officers shortly after commissioning, providing "systematic and progressive courses of instruction and training that will prepare each officer to perform the highest duties of command and staff commensurate with his ability." Although not specified in the order, the schools also provided a focal point for training reserve component officers.

Basic and advanced courses were specified for "systematic and progressive courses." The Basic Course, as outlined in the general order, could be as long as one year, and should precede any officer's first assignment. Subjects for instruction included:

> *Administration, military courtesy, customs of the service, interior guard duty, military law, military sketching and map reading, military hygiene and first aid, equitation, hipplogy* [care of horses]*, nomenclature and use of the pistol, saber manual, and so much of Field Service Regulations and Rules of Land Warfare as is necessary for officers of junior grades, training methods and principles of teaching, and such tactical and technical training in the particular arm as may be necessary.*

Subjects to be taught at the advanced course were not specified. Aside from prohibiting duplication of the subjects taught at the Leavenworth schools, branches could determine for themselves how best to build on the instruction in the basic course to adequately prepare their officers for the duties that would be expected of them as they advanced in rank, experience, and responsibility.

Surgeon General George Sternberg had been granted authority to establish the Army Medical School in 1893 in order to provide doctors joining the medical department with a post-graduate education in military medicine. There doctors attended classes in bacteriology, laboratory skills, microscopy, roentgenology (X-ray), and other classes that not all medical schools at that time taught. They learned about diseases soldiers might encounter during overseas service and how to diagnose and treat them. They also took some time to learn about service in the field. The Company of Instruction for enlisted men stationed at Washington Barracks (now Fort McNair) gave Army Medical School students the opportunity to practice handling troops, and cavalry officers from Fort Myer gave students weekly instruction in equitation. The primary purpose of the school, though, was to take doctors and turn them into specialists in military medicine.

Thirty-six years later, Surgeon General Merritte Ireland viewed General Order no. 112 as an opportunity to create a second school for the Medical Department that would better be able to accomplish what the department had tried with the Field Service School for Medical Officers at Fort Leavenworth before the World War. The school at Leavenworth had been hampered by its inability to detach officers from their assignments for an extended period of time in order to undergo training. Under the Army's new system of education all

officers would have the opportunity to attend training prior to their first assignment so they could achieve a level of proficiency in the duties they would be expected to perform. The Army Medical School had always been expected to teach medical subjects of importance to Army doctors. Other subjects, like administration, horsemanship, and troop leading had been shoehorned in out of necessity. Opening a second school that focused on preparing newly commissioned officers for the leadership, administrative, tactical, and technical aspects of their profession would complement the training at the Army Medical School while relieving that school of the necessity of training non-medical subjects.

The staff at the Surgeon General's Office considered the available options. Three training camps had opened in the United States in 1917 and 1918 to train newly inducted Medical Department officers and enlisted men at Fort Benjamin Harrison, Indiana, Fort Riley, Kansas, and Chickamauga National Military Park in Georgia. Camp Greenleaf, the facility at Chickamauga, had remained open longer than the other two and was Surgeon General Ireland's first choice, but it was not available. Staff examined other options, inquiring into the availability of Fort Bayard, New Mexico, Fort Benjamin Harrison, and Columbus Barracks, Ohio, but none of those sites were available either. Finally, they settled on a post that seemed well-suited for establishing a Field Service School for the Medical Department.

Ireland wrote to the Adjutant General on 28 April 1920 requesting that Carlisle Barracks, Pennsylvania, be permanently assigned to the Medical Department for use as a school, and that the location would be "perfectly suited to the Medical Department's needs." Carlisle Barracks was first established as a military post by the British in 1757 and was used for various purposes until 1879, when the War Department transferred the post to the Bureau of Indian Affairs for use as a school. The Carlisle Indian Industrial School operated from 1879 until the spring of 1918, when the school closed and the post was turned back over to the War Department for use as a General Hospital.

In 1918 Carlisle Barracks included 23 acres with 41 buildings: barracks, living quarters, the buildings of the former Carlisle Indian Industrial School, storehouses, and a physical plant along with 285 acres of adjacent farmland that was used to grow food for the hospital and included some livestock. Garrison facilities included officers' quarters, barracks for about 750 men, a mess hall, classrooms, a large auditorium, and an athletic facility.

General Hospital No. 31 opened in September 1918, but only saw a handful of shell shock (combat stress) patients until February 1919 when more patients began to arrive. Over the next few months General Hospital No. 31 cared for more than 4,000 patients, with a maximum inpatient census in August 1919 of 900 patients. With the war over, though, the number returning from overseas was diminishing. In mid-May, 1920, the Adjutant General wrote back to Surgeon General Ireland approving his request to open the Medical Department's newest school at Carlisle Barracks "upon the discontinuance of U.S. General Hospital No. 31."

COL Percy Ashburn. Courtesy National Library of Medicine

Six weeks later, on 30 June 1920, the Medical Department organization at Carlisle Barracks ceased to be called General Hospital No. 31 and began to be called first the Carlisle Service Medical School (June), then the Field Service School (July 13), the Medical Field Training School (July 15), and then back to the Field Service School, again. There were still about 400 patients admitted, the last of whom was not discharged until the end of September when the hospital closed in actuality. Finally, In November 1920 Surgeon General Ireland requested to name the institution The Medical Field Service School, Carlisle Barracks, Pennsylvania, which was approved.

For the first six weeks or so, the hospital commander, COL (later BG) Frank R. Keefer oversaw the administration of the post until COL Percy M. Ashburn arrived and began preparing Carlisle Barracks to serve as the Medical Field Service School. Despite Surgeon General Ireland's assertion that Carlisle Barracks was "perfectly suited," Ashburn had a great deal of work to do. The Indian School's classrooms were over forty years old and required upgrading. Ashburn needed staff to develop the curriculum, troops for the planned demonstration units to provide students with an introduction to the Medical Department's am-

bulance, treatment, and hospital units, and he needed officers to lead those troops. The hospital continued to operate independently and provided the post's medical care as well, but when the General Hospital closed in September, Ashburn would have to staff the post hospital as well. It was a daunting task made more so by post-war demobilization and an ongoing post-war occupation mission in Germany which created a manpower shortage. Budget cuts limited troop movements from one station to another, and left Ashburn scrambling to make the most of what he had: on 1 June 1921 students in the Army Medical School would graduate and travel to Carlisle Barracks to attend the first basic course.

On the 14th of July a tornado hit the post lifting tin roofs from hospital wards, tearing down electrical wires, crushing a house under a fallen tree, and taking most of the top floor off Building 17. Enlisted men found a 2x6 board embedded by the wind into a 5 inch square post. Two days later an oil heater exploded causing a small fire. In October a heavy rainstorm collapsed a coal shed. Ashburn, who had not particularly wanted this job, preferring medical and laboratory work to field work and tactics, must have felt like the elements themselves were conspiring to keep him from readying the school to receive its first class. Surgeon General Ireland hadn't picked Ashburn because of his personal preferences, though. Ireland picked Ashburn because he knew him to be an able organizer and administrator. Ashburn first came to prominence working with Charles F. Craig in the Philippines where, in 1907, CPT Ashburn and 1LT Craig co-authored *Experimental Investigations Regarding the Etiology of Dengue Fever*. Craig and Ashburn showed for the first time that dengue is transmitted to humans through mosquito bites. He authored textbooks, *Mosquito-borne Diseases* and *The Elements of Military Hygiene*, and before the war commanded Walter Reed General Hospital. During WWI he commanded one of the Medical Department's four major officer training sites at Ft Benjamin Harrison which provided him valuable experience organizing the personnel, materiel, and logistics necessary to operate a large training center.

One of Ashburn's and The Surgeon General's early priorities was creating a print plant for the school that could produce course materials. The printing press at Carlisle was unsuited for the quality and volume of work Ashburn anticipated and so in late August he requested the printing press at Lovell General Hospital (Fort Sheridan, IL). Surgeon General Ireland more than supported the request, relocating not just that press adding one from another hospital so Carlisle would be printing for four installations. Ireland wanted to create an enduring, organic printing capability for the Medical Department to produce not just school materials, but also general publications for the rest of the department. For the duration of its existence at Carlisle Barracks, the Medical Field Service School would also serve as the printing center for the AMEDD, producing manuals, regulations, and the *Army Medical Bulletin* for distribution to the force.

One of Ashburn's most pressing issues was manpower. Although General Hospital No. 31 had reflagged as the Medical Field Service School, its personnel were still busy caring for their inpatients. With the war over, most of wartime-only men were eager to return to civil life, but the Medical Department still had to treat the war's wounded and provide manpower for the occupation force in Europe, in addition to its pre-war responsibilities. Many of Ashburn's and his subordinates letters from late 1920 through early 1921 included pleas for junior officers and enlisted men to fill out the demonstration units for the post and serve as staff officers, and more senior officers for the teaching departments. Ashburn was personally involved in selecting officers for positions of responsibility, submitting lists of personnel he considered suitable for specific positions. The personnel officer who received them, COL Charles Reynolds, would succeed Ashburn as commandant of the MFSS before becoming The Surgeon General, and did what he could to accommodate Ashburn's requests. Not all positions could be filled, and Ashburn's desperation grew sufficiently that he requested warrant officers and MACs – Medical Administrative Corps officers, a recent addition to the AMEDD. MACs were, for the most part, former NCOs who had been commissioned to take some of the administrative burden from medical officers, so they would have more time to be doctors, researchers, and commanders.

To cover all duties from the post hospital, to instructional support staff, demonstration troops, and more, Ashburn had asked for 641 soldiers and NCOs. He had 260 on hand by the end of the school's first year of operation.

While Ashburn was overseeing many of the details required to ensure the school was equipped to begin instruction, the department heads oversaw instructional preparations. Five teaching departments were organized: Administration; Hygiene; Enlisted Training; Equipment and Transportation; and Military Art. Administration, and the aspects of hygiene related to field operations, were transferred from the Army Medical

School. The remainder followed in the tradition of classes developed for the Field Service School for Medical Officers at Fort Leavenworth, the WWI training camps, and the Army Sanitary School at Langres, France.

The faculty worked to create courses in each of the departments, focusing on distinct bodies of students who would attend the school. The main focus was on the basic course for Regular Army medical, dental, and veterinary officers. Once fully functioning, the Medical Field Service School would be their first stop, and the first step towards turning them into Army medical officers. Those who could not meet the requirements of basic course instruction would be thanked for their interest in serving and sent home. Those who met the requirements (the majority), would progress to the Army Medical School armed with an understanding of the AMEDD's role in the Army, the tactical employment of its formations, the care and training of soldiers, and the details of administration that would keep everything running smoothly. At the Army Medical School they would then receive practical instruction in the peculiarities of military medicine.

The school faculty was largely composed of Medical Corps officers, with some MAC officers teaching purely administrative classes. It also included a Senior Dental Representative and a Senior Veterinary Representative who ensured the curriculum contained appropriate dental and veterinary instruction, and also adapted curriculum for dental and veterinary students. All three corps were to be treated equally as they passed through the school, although it was also understood that the real focus was on training Medical Corps officers, the majority of AMEDD officers. COL Robert U. Patterson in the Surgeon General's Office made this clear in a message to the school:

> *The candidates for the three corps of officers in the Medical Department, as much as practicable, should be on a parity while [taking] their basic military training. Inasmuch as the duties of the future medical officers are the more important and they have and will always have the preponderance of numbers, it will be necessary and proper that their needs should be given the greatest weight in the curriculum at the Medical Field Service School.*

While it was clear that the Medical Corps was first among equals, genuine efforts were made to avoid segregation of the officers by branch. All officers received the same instruction and upon graduation, the same diplomas. Of course, this only extended to the three branches of practitioners. Nurses and Medical Administrative Corps officers were not eligible for attendance as students, although MACs assigned to the school who could demonstrate proficiency in the course material were permitted to receive diplomas. Writing again, Patterson was clear that this concession was only for those MAC officers on duty at the school. "The purpose of the Basic Course at the School is to qualify candidates for admission to the Medical, Dental, and Veterinary Corps, for their future duties as officers of the Army, including practical instruction in the tactical and field duties of all officers of the Medical Department."

The next course was the Basic Course for National Guard and Reserve Officers. While the Basic Course for Regular Army Officers was intended to last 4-1/2 months (later scaled back to 3-1/2 months) for National Guard and Reserve Officers it was condensed to six weeks. It was to focus on the duties of the medical officer in reserve component units, but would prove to be largely unsuccessful. The course was initially offered in the spring, and the first year (1922) it was planned for January-February and March-April, but fiscal restrictions meant only 12 could be ordered to the class, and so that course was consolidated with the March-April one. Even then, only 9 officers were actually able to leave their civilian practices for six weeks to attend. Results would be even worse the following year.

The third course of instruction was for ROTC summer camps, also getting a six week course. The school was not solely responsible for their instruction; a large part of the MFSS' role was providing training area and support while their professors of military history conducted training. The school did adapt its six week basic course for instruction of ROTC students as well, though. Classes like map reading, terrain sketching, drill, first aid, and field hygiene had universal application.

The final class that was planned was an Advanced Course as directed by War Department General Order 112. Because the Advanced Course was envisioned for later in an officer's career, planning the Advanced Course received little actual effort during the first year. When it was eventually offered several years later, it was essentially a reiteration of the material from the Basic Course and it would take several more years before the Advanced Course would evolve into a course that was both unique from the Basic Course and useful in content.

By May 1921 final preparations were underway for opening the school. Blank diplomas were produced. Classrooms were painted. Instructional materials were printed. Practical demonstration areas were pre-

pared. On the 27th of May, the first class of officers arrived at Carlisle. Nearly all had served overseas during the World War, and now, they had arrived at Carlisle not just to take the Basic Course, but to evaluate it and provide feedback. This pilot course was six weeks long, the nucleus of the course that would be provided to Regular, National Guard, and Reserve officers as well as cadets. Instructors would teach during the day and incorporate revisions based on feedback into the course after classes were finished because they only had two weeks between the end of the pilot course and the beginning of the first full 4-1/2 month Basic Course, beginning in August.

On the 1st of June, COL Ashburn stood before the class to give them their opening address. Ashburn acknowledged the class had been "shortened and condensed". He continued, perhaps reflecting on his own preference for laboratory work to administration,

> *This work will be, for the most part, on non-medical subjects, some of which are apt to be profoundly uninteresting to a man whose heart is all in being a doctor. But they are essential if he is to be able to use his medical knowledge to the best advantage in the Army…The function of this school is to fit this fine and important item [the doctor] into the military machine, to make the doctor a functioning member of the great team which constitutes the Army, and if we fail to make that adjustment, we fail as a school.*

Two weeks before the first class graduated the Quartermaster General sent a note to Ashburn informing him that the school's request for a coat of arms had been approved. The design incorporated the staff of Aesculapius, symbol of medicine, crossed over a downward pointing sword symbolizing the non-combatant status of the Medical Department. Above this were an open book, for study and learning, a hospital tent, for treatment, and a wheel, for mobility and evacuation. Below the shield was a scroll with the MFSS motto: To Conserve Fighting Strength. Those four words describe succinctly both the mission of the AMEDD and of the school. It is the Medical Department's mission to maximize the Army's combat power, conserving fighting strength, through force health protection and rapid return to duty of the sick and lightly injured. The school's mission was to prepare medical department officers for this work.

Coat of Arms of the Medical Field Service School, approved 1 July 1921.
Courtesy National Library of Medicine

One hundred years ago this May the first officers reported to the Medical Field Service School to attend the Basic Course, beginning a continuous program of instruction that continues with today's Basic Officer Leader Course (BOLC). Over the last century the school has moved from Carlisle Barracks to Fort Sam Houston, and the institution has evolved from the Medical Field Service School, through the Academy of Health Sciences, the AMEDD Center and School, Health Readiness Center of Excellence, and today's Medical Center of Excellence. It will doubtless continue to evolve, but the school's motto remains relevant today as it was one hundred years ago: To Conserve Fighting Strength.

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The AMEDD in Operation Desert Shield/Desert Storm

On Saddam Hussein's orders Iraqi forces invaded Kuwait on 2 August 1991. On 8 August, the first U.S. soldiers landed in Saudi Arabia, at first to defend America's long-time ally as Operation Desert Shield. When months of diplomacy failed, the operation shifted to liberating Kuwait by force, Operation Desert Storm.

The first AMEDD soldiers deployed with the first lift of the 82d Airborne, but the Armed Forces Medical Intelligence Center already had information on endemic diseases. In the next two months, XVIII Airborne Corps deployed two light and two heavy divisions, an armored cavalry regiment, and support troops – over 120,000 soldiers, plus troops from the other services and coalition allies.

One corps could defend Saudi Arabia, but more troops were needed to liberate Kuwait. VII Corps deployed from Europe, bringing more medical units – one medevac unit even flew from Germany. Reservists were mobilized, starting two weeks after American troops arrived in Saudi Arabia, both deploying and back-filling TDA hospitals. Reserve mobilization stepped up in January 1992 when President George H.W. Bush authorized the call-up of up to one million National Guardsmen and Reservists for up to two years. Ultimately just over half the AMEDD soldiers deployed to the Gulf were reservists.

The medical support was robust for several factors. Since Iraq could mobilize over 1 million soldiers, a large friendly force was needed. Army doctrine was designed for fighting the Soviet Union, a 'World War III' that would have generated many casualties. And Iraq was known to have weapons of mass destruction, which could generate large numbers of casualties; some predictions were for 2,000 per day. Thus 196 Army medical units, with over 50,000 soldiers, deployed. This included 44 hospitals with almost 14,000 beds from all components. The Navy and Air Force had more beds, and Saudi Arabia provided 9,000 beds that were staffed with American personnel. In addition, there were 5,500 beds staffed in Europe, and military and VA hospitals in the US were preparing for casualties. While preparing to fight a major war, the AMEDD still had to care for dependents and retirees.

Air, artillery, and missile attacks started on 17 January, and the ground assault on 24 February. The ground campaign would only last 100 hours, ending at 0801 28 February. American forces had only 467 wounded, and 293 dead; almost half the fatalities were non-battle. Redeployment began on 17 March, but much medical work remained to be done. Due to concerns about Iraqi chemical and biological weapons, drugs and vaccines were fielded although they were still being tested, and the services had trouble documenting what was administered to whom. There were also questions about environmental hazards to which personnel were exposed – ranging from air pollution to depleted uranium – which were poorly documented. When servicemembers began reporting a range of symptoms, there was no way to know what they had experienced. These issues led to development of Post-Deployment Health Assessments.

The large deployment also led to changes. If patients could be flown back to the US, it would allow a far smaller footprint in theater. This was a joint concern, since the Air Force would have to fly the patients. Technological solutions were tried, such as the Life Support for Trauma and Transport litter that was close to a portable intensive care bed, but eventually the solution was new units such as the Air Force's Critical Care Air Transport Team. Hospitals, even MASHs, had mobility problems in the Gulf, adding impetus to developing Forward Surgical Teams. Other systems were also changed in the continuing effort to prevent injury and disease, and provide the best medical care in harsh environments.

An M577 Armored Treatment Vehicle of 3d Squadron, 3d Armored Cavalry Regiment in Saudi Arabia during Desert Shield. Previously unpublished photograph, courtesy of Lewis Barger.

AMEDD Civilians, Centuries of support
By Nolan A. (Andy) Watson

On March 26, 2021 the AMEDD Civilian Corps turned 25. This anniversary recognizes service that dates back much earlier. Long before the AMEDD Civilian Corps (1996) and Army Civilian Corps (2006) were officially recognized, civilians were providing medical support to the Army, in fact from the very beginning of the Army in 1775. In the first few decades of the Army's existence, virtually all medical functions were provided by civilians, as contract surgeons, hospital stewards, cooks, laundry, and supply personnel.

In the early 1800s the medical profession advanced in knowledge and military status. In 1818 Congress approved a permanent Medical Department for the Army. However, the reliance on contract surgeons and supporting personnel continued because of limited numbers of military surgeons. Medical officers would not receive military rank until 1847 during the War with Mexico.

Even with the exponential growth of the Army during the Civil War there were not enough uniformed personnel, and use of medical civilians expanded. Dr. Mary Walker, a contract surgeon and the only female recipient of the Medal of Honor, was the most notable.

After the war, the Army dramatically decreased in numbers, but civilians were still hired to provide medical support. In remote locations, finding medical expertise for the Army could be challenging. Reliance on medical personnel not in uniform throughout the late 1800s continued through the Spanish-American War (1898) and war in the Philippines (1899-1913). Formerly recognized as contractors or by civilian titles, more medical specialties became part of the AMEDD in the early 1900s. The Army Nurse Corps became official in 1901, the Army Dental Corps in 1911, and the Army Veterinary Corps in 1916.

During and after World War I, the large numbers of wounded service members needing long term care greatly increased. This led to another civilian specialty included within the AMEDD, Reconstruction Aide. Serving in the United States and overseas the two categories of aides were physiotherapy and occupational therapy. Approximately 800 Reconstruction Aides were employed by the Army during World War I.

As is the pattern after wars, the numbers of AMEDD uniformed and civilian personnel decreased after World War I. By 1922 the Surgeon General's Office consisted of 33 soldiers and 120 civilians. Although not previously mentioned, the clerical, correspondence, and supply needs of the AMEDD led to growth for employment in those positions.

Although reliance upon medical civilian employees increased during World War II, at first they were not viewed as full replacements, and there were limitations on their use. Restrictions on civilian labor were relaxed as U.S. deployed more medical units overseas. At peak strength, there were approximately 150,000 AMEDD civilians serving in America and overseas, with local nationals contributing to the numbers. Their jobs ranged from numerous hospital positions and laboratory tasks to supporting positions such as switchboard operators and security personnel.

Due to the lack of dietitians, physical therapists, and occupational therapists to meet the needs of the Army during World War II, the Army initiated a War Emergency Course to train additional personnel. All civilians would be under Civil Service oversight and the training for occupational therapists was organized into a four month academic component followed by an eight month clinical component.

After World War II the subsequent drawdown was large, but the

A civilian employee at the San Francisco Medical Depot wearing a locally-encouraged uniform, 1943. Stripes were given for each six months of service. Army Medical Department Bulletin.

Cold War soon caused an expansion. The larger "peace time" force and a new major requirement of dependent care, compelled AMEDD leaders to employ more personnel. Over the following decades thousands of contract and civil service employees worked for the AMEDD. Their specialties varied in scope and complexity, and even included historians. Some wartime veterans continued serving, as Dr. Michael DeBakey did in editing several volumes of the WWII clinical histories.

Chief of Staff GEN Dwight Eisenhower about to receive treatment from a civilian dental hygienist, Walter Reed General Hospital, c.1946.
U.S. Army photo.

AMEDD Civilian Corps

Despite the numbers and years of support, recognition as an AMEDD Civilian Corps took time. When the Department of the Army implemented a civilian personnel proponency plan in 1991, the Surgeon General was designated as the civilian personnel proponent for health care occupations. The Surgeon General, in turn, relied on the HSC (Health Services Command) Civilian Personnel Director to oversee lifecycle management of AMEDD civilians. As early as 1988 the term "Civilian Corps Chief" was used informally within the Medical Department to refer to the HSC Civilian Personnel Director, but the title was merely colloquial and never documented in written orders.

The legitimacy of the Civilian Corps Chief title received a boost when Surgeon General Ronald R. Blanck recognized the position in 1996. It is due to the Surgeon General's public recognition of the Corps Chief that we now celebrate 26 March 1996 as the founding date of the AMEDD Civilian Corps.

AMEDD civilians have served proudly alongside uniformed service members to provide the best possible medical care and support to the Army. Over the course of more than two centuries they have become trusted partners and colleagues in the AMEDD.

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CPT Orrin Crankshaw, MC: South Pacific to Battle of the Bulge

John McParland

U.S. Army Medical Corps Captain Orrin F. Crankshaw died at the age of 34 when the jeep he was traveling in hit a land mine in Germany on February 23, 1945. He had just established a front line aid station for the 69th Tank Battalion of the 6th Armored Division near the village of Dasburg on the German-Luxembourg border. He and the two soldiers who accompanied him were killed instantly. Over 12 million American men served in the U.S. Army during WWII. Every soldier's service and story is unique. Captain Crankshaw's remarkable journey took him to the fetid jungles of Guadalcanal, across France during the Normandy breakout, ending in the frozen foxholes of the Battle of the Bulge.

The journey that took him to two battle fronts began in Lyndhurst, NJ on Christmas Eve, 1910 when Alfred and Johanetta Crankshaw welcomed their first son into the world. Orrin Fluhr Crankshaw joined five older sisters and in 1914 a second brother was born. Orrin graduated from Rutherford High School, Dartmouth College, Cornell Medical School and was an instructor at Yale Medical School before joining the staff at Overlook Hospital in Summit, NJ and becoming Staff Physician at Bell Labs. He was a published researcher; "Chloride depletion in conditions other than Addison's Disease" appeared in the *Journal of Clinical Investigations*. On July 2, 1938, Orrin married Miss Adeline Mair. Shortly thereafter, the newlyweds moved from Connecticut back to New Jersey, where Orrin established a private practice in Summit, joined the staff at Overlook Hospital, and became the staff physician at Bell Labs in Murray Hill, NJ.

1LT Crankshaw leaving his job on being called up. All images courtesy of the author.

In September of 1940, Europe had been engulfed in war for one year. Though officially neutral, the United States was supporting Britain with equipment, armaments, and supplies. The Roosevelt Administration built up the U.S. military, including re-establishing the Selective Service. Orrin did not wait to be "drafted;" along with thousands of others in the medical profession he answered the call to service. Entire units were formed with cadres made up of doctors and nurses from individual hospitals and medical schools from across the country. One such unit was the 39th General Hospital, also known as the Yale Hospital Unit. Dr. Crankshaw was one of 48 physicians, 7 dentists, and 103 nurses from the Yale community that reported for duty in July 1942 at Camp Edwards, Massachusetts. After training, the Yale Unit embarked from San Francisco on November 2, 1942 with a final destination of Auckland, New Zealand where the 39th General Hospital was established. Orrin's time with his Yale colleagues was short – in December he was transferred to the 101st Medical Regiment of 23d "Americal" Infantry Division, recently arrived on Guadalcanal in the Solomon Island chain.

Guadalcanal was the scene of the first major American ground offensive of the Pacific War. The Americal Division and the 25th Division began arriving in the fall of 1942 to relieve the 1st Marine Division which had landed in August and had fought a fierce campaign against the Japanese. When the Army units arrived they faced a weakened but still potent Japanese enemy who would continue their bloody defense until their last strongholds were eliminated in February of 1943. Located nearly 10,000 miles from Lyndhurst and just 650 miles south of the Equator, Guadalcanal is a 2000 square mile tropical island covered in dense jungle with a mountainous interior. Conditions on "the Canal" were insufferable - heat, humidity, and frequent driving rain made for an unholy alliance of mud and mosquitoes. For American units there the numbers of soldiers who died of disease was nearly as high as those who were killed in action. Battle casualty statistics told only a part of the story of what the doctors and medics of the 101st Medical Regiment had to deal with; nearly 65% of casualties on Guadalcanal

CPT Crankshaw in the U.S. with his brother 2LT Allan Crankshaw, USMC.

were from disease and 25% wounded. The main culprit was malaria, followed by gastroenteritis. In this morass Doctor Crankshaw and his comrades tended to the wounded and sick of the Americal Division. Roads were almost non-existent, while those that had been carved out of the jungle were virtually impassable with mud after the frequent rains. The 101st's medics and corpsman improvised – devising pulley systems to lower stretcher bound wounded men down steep ravines and utilizing small boats to ferry casualties back to aid stations on the many rivers and streams on the island. At some point, Crankshaw contracted malaria and was sent back to the U.S. After recovery, he was assigned to the 6th Armored Division.

The "Super Sixth" arrived in Liverpool on February 25, 1944, part of the buildup of troops, equipment, planes, tanks, fuel, and ammunition for Operation Overlord – the invasion of Nazi occupied France. After beachheads had been established on the Normandy coast, the Allies poured men and material across the English Channel at a furious pace. The 6th Armored Division landed on Utah Beach on July 18, 1944 (D+42) and became one of the key units of the recently activated 3d Army, commanded by General George S. Patton. Strong German resistance combined with the patchwork of hedgerows in the Normandy countryside kept the Allies bottled up near the invasion beaches for all of June and most of July. When the breakout from Normandy finally started with the success of Operation Cobra, the Allied armies began a mad dash across France in pursuit of the retreating Germans. On July 30th Orrin found himself speaking to an A.P. reporter in the seaside village of Lingreville, remarking on the high number of surrendering Germans: "They just got 15 or 20 prisoners down the road. Hell, that was a month's supply on Guadalcanal."

CPT Crankshaw's medals.

After capturing the port of Brest in Brittany, the 6th Armored moved across France to join the fight against the regrouped German forces in the area of Moselle. Captain Crankshaw was the Battalion Surgeon for the 69th Tank Battalion. The 69th was one of the armored "fists" of the Super Sixth along with the 15th and 68th Tank Battalions. Each battalion fielded 53 "Sherman" medium tanks and 17 "Stuart" light tanks, and the Medical Detachment's main role was "to provide close medical support." The Battalion Surgeon was in charge of a relatively small contingent of men. A former battalion surgeon described the role: it "combines the skills of auto mechanic, chaplain, platoon leader, engineer, military policeman and doctor." It was also a dangerous assignment; a least 60 battalion surgeons were killed or died of wounds including 14 assigned to armored divisions. Captain Crankshaw had a Medical Administrative Corps (MAC) officer and 18 enlisted men. Equipped with one ¾-ton truck and trailer, and four jeeps which could carry stretchers and act as ambulances, the medical detachment followed just behind the tanks and armored vehicles in the line of march and during attacks. The battalion surgeon would tend to the more seriously wounded, while the MAC or the medics would handle the minor cases. They had to do their job quickly and with skill, often under fire. Their goal was to stabilize the wounded either in the field or at the Battalion Aid Station and then get them to a Division Clearing Station for further treatment. Crankshaw's role would include close coordination with the divisional medical unit, the 76th Armored Medical Battalion, as well as with the staff within the 69th Tank Battalion. Captain Crankshaw was a hands-on leader. He received the Bronze Star in October 1944, and the citation reads in part: "he operated personally with the advance guard, travelling in an open vehicle in a column of armored vehicles. On numerous occasions, he braved small arms and mortar fire to treat injured men on the spot. His courage and devotion to duty were undoubtedly responsible for saving the lives of many wounded men."

On November 11, 1944, the division was attacking to secure a bridgehead across the Nied River, a tributary of the Moselle. Soldiers of Combat Command A found the wooden bridge at the tiny village of Han-Sur-Nied intact and quickly stormed across with two Sherman tanks and infantry before the Germans could detonate the explosive charges that had been rigged underneath the bridge. After the wires were cut, the threat of immediate destruction was removed, but the threat from the German defenders was far from over – they repeatedly shelled the bridge and peppered it with thousands of rounds of small-arms fire. The struggle to hold the bridgehead continued into the next day. It was on November 12, 1944 that Captain Orrin Crankshaw earned the Silver Star Medal. The citation reads: "For gallantry in action in the vicinity of Han-sur-Nied,

France on 12 November 1944. As Battalion Surgeon, he crossed the Nied Francaise River numerous times to enter the town and treat and evacuate wounded men from the point of the task force. Rather than send his regular litter crews through the intense fire, he would personally cross the bridge, a target for enemy artillery and mortar fire, and provide medical aid. His brave leadership and gallantry were an inspiration not only to the men of the Medical detachment but also to the line officers and enlisted men of the Battalion, and reflect the highest credit upon himself and the Medical Corps".

On December 16, 1944, three German armies with over 400,000 men and 1000 tanks and armored vehicles attacked the four American divisions holding a thin front line in Belgium's Ardennes Forest. Their objective was to dash to the North Sea to capture the strategic port of Antwerp and isolate the bulk of the Allied armies in Northwest Europe. Complete surprise and overwhelming local advantage in men and equipment led to early German victories that created a deep bulge in the Allied front lines giving rise to the well-known nickname, "the Battle of the Bulge." Reserve American units were rushed forward to bolster the reeling defenders and blunt the German offensive to avert a total collapse. The 101st Airborne Division was trucked to the strategic crossroads town of Bastogne Belgium and joined units already defending the town. On December 20, 1944, elements of the advancing German armored divisions surrounded and laid siege to Bastogne. Bastogne was relieved on December 27th by tank units from General Patton's 3d Army, but there were still strong German forces in the area that continued to attack tenaciously. The Sixth Armored Division joined the fray and helped to push back German armor and infantry across the Our River by late January, 1945.

Conditions for the fighting men during the Battle of the Bulge were horrific. On top of artillery and aerial bombardment, machine gun and rifle fire, the soldiers and medics had to contend with ice, snow and sub-zero temperatures. The winter of 1944-45 was one of the coldest on record in Belgium. In addition to wounds received in battle, many men were put out of action by trench foot, frostbite, illness, and combat fatigue. The casualty statistics for the Sixth Armored Division from July, 18, 1944 until May 8, 1945 are startling. Against a normal manpower strength of 12,366 men, the division suffered 813 killed in action, 5,704 wounded in battle and 10,696 non battle casualties. Tank, artillery, and mortar fire by far caused the most damage. 55% of the wounded were injured by shell fragments, while the top non-battle casualties were diseases 956%) and neuropsychiatric (19.4%). Today it would be classified as combat/operational stress, but in WWII the common name was battle fatigue. 9.4% of the non-battle injuries were due to trench foot and frostbite.

Near Boevange, Luxembourg, on January 27, 1945, Orrin wrote a long letter to his sister Jean, thanking her for a parcel of goodies that included cookies and soap: "If I ever get to take a bath or shower again I shall use a cake of the soap you sent… and smell like a veritable pine forest." He reveals that he had just changed his underwear for the first time in three weeks and had not had a shower or bath since the week before Christmas. That corresponds to the German offensive and gives an indication of the long hours and challenging conditions he worked in for almost a month and a half. He also references a "dirty trick" that one of those "stinking Germans played on me," resulting in a "ruptured ear drum" and a "Purple Heart to add to my ribbons." This undoubtedly refers to an incident in December 1944 that was reported in the *New York Herald Tribune:* "Captain Crankshaw received the Purple Heart in January after he was wounded when the jeep he was riding in struck a German mine" and that "he continued his duties, despite severe injuries."

Less than a month later, Crankshaw's jeep struck a land mine near Dasburg Germany. He was not so lucky this time. The letters sent to his wife and family by comrades afterwards sought to reassure them that he was "killed instantly" and that "he and his companions knew no suffering." The letter to his sister Ruth, sent by Lt. Colonel Chester Kennedy (CO of the 69th Tank Battalion) reads: "throughout his service he proved himself a wonderful leader and officer. The men in his battalion trusted his ability and decisions completely. The medical skill of your brother saved the lives of many, many allied personnel as well as those of the enemy". The CO of the 76th Armored Medical Battalion and Division Surgeon, Lt. Colonel James Branch, wrote to Adeline Crankshaw that he was "personally grieved at the loss of a friend and an excellent Medical Officer." Branch lauded Orrin: "His personal courage was almost legendary" and "In large measure he epitomized the ideal Battalion Surgeon."

Captain Crankshaw's body was buried at U.S. Military Cemetery Number 1, Foy, Belgium on February 26, 1945. His widow Adeline submitted the necessary forms to have her husband's remains returned to the United States. Orrin Fluhr Crankshaw, Captain, United States Army Medical Corps, recipient of the Silver Star, Legion of Merit, Croix de Guerre, Bronze Star, and two Purple Hearts, was buried with full military honors at Arlington National Cemetery on April 13, 1949. He is memorialized in three New Jersey towns, one

county, and at Dartmouth, Cornell, and Yale.

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On 13 July and 8 August the Adjutant General of the American Expeditionary Forces instructed all division and hospital commanders to report cases of suspected self-inflicted wounds to the AEF's inspector general office following investigation by the unit inspector and unit medical personnel. Cases were to be classified as "unavoidable," requiring no further action; as "gross negligence," requiring a summary court-martial; or as "intentional," requiring a general court-martial. Cases would be treated only in division hospitals, and not evacuated further to the rear. Any soldier sentenced to hard labor as a result of a courts-martial was ordered to serve his sentence at the most dangerous place on the line, wearing a brassard displaying the letters SIW, Self-Inflicted Wound.

Although unable to locate this brassard in uniform regulations, general orders, or supply regulations, the practice of using the SIW brassard continued into the mid-1930s. A 1935 War Department manual for commanders of large units commented: "Malingering is always a problem in war. To stop self-inflicted wounds, malingers of this type will be segregated and required to wear a brassard upon which appears the letters "S.I.W."

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Courtesy U.S. Army Engineer Museum

Stark Army General Hospital
Dave Berg, COL USA (Ret)

Stark General Hospital was located in North Charleston, SC, on the north bank of the Ashley River and was officially named in honor of Colonel Alexander N. Stark on February 11, 1941. It accommodated 2,400 beds and was ready for patients on May 18, 1941. It specialized in general and orthopedic surgery. As the war progressed it became a fully-functional debarkation hospital for casualties and sick personnel arriving at the Port of Charleston. Stark General Hospital transferred its last patients on 23 October 1945 and was turned over to the Charleston County Board of Control for local use.

The land (266 acres) was acquired by eminent domain from Mrs. Mamie M.G. Pieper and Catherine M.A. Pommer in 1941. The hospital was named after Colonel Alexander Newton Stark (1869-1926). He was commissioned as an assistant surgeon on 12 May 1893. In July 1898 he was ordered to Montauk Point, N. Y., and assigned to the hospital ship *Missouri* and served on several hospital ships in 1898-99. He was engaged in the transfer of patients in West Indian waters, then was assigned to Military Hospital No. 1 at Havana and later to Camp Columbia. With U.S. entrance into WWI he was ordered to Charleston, SC, as surgeon of the Southeastern Department, serving there until December 1917. He was then ordered to France, where he was assigned to duty as surgeon of the Advanced Section, Service of Supply. When the American First Army was formed in the summer of 1918 he was named its surgeon. Stark had a tremendous task in the evacuation and hospitalization of the casualties of First Army operations, and in the supply of the medical units during the influenza pandemic.

Stark G.H. filled several roles in the Army's WWII hospital system. As a debarkation hospital, it received patients from the hospital ships that brought most of the overseas wounded, ill, and injured back to the U.S. Charleston was one of four east coast ports to handle returning patients. At a debarkation hospital they would be checked and sent to a hospital near their home for definitive care when they were ready for travel. As a general hospital, Stark provided some of that definitive care as well; about ten percent of Stark's beds were for the long-term patients.

Above: Inside a ward, Stark G.H.
Below: Patients debarking, Charleston Port of Embarkation.
All images courtesy of the author.

The Port of Charleston was designated as the home port for Army hospital ships serving the European and Mediterranean theaters. To debark patients from ships and transport them to general hospitals, port commanders normally used personnel and vehicles belonging to installations under their control. For example, the Charleston Port trained enlisted men as litter bearers from its own medical detachment and port and service battalions in training or on duty in the area. It also used its own ambulances, trucks, and passenger cars to carry patients to Stark, which was located nearby. This procedure sufficed when the number of patients received was small.

Later, as the number of hospital ships in service increased, the Charleston Port issued a sixty-one-page manual of instructions for their commanders. As ports gained experience in operations and improved procedures, the time required to unload ships decreased. The Charleston Port cut the debarkation time from five hours (in early 1944) to two hours by the end of 1944 and then to just one hour for a 600-patient hospital ship during 1945.

During the winter of 1944-45 another measure toward simplifying the work of debarkation hospitals was adopted: the installation of addressograph equipment. This equipment let hospitals prepare templates for making rosters and issuing orders, and thus eliminated the necessity of typing each separately. Though seemingly small when considered individually, the significance of such measures can be judged more accurately if the total evacuation load of different hospitals is taken into account. Stark G.H. admitted 44,003 patients in the nine-month period from 1 January 1945 to 30 September 1945, while Halloran G.H. (NY) admitted about 69,500 and Letterman G.H. (San Francisco) about 73,000 during the entire year. There were no computers or internet – everything was

done on paper using typewriters. Every time patient changed hands – more paper work.

Cots laid out for the temporary care of patients unloaded from a hospital ship, 1944.
Dozens of ambulances and buses were needed to move patients to the hospital.

The first large-scale movement of patients by air in the United States was made in January 1944. At that time three planes, with personnel from the School of Air Evacuation, were sent to Stark G.H. to move patients being debarked from two hospital ships. In a period of ten flying days between 7 and 19 January these planes flew 661 patients in 29 loads to five general hospitals.

Rapidly built of wood, Stark General Hospital was always going to have a limited lifespan. It was 95% torn down and is now an industrial site, although the roads and concrete pads for many of the buildings are still extant. Unfortunately, there is no sign or marker indicating the hospital was ever there. It did great service our wounded soldiers during WWII.

Below are photos of the two remaining buildings.

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Special thanks to Robert Sorenson, COE – Charleston District, for helping me find the location

The Charleston Port of Embarkation in WWII
Dave Berg, COL USA (Ret)

Stark General Hospital and the Charleston Port of Embarkation (POE) worked as a team for handling wounded soldiers. An Army POE was a command structure and interconnected land transportation, supply and troop housing complex devoted to efficiently loading overseas transports. Regulations laid out the scope:

The commanding officer ... will be responsible for and will have authority over all activities at the port, the reception, supply, transportation, embarkation, and debarkation of troops, and the receipt, storage, and transportation of supplies. He will see that the ships furnished him are properly fitted out for the purpose for which they are intended; he will supervise the operation and maintenance of military traffic between his port and the oversea base or bases; he will command all troops assigned to the port and its component parts, including troops being staged, and will be responsible for the efficient and economical direction of their operations. He will be responsible for the furnishing of necessary instructions to individuals and organizations embarked or debarked at the port…. He will be responsible for taking the necessary measures

Patch for a POE.

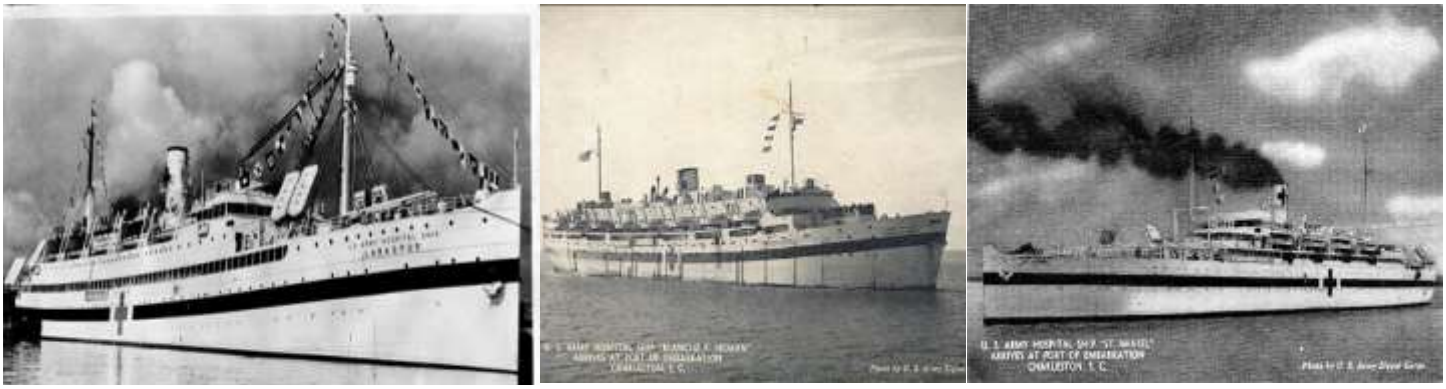
to insure the smooth and orderly flow of troops and supplies through the port.

The Charleston Port of Embarkation (CPOE) was responsible for the movement of troops and supplies from the United States to overseas commands. It was also used for the evacuation of wounded soldiers from Europe. It was established in Charleston to relieve pressure on the New York POE; initially it largely focused on traffic to the West Indies and Caribbean. Later in the war, more use was be made of the Port.

The first three hospital ships were assigned to the port on November 1, 1943, the USAHS *Acadia*, the USAHS *Seminole*, and USAHS *Shamrock*. Subsequently, as additional Army hospital ships were placed in service for the Atlantic, all were assigned to the CPOE. However, Charleston's function was long concealed in the press under the guise of "An East Coast Port."

At the peak of the war, 21 of 26 Army hospital ships were assigned to the CPOE. It was designated as the home port for Army hospital ships serving in the European and Mediterranean Theaters. The CPOE was behind the New York POE as the second-busiest East Coast port for evacuation of wounded.

Medical supplies and hospital ships were a small part of CPOE's responsibilities. It handled cargo and unit movements, and trained watercraft companies. In the spring of 1943 the Chief of Transportation began to train personnel for the operation and maintenance of small boats and amphibian trucks at CPOE, before they were moved to Camp Gordon Johnston, Florida. The CPOE also served as a training area for army beach landings. On July 1, 1952, the CPOE officially became the Charleston Transportation Corps Marine Depot.



Three of the hospital ships based at Charleston POE. Left to right, USAHS *Larkspur*, USAHS *Blanche F. Sigman*, USAHS *St. Mihiel*.

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The 1918 Influenza and the US Army "Porto Rico" Regiment.

J. Edwin Nieves MD, McDonald Army Health Center, Fort Eustis VA

Introduction: The 1918-1919 Influenza

The A/H1N11918-1919 influenza or "flu" pandemic consisted of three "waves" between the spring of 1918 and winter 1919. The first occurred in spring and summer 1918; it was highly infectious, but with a mild clinical course. The second wave, which occurred in the summer and fall of the same year was also highly contagious, but had a high mortality rate; this wave accounted for the highest number of deaths. A third wave appeared in the winter of 1919, with a mortality level between the preceding two.

World War I, with its resultant movement of peoples and crowded conditions, contributed significantly to the spread of the disease among the civilian and military populations. Just as typhoid fever spread during the Spanish-American War nearly 20 years earlier, the influenza virus spread through the military training camps, garrisons, and battlefields with devastating consequences for the young soldiers in them. This virus would hit those between the ages of 20-40, men of military age, particularly hard.

Puerto Ricans Join the U.S. Army, Camp Las Casas

Following the change in sovereignty in 1898, Puerto Rico, (PR) became a United States territory. In June 30, 1901, the U.S. Army organized the "Porto Rico Provisional Regiment of Infantry" for local defense. In 1904, "Camp Las Casas" was commissioned as an area of encampment, training, and maneuver and named after Bartolome de las Casas, a 16th Century Dominican friar who was an advocate for local indigenous people. The Camp was located in a (then) unpopulated area east of San Juan, known as "Santurce" near the San Jose Lagoon. The camp was on a plateau near a swampy mangrove area where mosquito-transmitted febrile illnesses such as dengue and malaria were common. The site was chosen for its proximity to the rail and wagon train connections to Army administrative and supply centers in San Juan.

Shortly after U.S. declared war on Germany in April 1917, a selective service draft was instituted. About 18,000 Puerto Ricans would be recruited to serve in the Army during WWI and nearly all received their basic training at Camp Las Casas. Like many other Army training camps, it would become an infectious disease hotbed during the flu of 1918.

Puerto Rican 'Doughboys.' Image courtesy PRARNG.

Influenza arrives in San Juan Harbor and Las Casas Training Camp

The 1918 influenza virus is thought to have arrived in PR on 13 June 1918 aboard the Spanish Steamer S.S. *Patricio de Satrustegui,* which docked in San Juan with 30 influenza cases. Five cases were severe enough that the patients remained in the ship's sick bay. The rest of the infected passengers, along with all the other passengers, were allowed to disembark and were not quarantined. The flu spread quickly to the "Puerta de la Tierra" (Land Gate) neighborhood section of San Juan. Many immigrants and dock workers lived in the district, known for its crowded, unsanitary conditions. It had been the starting point of other local epidemics .

From here, it spread to the rest of the city. The 4th of July celebration festivities two weeks later brought many people from the neighboring towns and wards of San Juan to the center of city. Many of them used the opportunity to visit their relatives training at Camp Las Casas. This likely caused the first outbreak of the flu among the Camp Las Casas soldiers. It would spread to the rest of the island as everyone returned home.

Camp Las Casas

During the 1918 summer months Camp Las Casas had received nearly 12,800 soldiers for training. Army records indicate that between 5 July and 30 August 1918 (about a month after the arrival of the *Satrustegui*) there were 17 deaths due to disease at the camp. Camp Las Casas ranked fifth across the nation in soldier's deaths due to disease, higher than 30 other training camps in the U.S.

During the same time period, a measles epidemic ravaged the camp as well, causing 173 hospitalizations. Las Casas ranked second in the nation with the highest number of hospitalizations due to measles for the same period. It had the highest number of hospital admissions for pneumonia of all 35 WWI Army training camps with 123 admissions per 1000 soldiers in those months, or 55/1000/year. Measles is a serious risk factor for the development of pneumonia and likely accounted for the high infectious disease mortality at Las Casas during that fateful summer of 1918.

Two views of the housing in Puerta de Tierra near the post, showing the lack of drainage and sanitation that contributed to the high disease rates at Camp Las Casas.
Courtesy Dr. Ann Zulawski used with her permission.

The Canal

Elements of the Porto Rico Regiment were sent to the Panama Canal to protect the Atlantic coast Coco Solo Base and liberate continental troops for service in Europe. They were under the command of Capt. Luis R. Esteves Volkers.

Transported in a Spanish-flagged commercial ship, which had stopped in PR the week prior, it is suspected that they were exposed to flu-carrying passengers and/or crew while in transit. During the first days of July 1918 flu-like symptoms developed in many of these soldiers. 449 soldiers had symptoms severe enough to require inpatient treatment at the Ancon Hospital. However, there were no fatalities. These soldiers recovered after a seemingly uneventfully course with bed rest, "liquid diet and 15 grains of sodium salicylate" and "either codeine syrup or an elixir of heroin" for cough.

There were no serious complications. Notably, the most common comorbid infections were intestinal parasites. Out of 249 stool samples tested, 100 or 42% were positive for uncinaria. Tricocephalus was the second most common finding in 42 specimens.

Luis R. Esteves Volkers was the first Puerto Rican to graduate from West Point (class of 1915), where he tutored Dwight Eisenhower in Spanish.
U.S. Army photo

Remarks

The morbidity and mortality among soldiers in the Porto Rico Regiment during 1918 appears to have varied according to a range of factors. Although the segregation of units by ethnic background at the time kept the demographic and socioeconomic background of the soldiers within the regiment fairly constant, it is likely that other factors had a significant impact on soldiers that remained at the Las Casas Training Camp vis-a-vis those who were deployed to the Canal Zone.

Soldiers in Las Casas Camp were exposed to an outbreak of measles that overlapped with the flu of 1918. This was likely a key determinant in their susceptibility to pathogenic bacteria and thus caused a higher mortality among those soldiers, as measles was a predisposing factor to bacterial pneumonia in the training camps. These soldiers were also exposed to a range of mosquito-borne febrile illnesses by virtue of the

location of the camp. It is also likely that these soldiers had comparable helminthic parasitic infestations (worms) as those sent to the Panama Canal, since worms were endemic in the Puerto Rican population at the time. These two factors likely increased their vulnerability.

Those soldiers from the regiment that were sent to the Panama Canal avoided exposure to the measles epidemic and thus complicating pneumonia, a serious and frequently fatal flu complication. Hypothetically by being a "closed" unit, it avoided the influx of new personnel, perhaps allowing the development of some sort of resistance to a more severe clinical syndrome while avoiding exposure to more deadly strains of the virus.

In summary, as noted in other groups of servicemen, the flu mortality risk among era Puerto Rican soldiers depended on several epidemiological factors.

The Ancon Hospital (later Sternberg General Hospital) was the main hospital for U.S. personnel in Panama. A concrete building had just opened in 1915, but the standard of care was still limited.
Image courtesy Library of Congress.

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History of Proficiency Designators

The AMEDD adopted proficiency designators in WWII. The Army had over 55,000 doctors, and needed to put them where their skills fit best.

In 1940 TOEs had not been seriously updated since the 1920s, before most specialty boards had been organized. Thus, TOEs simply listed a number of doctors, and rank would indicate who was senior and more experienced. However, in the 1930s most specialty boards had formed, and the AMEDD had to recognize there were new differentiations among doctors and to find new ways to identify who was appropriate to put where. This was part of a broader Army problem of needing to identify individuals with various technical skills and put them in the right positions. To do this, the Army created the MOS system (now MOS for enlisted soldiers and AOCs for officers, but then MOS for all). Alongside sorting by type (MOS) the AMEDD recognized there were variations in skills and experience of medical personnel and adopted a four-tier system of proficiency designators, A through D.

Introducing this system in wartime was problematic, as officers moved, gained experience, and different commands had classification boards with different opinions. By mid-1945, when the Medical Corps was roughly at its peak, approximately 55% of doctors qualified as 'specialist.' 0.74% were A, 18.9% were B, 34% were C, and 46% were D.

Criteria were defined thus:

Group A. Officers with civilian or military background of recognized and outstanding ability in a specialty, for example, officers who were professors and/or heads of departments and associate professors in large teaching centers; officers who can function within their specialty without professional supervision.

Group B. Officers with superior training and demonstrated ability. Classification in this group indicates a probable training period of one year as an intern and a three year residency or fellowship devoted to the specialty in a recognized teaching center. Officers with mature experience and demonstrated ability may be classified in this group even though they have not had the formal training indicated above. Diplomates of American Specialty Boards are classified in this group or higher but absence of certification does not prohibit inclusion in this group. These officers can function within their specialty without professional supervision.

Group C. Officers who have recently completed periods of training including one year as an intern and one year of residency; officers who have demonstrated some ability in a specialty; officers with shorter periods of training but with minor proportion of practice devoted to a specialty such as general practitioners giving particular attention to the specialty for a period of at least three years.

There is no indication of the criteria for Group D.

In late 1943, TSG directed classification of medical, dental, and veterinary officers. There is some indication that at least some officers of the Sanitary Corps and Medical Administrative Corps (precursors of the Medical Service Corps) were classified, although there are no details on the system, the numbers, or the criteria except for physicians.

After WWII, both MOS and proficiency designators continued as personnel management tools. Proficiency designators were apparently awarded in non-clinical specialties (e.g. logistics, human resources, and medical operations) after clinical specialties.

Available records beyond WWII are patchy. In the 1960s multiple Corps had A-D levels, and at times MC "D" proficiency specialists had to be used as general medical officers because of a shortage of GMO.

Requirements and qualifications have changed over time. In 1969 the DC was awarding a B designator by passing an examination for the Army Board of General Dentistry. In 1963 the ANC purged its list of designated officers because getting the designators had become "associated with position, rank, length of service, or solely formal training." The ANC suspended awarding any proficiency designators until 1969. The first AMSC proficiency designations found were in 1970. That year the MC reassessed their requirements and decided the A designator was only for those with national recognition in their specialty and who had acquired professional stature among colleagues.

Sources

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Easing Pain on the Western Front: American Nurses of the Great War and the Birth of Modern Nursing Practice, by Paul E. Stepansky. McFarland & Company, 2020; 232 pp., $39.95 softcover.

Reviewed by: G. Alan Knight

Easing Pain on the Western Front presents a fascinating account of military nursing in World War I and how operational needs propelled nurses, primarily in France, into what became an increasingly technical profession while still adhering to the principles of compassionate care practiced and advocated by Florence Nightingale, the founder of modern nursing. Through extensive use of diaries, memoirs, letters, organizational histories, professional journals, and a plethora of government publications, the author demonstrates that the massive numbers of casualties, the increased lethality of wounds caused by the weapons of the first modern war, the shortages of medical officers, limited specialty care, and the development of new technology and medicines combined to create a dramatic expansion in the role played by nurses.

Some of the versions of ANC branch insignia worn in WWI.

AMEDD Museum collection

COL Richard M. Prior, a former Army Nurse Corps historian, says of author Stepansky that he "Expertly charts the evolution of nursing care on the battlefields of World War I, recording treatment advances that would benefit the nurses of World War II along with civilian nurses..."

By World War I nurses were fully wedded to science and technology and their application in patient care, though for the most severe gas casualties it was mainly palliative, and for the shell-shocked, largely just a regimen of compassionate care. By the time of this conflict, knowledge of bacteriology impacted nursing regimens, as it had since 1900. The author suggests the nurses now manifested a professional assertiveness not seen in their predecessors. Often located in medical treatment facilities close to the battlefields, they saw themselves as "combat nurses."

Stepansky contrasts the casualty care provided in World War I with that provided in the Civil War, the Spanish-American War, and the Boer War fought in South Africa by the British, both around the end of the 19th Century. He characterizes the Civil War as "all about food, water, and dying," clearly an account of the provision of very rudimentary non-specialized care. While his account is focused on female American nurses (both Red Cross and military serving with the American Expeditionary Forces, AEF), he also draws upon accounts of British and Canadian nurses and examines the content of wartime nursing care starting in 1914 when the first American and Canadian nurse volunteers began to serve with British and French medical treatment facilities. However it is important to note that the focus of the book and any nurse accounts cited within it are all centered on the technical aspects of care they provided.

Stepansky takes the reader to often far-forward facilities where nurses triaged incoming casualties when doctors were not available to perform this function, and to field hospitals where nurses were utilized as nurse anesthetists, surgical assistants and at times as de facto assistant surgeons. The reader also sees nurses providing both medical and surgical care on the wards, somewhat in the manner of today's hospitalist physicians. Nurses played a central role in wound management from initial stages to lengthy post-operative care. Wounds from a mechanized and industrialized war were increasingly complex. The rural terrain of France and neighboring Belgium, with soil heavily fertilized by manure, posed significant infection challenges in penetrating wounds into which soil, clothing, and other battlefield debris was driven. The wartime invention of what was essentially a disinfectant, Dakin's Solution, became standard treatment for deep wounds. Sulfa

drugs, let alone antibiotics, were as yet unknown. The apparatus to administer Dakin's required extensive training and became a primary nurse responsibility. Advances in technology also involved new inventions for stabilizing long-bone fractures and nurses assumed responsibility for adjustment of these complicated devices based on their assessment of a patient's condition and progress in healing.

Nurses, aided by enlisted medics, provided much of the care provided to the chemical casualties of war, victims of chlorine, phosgene and mustard gasses. Nurses also played a vital role in caring for those diagnosed with "shellshock" or PTSD. The causation of this was not definitively known in 1914-1918 and while compassionate treatment was ideally (but not always) provided, the author suggests that some nurses had difficulty accepting and treating a malady which did not display the then-expected signs of wounding or physical illness. Finally the author chronicles the role nurses played in handling the massive number of soldiers infected in the Pandemic of 1918, a disaster that also claimed the lives of a number of military and Red Cross nurses in the U.S. and overseas with the AEF.

Stepansky concludes with observations on the postwar difficulties experienced by combat nurses in integrating back into civilian nursing, to include comparisons with the experiences of World War II and Vietnam War deployed nurses. He also examines the interface between modern scientific nursing and Nightingale values. Ending his account with Vietnam, he does not address the commissioning of male nurses in the military and their impact on the profession.

Exceptionally well-written, end-noted, and with some illustrations and an extensive bibliography, this book will be an informative and engaging read not only for Army nurses and their civilian colleagues but for any readers who are interested in military nursing as a key component in the historical development of the American nursing profession and our nation's health care in the 19th and 20th Centuries.

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.

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