




Army Medical Department Center of History and Heritage, Fort Sam Houston, Texas

Number 38 Summer 2022

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Prisoner's sketch of boredom in a prison camp. Courtesy Library of Congress.



WELCOME to issue #38 of the *AMEDD Historian*! Care for and by Prisoners of War (POWs) and Enemy Prisoners of War (EPWs) is the featured topic for this edition of the newsletter. Providing for captured and wounded enemy combatants has wide acceptance on humanitarian grounds and there are international agreements in place to ensure their well-being. Similarly, captured medical personnel are to be protected, at least on paper. War is never clear-cut and rivalries, logistical issues, medical problems, and punitive measures, could all be part of captivity during conflict.

The American Army has treated injured captured soldiers and provided for their subsistence during confinement, often in large numbers. When the Ruhr Pocket collapsed in Germany at the close of World War II, the Allies suddenly had over 300,000 prisoners to manage. Understandably, there have been logistical problems, requiring not just medical supplies, but also U.S. Army medical personnel to provide care when there were no medical EPWs. There are also further complications when captured personnel are not EPWs/POWs but detainees, which is a different category under international law.

What of physicians that are captured? Equipped with medical knowledge and skill, they have the added responsibility of providing care in often extreme condi-

The Elmira Prison Camp By Gary Emerson

On July 6, 1864, the first Confederate prisoners entered the gates of barracks number three in Elmira, New York. Prisoner exchange agreements had broken down in the summer of 1863, when the Confederacy refused to treat captured African American soldiers the same as white soldiers. Suddenly, both the Union and Confederate armies were forced to find places to hold captured men for long periods. Elmira was the site of four barracks to gather and train Union soldiers during the war, but by 1864 Barracks Three was no longer in use, making it available to house Confederate prisoners. The men who entered the camp that day, and the many who joined them later, had no idea that their new residence would come to be regarded as the worst of the Union prison camps.

Of the 12,122 Confederates held at Elmira, 2,933 would never return home. Elmira's death rate of 24% was the highest of any Union prison camp, leading to comparisons with the notorious Andersonville, a Confederate prison where 28% of the Union soldiers died. What made Elmira so deadly?

One immediate problem was overcrowding. Lt. Colonel Seth Eastman, the commander of the Elmira barracks, told the War Department that Elmira could hold per-

haps five thousand men. Yet by the end of August 1864, the camp overflowed with 9,600 prisoners. The flood of bodies forced Eastman to house many prisoners in tents. It was not until January 1865 that enough barracks were constructed to shelter everyone.

Living in tents was problematic as winter arrived early in Elmira. Snow was on the ground in early October while Confederate prisoners sheltered in tents, sleeping on the ground with few blankets and little warm clothing. Having been captured during the summer campaigning, the prisoners did not have proper clothing and many lacked shoes.

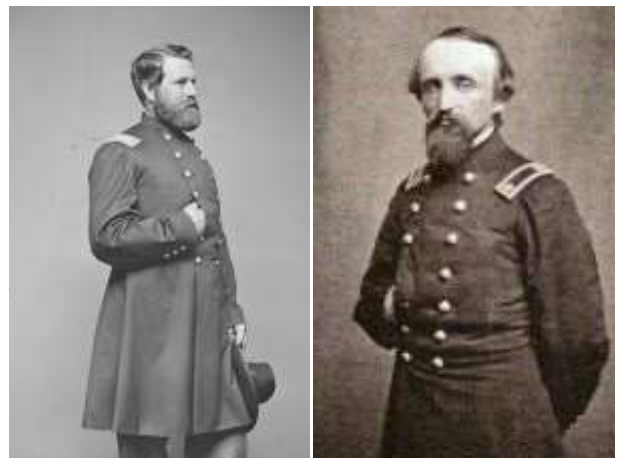
Overcrowding led to a far deadlier problem than sleeping in a cold tent. Within the camp was a stagnant pool of water known as Foster's Pond. Located near the cookhouse, the pond became a convenient place to dispose of wastes. It also had the misfortune to have the sinks (latrines) located along it. Human wastes emptied directly into the pond. One of the camp's doctors estimated that 7,000 men in the camp were excreting 2,600 gallons of urine every day. Drinking water for the camp was provided by several wells, and two of the wells were near Foster's Pond. The polluted pond contributed to the leading causes of death at Elmira: diarrhea and dysentery. Nearly half of the men who died at the camp were victims of those illnesses, with the peak number of deaths occurring in late August and into September, when the camp's population was at its highest, and when the pond was at its worst.

All the illness at the camp was exacerbated by another problem. For the first month of the camp's existence there was no army doctor. A local physician, Doctor William Wey, tried to help as best he could, but a camp surgeon did not arrive until August. His name was Major Eugene Sanger, and he would become a controversial figure at the prison.

Sanger arrived at Elmira with a reputation for not getting along with his superiors. While serving in Louisiana and Mississippi he earned the ire of Generals John Phelps and Benjamin Butler for his constant criticism. Despite his annoying qualities, Sanger had a reputation as a good surgeon and for his efforts to improve sanitary conditions. In July 1864 he was ordered to report to the Elmira Prison Camp to serve as the Chief Medical Officer.

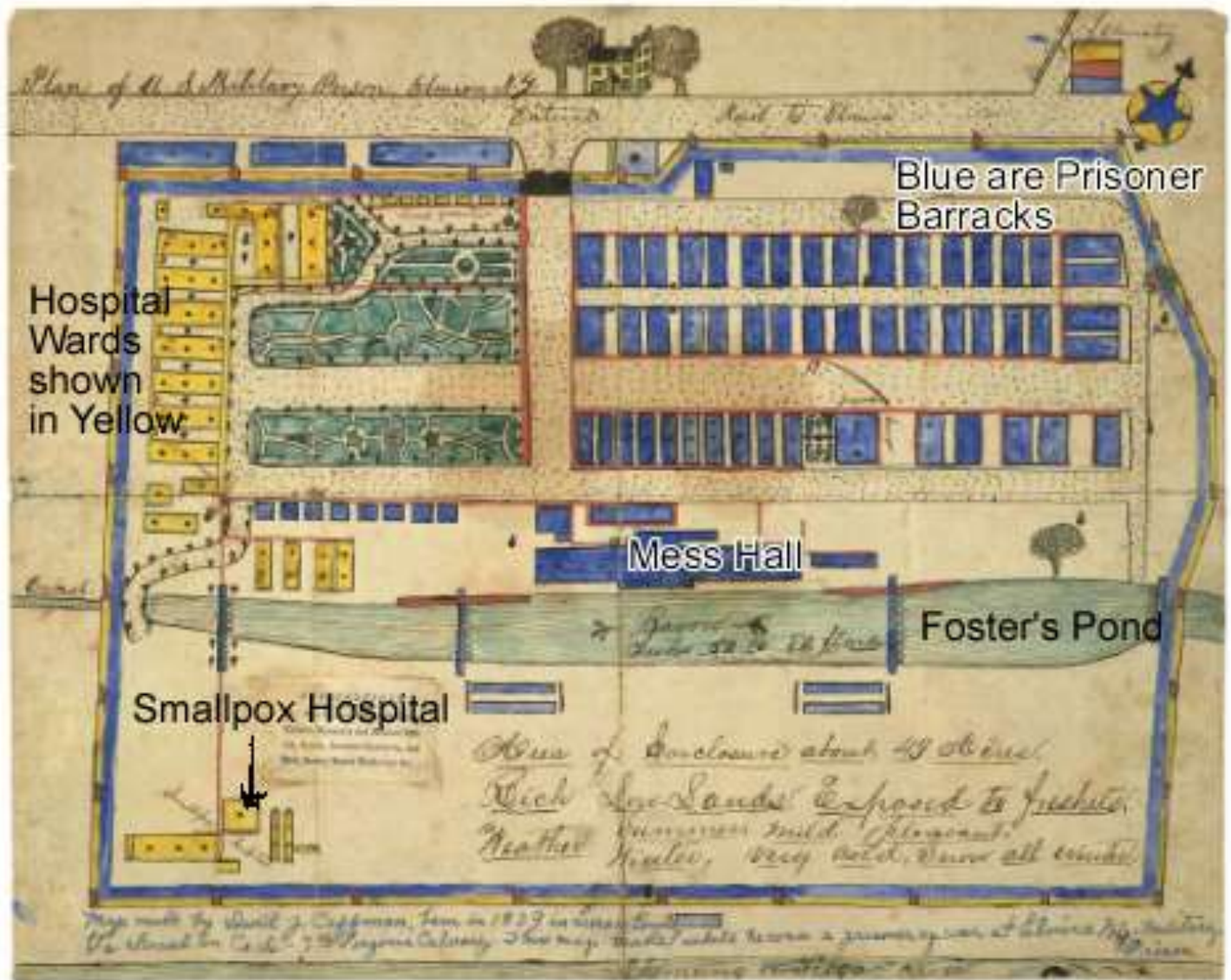
At Elmira, Sanger inherited a maelstrom of problems in the overcrowded camp. Polluted Foster's Pond was causing ever-rising cases of diarrhea and dysentery. Scurvy became rampant due to cuts in prisoner rations ordered by Secretary of War Edwin Stanton, who supported retaliation against the Confederacy for the poor care provided to Union soldiers in southern prisons. At Elmira, the camp sutler was also prohibited from selling food to the prisoners. The poor diet, deficient in vegetables, led to the scurvy outbreak.

Sanger reported to both the camp commander, Lt. Colonel Seth Eastman, and to the Surgeon General, J. K. Barnes, that steps should be taken to clean out the pond and to provide more vegetables in the prison diet. His pleas were not acted upon in a timely fashion. It was January 1865 before a channel was completed from the Chemung River to help flush out Foster's Pond. Sanger's plea for more vegetables to combat scurvy did get the Commissary General of Prisoners, William Hoffman, to allow the sutler to sell fruits and vegetables to the prison-



(Left) COL Tracy (Right) Dr Sanger. Their arguments did not help medical care. (Below) The Elmira camp. Courtesy Library of Congress.





ers when the incidence of scurvy was prevalent. It provided some relief, but scurvy persisted throughout the camp's existence.

Prisoner's sketch map of Elmira Prison Camp, after the river was diverted to drain the stagnant pond. Courtesy Library of Congress, annotations by author.

Although Sanger took steps to address the sources of medical issues at the camp, he was not thought well of by the prisoners. As cases of diarrhea and dysentery raged through the camp, there was almost no opium on hand to treat the afflicted. (Opium was then a standard treatment because of its constipating effects.) On one occasion, Sanger told another doctor to prescribe "four or five drops" of Fowler's solution of arsenic for some sick Confederate prisoners. The doctor mistakenly wrote forty-five drops. The patients who received the medication all died. Such incidents only convinced the prisoners that Sanger was purposely trying to kill them. One prisoner, Anthony Keiley, said of the doctor, "Sanger is simply a brute."

One person who did get along with Sanger was Lt. Colonel Seth Eastman. Eastman mostly tried to accommodate Sanger's requests and let Sanger requisition what he needed. Unfortunately for Sanger, Eastman was in poor health and asked to be relieved. His replacement, Colonel Benjamin Tracy, arrived by the end of September 1864. Tracy was a stickler for details and demanded that Sanger follow proper channels in making his requisitions through his office and await approval. That did not sit well with the doctor. The two men would never get along, which became a problem when the next great health threat arrived in the prison.

Near the end of October, some Confederate prisoners arrived from Alabama. Shortly after their arrival,

it was discovered that one of them had smallpox. Soon other cases appeared. As Tracy and Sanger continued to feud, nothing was being done to check whether prisoners in the camp had been vaccinated or inoculated against smallpox, nor was proper isolation being carried out. Although both armies called for medical inspections of volunteers entering the service, physicals were often lax, and many men entered both armies unprotected against smallpox.

Every time camp officials thought they had the outbreak under control, more cases would suddenly appear, and the number of cases began to increase. As the crisis worsened, Sanger was suddenly placed on house arrest by Colonel Tracy in mid-December. A new camp doctor arrived by the end of the month. Major Anthony Stocker was named to replace Sanger. Stocker immediately took more aggressive measures to address the smallpox epidemic, but the disease was spreading too quickly inside the crowded barracks. Stocker began quarantining men with smallpox in tents beyond Foster's Pond. He also started a campaign of inoculating prisoners using smallpox scabs from people who had experienced mild cases of the disease. That created another problem when either the scabs used were contaminated, or the men were already suffering from scurvy. The inoculated men quickly developed horrible, painful sores on their arms, which made other prisoners reluctant to be inoculated.

Even with Stocker's aggressive steps, the disease continued to spread and killed many men. In 1865, the months of January, February, and March proved especially lethal with 285, 426, and 491 deaths, respectively, making Elmira the deadliest Union prison camp at the time. Relief from smallpox only came when the camp population began receding due to an increase in prisoner exchanges as the war neared its end, and due to the coming spring weather.

With the end of the war in April 1865, the prisoners were gradually released, after taking a loyalty oath, and shipped home. The Elmira Prison Camp officially closed in July 1865, but during its one-year existence it accounted for the highest death rate of any Union prison camp, a distinction that made it a target of Southern criticism in the years after the war.

In 1876, Congressman James Blaine from Maine took the House floor to demand that a proposed bill granting amnesty to all remaining Confederate soldiers exclude former Confederate President Jefferson Davis; Blaine argued that Davis bore direct responsibility for the atrocities of Andersonville. Blaine's suggestion created a partisan firestorm. Benjamin Hill, a Congressman from Georgia, rose to defend Davis. In his speech, Hill declared that the prison at Elmira was every bit as criminal as Andersonville, and was perhaps even worse, since the North had the better means to provide proper care to prisoners. In the end, the Amnesty Bill failed to pass, but Elmira became synonymous with Andersonville. The South finally had an answer for the vile criticism of Andersonville that it had endured for years.

At times, locals have felt tarred by the reputation of the camp. In 1912 a local author said the camp was an example of Christian morality, and deaths were largely due to forces beyond human control. In 2002 another author blamed Secretary of War Edwin Stanton's deliberate plan to retaliate against Confederate prisoners for the many deaths of Union prisoners held in the Confederacy.

Somewhere in the middle is perhaps the real story about Elmira. The high death rate at Elmira was the result of human agency. Decisions were made that contributed to the deaths of prisoners. The slow response in dealing with Foster's Pond led to many deaths due to diarrhea and dysentery. Likewise, many deaths from smallpox could have been prevented if Dr. Sanger had been more proactive in quarantining and inoculating men during the outbreak. Also, the reductions in rations did little to help the condition of men who were sick and weak. Those were all things that could have been controlled with better management. Proper exercise of the prevalent medical knowledge of the time would have mitigated the number of deaths at Elmira.

Providing good sanitation and preventing smallpox and scurvy were measures physicians knew were necessary by the time of the Civil War. They were also lessons relearned the hard way when the Union and the Confederacy gathered soldiers into encampments at the start of the war. Yet, in the rush to find places and prepare them for an overwhelming number of prisoners those lessons were forgotten or overlooked, making Civil War prisons unhealthy receptacles for captured men.

Yet Elmira was not a "death camp," where Confederate prisoners were purposely starved to death. Certainly cutting the rations left prisoners hungry; some turned to catching and eating rats. Yet, the men were getting as much food as they likely would have received in the Confederate Army. The leading causes of death at Elmira were diarrhea/dysentery, smallpox, and pneumonia, not starvation. Certainly, retaliation by cutting ra-

tions contributed to the misery at Elmira, but it was not the sole cause of the high death rate at the prison.

The death rate at Elmira, and Benjamin Hill's condemnation of the prison in Congress, led some to refer to it as "Helmira." Southerners often claimed Elmira was worse than Andersonville. But looking at the death rate can be deceiving. Andersonville was a larger prison and death occurred there on a greater scale. In the month of August 1864, three thousand Union prisoners died at Andersonville. In that one month, more prisoners died at Andersonville than died in total during Elmira's existence.

Just like Civil War battles, prison camp conditions were contingent upon leadership, environment, and nature. Battles were all different due to those contributing factors, and the same was true of prison camps. Better leadership at Elmira could have saved lives. Sanitation, managing the smallpox outbreak better, and a better diet were all within the limits of knowledge at the time. Also, locating a prison camp at Elmira was not a good choice because of the harsh winter months. The winter of 1864-65 was an especially cold one.

Both armies were unprepared for the sudden influx of prisoners, and managing the health of imprisoned men. The failure led to bitter feelings and accusations for many years after the war. As historian David Blight wrote in his book *Race and Reunion: The Civil War in American Memory*, "No wartime experience. . . caused deeper emotions, recriminations, and lasting invective than that of prisons. Civil War prisons were, by and large, hellholes of disease, misery, and death (152)." Elmira is still remembered as one of those places.

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— 27 July 1775 —

Private Clyde Grimsley and the Tüchel Prison Camp Hospital: from prisoner to orderly By Nalia Warmack, Oregon State University

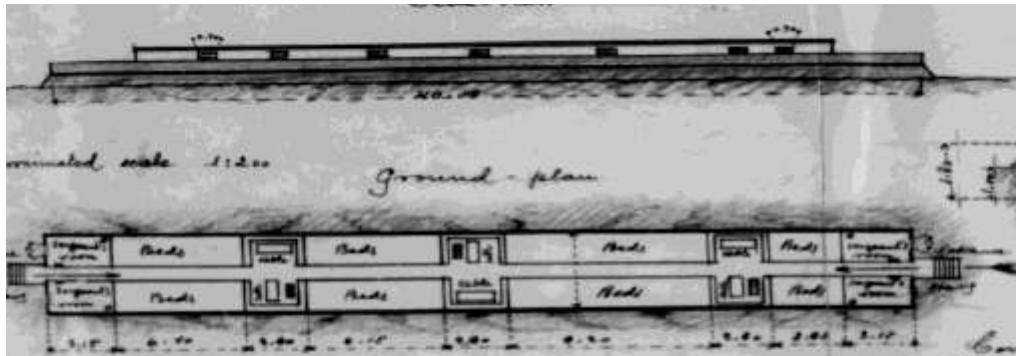
Clyde Irving Grimsley enlisted in the U.S. Army in 1917 as a band leader before he was deployed as part of Company F of the 16th Infantry Regiment, 1st Division, with the onset of American entrance into World War I. On the night of November 2 - 3, 1917, Germans raided Company F, and the company sustained the first American combat casualties of the Great War. Among these was Private Grimsley, who was captured that night, becoming one of the first eight American Prisoners of War in WWI. After spending 30 days confined at Metz (approximately 60km away), Grimsley eventually arrived at Tüchel Prison Camp located in West Prussia on January 12, 1918.



PVT Grimsley and the first U.S. prisoners, from a German postcard. Courtesy Library of Congress.

Tüchel Prison Camp held dismal conditions for those confined within it. The quarters were dugout barracks, damp and often overcrowded, with a stove in the middle and two levels of bunks on either side. At the arrival of Grimsley and the first American prisoners at Tüchel, the total number imprisoned in the camp numbered approximately 25,000, mostly Russian military prisoners. Upon arrival, the Ameri-

cans were stripped of their warm clothing and leather boots, leaving them vulnerable to the coming winter. The water and food rations were meager and to make the situation worse, they were often denied the Red Cross parcels sent to them. There was hospital for the prisoners, a bleak but tall and well-ventilated wooden barrack with a small library attached. After almost two weeks in Tüchel, Grimsley was admitted to this hospital on January 25th after he had severely scalded his left foot while making tea in his camp hut.



Side profile and overhead diagram of the Tüchel camp hospital. Courtesy National Archives.

Those in the hospital were treated well by the camp's able doctors, who were prisoners themselves. In addition to the treatment the patients received, they also were given substantially more food – almost double the rations of their fellow prisoners. During Grimsley's recovery there were approximately seven other Americans in the camp's hospital.

One of which was Pvt. William Hoyt Decker who had been captured alongside Grimsley and had undergone treatment for complications from a dislodged eyeball that had been pulled from its socket. He was treated for a short time at the camp's hospital before being sent to a permanent hospital outside the camp for further treatment and to be fitted for a glass eye. The majority of the camp hospital's future patients, including the other six Americans, would be admitted due to the wide-reaching influenza (known as the 'Spanish Flu') which did not spare the camp.

After his foot had healed, Grimsley was removed from the hospital on March 10th, 1918. The following week however, he would return to the hospital, having contracted tonsillitis and bronchitis in the camp. While not in critical condition, for over a month Grimsley was weak and unable to speak. It was during this time that two American doctors arrived at Tüchel and were immediately employed in the camp's hospital; 1st Lieutenant John S. Abbott captured on March 21, 1918, in Lagnicourt-Marcel, France, and 1st Lieutenant Joseph P. Burke, captured on April 20th in Seicheprey, France. Due to Abbott and Burke's persistence, Grimsley was granted the role of their orderly by the camp authorities while he continued to recover. Following his recovery, Grimsley was allowed to continue the role to assist with the increasing American patients rather than being forced to return to camp labor.

Grimsley remained at Tüchel Prison Camp until late summer of 1918 when he and the remaining American prisoners were transferred among transit camps until they were eventually reconcentrated at Rastatt Prison Camp in Baden, Germany. Grimsley was liberated in December, 1918 and returned home to Stockton, Kansas, three months later on February 19, 1919.

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Medical Care for Recovered American POWs

Scott Woodard, ACHH

The prisoner of war (POW), detainee, or captive has borne additional suffering in armed conflict. Repatriated POWs who emerge from captivity must also survive the stress of societal and military reintegration. Prisoners often face food shortages or starvation and poor to nonexistent medical care. Army medicine has, and continues to play, a key role in post captivity. This article will survey medical care provided to released American prisoners in World War II, Korea, and Vietnam.

World War II, European Theater

The policy outlining procedures for evacuation, disposition, and physical examination of freed Americans from the Germans in Europe was "Procedures for Processing, Return and Reassignment of Recovered Personal," dated April 21, 1945. Priority of evacuation from forward areas was for the sick and wounded via air or train. Intelligence gathering was much of the focus at embarkation staging areas. Former POWs requiring further treatment were to report to reception centers near their home in the United States after completion of care at a debarkation hospital in the United States.

The medical procedures established included initial first aid; disinfection of the newly freed prisoners (including their clothing and baggage); a brief medical inspection to verify no infectious disease was present before transport; and triage into medical or nonmedical channels for evacuation. Former POWs litter-bound or hospitalized in prison camp were automatically categorized for medical evacuation. A thorough physical "at the earliest practicable moment" was mandated and included a detailed medical history, X-rays, urinalysis, blood, and other laboratory tests. Chest X-rays were required only if it was warranted after examination. Attention was given to potential psychiatric issues and was focused on depression, resentment, guilt, apathy attitudes toward authority, further military service, anxiety, self-confidence, concern over health, and domestic problems. Of course physicians and other healthcare professionals were to examine the patients, but a psychiatrist was specifically required for the psychological examinations when available. If the former POW required continued medical care, he was classified as a patient where he would continue receiving care at a debarkation hospital near his home. Upon release, he would report to a redistribution station for his final out-processing.

Almost 10% of the newly freed prisoners were evacuated by medical channels. These patients were characterized by severe malnutrition (avitaminosis), 20 to 40 pounds of lost weight, "inflammation of the tongue (glossitis), the lips (cheilosis), and mouth (stomatitis), swelling of the extremities (edema), diarrhea, gastroenteritis, and pellagra." Pulmonary disease such as tuberculosis was evident. Upon physical examination, nonpatients evacuated through nonmedical channels had lost an average of 14 pounds in captivity. Approximately 43% showed malnutrition – nutritional edema and night blindness. Jaundice and hepatitis were very common. Gastrointestinal problems were exasperated by well-meaning fellow soldiers and Red Cross volunteers giving rich foods to the newly released. Physicians prescribed a bland diet to allow a gradual assimilation of food.

One little-known member of the Army Medical Department held captive in Europe was flight nurse and 2LT Reba Z. Whittle. She was shot down and detained by the Germans from September 27, 1944 until



Medics treat 63 American POWs who survived a death march from the Berga concentration camp and were liberated by soldiers of the 357th Infantry Regiment. Courtesy National Archives.

January 26, 1945. Like her nursing sisters in Asia, she continued to treat the sick and wounded. Unlike her counterparts in the Philippines, not much weight loss occurred. At Stalag Luft IX she received rations and Red Cross packages. At this point in the war, the repatriation procedures following most releases were not yet established. Whittle returned home with many sick soldiers following a prisoner exchange and a brief stay on a hospital ship. Once in the United States, she completed security screenings and physical examinations. Follow-on medical treatment was performed at Walter Reed Hospital and then she was moved closer to home for continued care at Brooke General Hospital, where she continued urological treatment. She was plagued by dizzy spells, weakness, and headaches from her lacerations and other injuries sustained in the aircraft crash leading to the eventual revocation of her flight status and subsequent discharge from the service.

World War II, Pacific Theater

The large influx of former captives released by the Japanese was met with a deliberate plan, War Department Directive "Handling and Disposition of Recovered U.S. Military Personnel Who Formerly Served on Wake, Guam, and the Philippines" dated February 19, 1945. Upon release, former prisoners were given emergency first aid and a physical examination at the "earliest practicable moment." The examination was usually minimal and measured height, weight, examined ear-nose-throat, and teeth. From this cursory view, they were categorized as patients or nonpatients. All former prisoners were transported back to the United States primarily by ship and sent to debarkation hospitals upon their arrival. While on ship, they received care – "vermifuging ("de-worming"), chemotherapy, and whole blood and plasma transfusions" if needed. Like European Theater American POWs, the Pacific Theater POWs were sent to debarkation hospitals followed by reception and redistribution centers. After reception center processing, they were given 60 days leave, then out-processed if indicated. Those requiring more hospital care after their first review at the debarkation hospital were given up to 90 days of leave and followed the same procedures.

Special teams consisting of internal medicine specialists, dentists, and behavioral health personnel were positioned at varying debarkation hospitals in the United States. BG Hugh J. Morgan, chief Medical Consultant, chaired a board that produced a health survey that planned for future research while patients received treatment. The examination included "medical history, height and weight, blood pressure, eyes, skin, heart, oral and dental, chest X-ray, liver, spleen, muscle, psycho-neurological functions, and laboratory tests."

The most significant (50-70%) result of captivity was malnutrition, with average weight loss from 20-110 pounds. The Morgan Board report noted "[p]ellagra; fissures around the lips (cheilosis) and mouth (stomatitis); inflammation of the tongue (glossitis) and skin (dermatitis) and severe diarrhea and dysentery." Wet beriberi afflicted 77% and 50% suffered from dry beriberi.

Laboratory tests were performed for parasites, stool cultures, blood work, plasma protein, calcium and phosphorus analysis, and urinalysis. Before arriving at the debarkation hospital, there was much improvement because of care provided on the long journey home on ships. Intestinal parasites were present in 60%-70% of POWs. Active malaria was surprisingly low, but most had had malaria during their captivity. Over 50% of the earliest returnees had anemia, but this reduced to only a third from shipboard treatment. Most had diarrhea. It was noted that the "will to live" enabled survival among the captives.

Outside of the typical prisoner during war, civilians were detained by the Japanese in the Philippines when Allied Forces retreated early in the war. Female Army and Navy medical personnel were categorized as "civilians" since female soldiers were a concept unfamiliar to the Japanese. As internees, these clinicians encountered Japanese imprisonment similar to their military male counterparts while continuing to provide care



Army nurses, freed after three years imprisonment in Santo Tomas Internment Compound, climb into trucks as they leave Manila on their way home to the U.S. The nurses are wearing new uniforms given to them to replace their worn out clothes. U.S. Army photo.

to patients. After liberation from the Santo Tomas Internment Center the Army officers were evacuated by truck and plane. In a C-47, they were greeted by billowing DDT sprayed to remove their “contagious bacteria.” The 66 Army nurses, 1 dietician, and 1 physical therapist were in pitiful shape when they reached the 126th Army General Hospital. Three years of captivity and a starvation diet had taken its toll. Ailments included intestinal obstructions, beriberi, limb infections, malaria, dengue fever, tuberculosis, dysentery, dental problems, low body weight, and dehydration. After an onslaught of press attention, most were moved to the more secluded location of the 1st Convalescent Hospital followed by the flights eventually leading back to the United States. At Letterman Army Hospital, they received a battery of tests and examinations. They were given 60-day leave and sent to redistribution stations per the normal recovery procedures. The desire to eat American food and get back to a normal life was just as strong as their male former captives. The “Angels” became celebrity press stories and objects to support the war effort. This onslaught of attention interfered with recovery. It appeared that the physician and psychiatric focus on returning prisoners was aimed at the men. Disease was often undiagnosed. These women would suffer with their war-induced illnesses, which became chronic, and often, disabling.

Unfortunately, from former captive testimony, the World War II repatriate examinations were often hurried. Everyone was euphoric to quickly get back home and eat American food. The right questions were often not asked and ailments were not divulged in an effort to quickly return to a “normal” civilian life.

Korean War

The return of U.S. prisoners from the North Koreans and Communist Chinese were conducted in two operations, “Little Switch” (April 21 to May 3, 1953) for the most seriously sick and wounded and “Big Switch” (August 4 to September 6, 1953) for most of the remaining POWs. In this conflict, the AMEDD initially cared for all returning prisoners at deployed medical units. Evacuation, treatment, and disposition were the responsibility of U.S. Army Far East Command (FECOM) as outlined in “Procedure for Processing, Return and Reassignment of Exchanges in Korea,” dated December 20, 1951. As patients, Little Switch returnees went through administrative and intelligence debriefs in Korea. Medical surveys were to be administered at military hospitals in Japan. A brief initial examination and emergency care was provided at an evacuation hospital near Seoul. The following day, the patients were flown to the two Army hospitals in Tokyo where their medical examinations were completed. The hospital staffs in Japan were augmented to provide dedicated care to their newest patients. On their arrival, the soldiers were given a complete physical examination to include a neurological, dermatological, psychiatric, and psychological review. Extensive laboratory work was performed, ranging from blood testing to stool samples. Avitaminosis was the most evident clinical finding. Coupled with the lack of nutrients, diarrhea took its toll on the captives whose weight loss averaged 25 pounds.

Half also showed evidence of possible pulmonary tuberculosis. Almost 81% showed evidence of intestinal parasites, yet only 16% complained of diarrhea. Upper respiratory infections accounted for 98% of those treated. All former prisoners had a history of cough. Patients were numb and apathetic for the first 3 days. As time progressed, these symptoms were reduced, only to be replaced with dread of returning home for many. Seemingly familiar to today’s returning combat veteran, there was a frustration of coming back to an indiffer-



Panmunjom, Korea, 21 April 1953. POWs (recently repatriated in the UN POW exchange) are off-loaded from ambulances. Note the ones in the foreground walking towards tent. Courtesy National Archives.

Half also showed evidence of possible pulmonary tuberculosis. Almost 81% showed evidence of intestinal parasites, yet only 16% complained of diarrhea. Upper respiratory infections accounted for 98% of those treated. All former prisoners had a history of cough. Patients were numb and apathetic for the first 3 days. As time progressed, these symptoms were reduced, only to be replaced with dread of returning home for many. Seemingly familiar to today’s returning combat veteran, there was a frustration of coming back to an indiffer-

ent civilian population, family members who remembered who you “were” rather than who you “are” now, and contempt for those who inquired about your experience.

Specific examples of anxiety were confronted through group psychotherapy sessions meeting with gradual success. One psychiatrist, MAJ Henry A. Segal, noted the “copious” amounts of “tender loving care.” He felt the 3-day examination timeline did not provide for adequate psychotherapeutic care. This was in spite of FECOM’s mandated 1-hour psychiatric interview and batteries of tests.

Big Switch service members received immediate first aid and were triaged for movement by ambulance or truck to the reception center. Former captives were disinfected by spraying at the center. In robes, they moved from the showers to the reception hospital and initiated the medical paperwork. After laboratory tests, dental and physical examinations, and a chest X-ray, the POWs were identified as patients and nonpatients. The Big Switch repatriated service members, in theory healthier, followed a similar regimen to their Little Switch comrades after receiving the same label. Unlike the earlier release, Big Switch repatriates were allowed to interview with the press. With minimal intervention, patients were flown to military hospitals in Japan for more extensive tests and treatment. After the newly designated patients’ histories were obtained, they were examined by an ophthalmologist, otolaryngologist, internist, neurologist-psychologist, surgeon, orthopedic surgeon, and dentist. CPT William C. Matousek, a physician at one Tokyo hospital, relays that these procedures averaged 7 to 8 days. As expected, the Big Switch patients were much better off. Medical treatment mainly assuaged the hunger and stress in which these men had grown accustomed. Their conditions improved very quickly as they began to receive nutrients and eliminate parasites.

Big Switch, the supposedly “healthy” prisoners, experienced 14 to 45 pounds weight loss. Nonpatients were put on board ships heading back to the United States. Here, they underwent intelligence interviews and administrative processing. After debarkation, the returnees had a 30-day rest period for recuperation and recovery before disposition. Patients followed the Little Switch protocol flying to Japan for examination, Letterman General Hospital, and later other U.S. hospitals for follow-on care, whereas nonpatients conducted medical examinations on board ships sailing to the United States lasting about 2 weeks. The prescribed medical examination included: “medical history, neurological junction, oral and dental exam, laboratory tests (i.e., urinalysis, serology and blood analysis, malaria smear, stool test for parasites, and stool culture), chest X-ray, distance vision, height and weight measurements, blood pressure reading, skin examination, and internal medicine (heart, liver, and spleen) examination.”



1LT Alvin Anderson, one of the many repatriated POWs embracing his mother and sister as other members of his family look on. Fort Mason, California, September 14, 1953. Courtesy National Archives.

In-depth interviews were conducted during the psychiatric reviews. Group therapy sessions were common. Aboard the ship, intelligence interrogation and psychiatric exami-

nation were concurrent spurred by the fear and allegation of “brainwashing” of 21 American POWs who refused repatriation. From all the released prisoners in the Korean conflict, only 3% had malaria, 2% had tuberculosis, and 2% presented upper respiratory problems. Symptomatic of the indigenous diet, 40% of the former prisoners had parasites. A total of 18% were neurotic, with 1% determined as psychotic.

Vietnam War

In “Operation Homecoming” (January 27 to April 4, 1973) released prisoners processed through the Clark Air Force Base Hospital in Manila and were triaged into patient and nonpatient categories. Emergency first aid was provided during the flight to the Philippines when required. Everyone completed the “medical

history, dental, lab (e.g., stool, urinalysis, blood count, malaria smear), X-ray, electrocardiogram,” and initial skin portions of the medical examination while awaiting transport to the United States. Nonpatients examined at Clark were then sent for follow-on care at military hospitals near their home. Former POWs, categorized as patients, remained at Clark for medical care and examination which included a “medical history (pre, during, and post-captivity); nutritional assessment; height and weight measurements; neck and thyroid tests; eye-ear-nose- and throat examination; orthopedic examination; chest X-ray; pulmonary function test; cardiac, abdomen, rectum, and skin test; and psychiatric examinations and interviews.”

Similar to previous Asian captivity, most Vietnam War POWs had intestinal parasites whether held in the North or South. Fractures were common mostly among the downed pilots and malaria was ever present. Most captives held in the South suffered from malnutrition, malaria, transient situational reactions, and skin diseases. Nerve damage was fairly common. Malnutrition was evidenced in about 12% along with its associated dental disease. Only 6% of the former POWs were diagnosed with psychiatric disorders, neurotic rather than psychotic. All Army personnel received follow-on care at Brooke Army Medical Center. Here they underwent a physical examination, blood work looking for malaria and other parasites, X-rays, stress tests on the heart, testing of the lungs, the inner ear for balance issues, and psychiatric studies. Specialists were brought in where needed.



American servicemen, former POWs, cheer as their aircraft takes off from an airfield near Hanoi as part of Operation Homecoming. Courtesy National Archives.

One Air Force flight nurse, Col. (retired) Patricia Campbell Kowal, remembered providing care for the returned servicemen from the Philippines through Guam, Hawaii, and finally the U.S. mainland. Preparation was made on board the C-141 for medical care en route. Specifically, drinks were on hand that would not cause further irritation to the already stressed gastrointestinal systems of the patients. Her final mission was to pick up released POWs directly from Hanoi and provide immediate care in flight. While not requiring any visible medical intervention, she pondered “what hidden physical and emotional scars each had.”

During Operation Homecoming, there was an increased emphasis on the psychiatric side of medicine. Detailed instructions on addressing the special physical and psychological issues the prisoners endured were directed. There was a concerted effort to include counseling for family members by military social workers back in the United States. Military medicine recognized the need to include families in the healing process. All former POWs received care from military facilities for 5 years following their return.

Also occurring during this era, the USS Pueblo was captured by the North Koreans. These prisoners are categorized as having been captive during the Vietnam War era. After 11 months in captivity, the crew was released in December 1968 and flown to the San Diego Naval Regional Medical Center for examination and care. Their physicals were not as extensive as the North Vietnamese released captives that followed 4 years later. Four sailors were eventually found unfit for duty and the rest fit only for limited duty.

Conclusion

While written and implemented before the actual release of prisoners, the procedures for administratively and medically examining former prisoners in WWII and Korea were not always followed. Repatriation procedures were not fully implemented for WWII and Korean former POWs. Korea had better documentation than the previous war, while the Vietnam medical care and follow-up was the most thorough. Former Vietnam POWs received much better follow-up care and examinations. The most prevalent service-connected disability

since repatriation noted by the Veterans Administration was anxiety. Anxiety issues plagued former POWs more than other wartime veterans. There was a lack of thorough medical review and follow-up after WWII repatriation. The eagerness to return former POWs home resulted in little documentation or diagnosis connecting follow-on complications. The patients of Little Switch and Big Switch were extremely tolerant of the whole administrative and medical processing. Seemingly, there was a resistance to return home quickly as manifested in requests for more time, and physical complaint exaggerations.

CPT Matousek foreshadowed many of the issues faced today when he remarked about the soldiers' desire to delay returning to face the problems of home, "The manner and nature of their solutions to these problems, unknown to us, will to a great extent determine their future well-being."

The Army Medical Department has taken note of previous measures used to treat those who have suffered in captivity. The standard procedure on release now is a time for debriefing or readjustment. Providing information on current events, news, and allowing for protected time to rejoin family is now seen as critical to the recovery phase just as the treatment of any visible wound. Media classes, group therapy, and education all relieve the scars formed on the mind.

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Continuing to Serve: AMEDD POWs

Paula Ussery and Charles Franson, AMEDD Museum

AMEDD personnel have two unique responsibilities related to the issue of Prisoners of War. First they are required to provide health care for any enemy soldier who becomes a POW of the United States Army and secondly they continue to care for their fellow POWs if they are captured.

The Second and Third Geneva Conventions, written in 1929, spelled out the specific conditions and responsibilities of belligerent nations toward, "Sick and Wounded in Armies of the Field" and "the Treatment of Prisoners of War." Article 1 of the Second Convention stated "Officers and soldiers and other persons officially attached to the armed forces who are wounded or sick shall be respected and protected in all circumstances; they shall be treated with humanity and cared for medically, . . . by the belligerent in whose power they may be." The Convention for POWs stated that the prisoners should be humanely treated and protected, shown respect at all times, be given adequate food and clothing, provided shelter equivalent to those of the belligerent nation's forces, be given medical care and sent home if seriously ill or wounded.

The 1929 conventions set the standards of care that most of the combatant nations of WWII would follow. Although Germany, France, Great Britain and United States ratified both of the 1929 conventions, the Japanese government did not ratify the convention about the Treatment of Prisoners of War. The lack of ratification reflected the Japanese military belief that combatants were expendable and that surrender was a shameful act. A soldier was expected to die for the emperor rather than surrender. This attitude produced a life-threatening environment for the approximate 27,000 American soldiers captured in the Pacific and China-

Burma-India Theaters between 1942-1945. In general the Japanese military's actions in regards to the health of their prisoners was one of neglect. It was of no great concern if the prisoners lived or died. Medical supplies and equipment and Red Cross parcels were sporadically distributed in most camps. The inadequate diet, lack of medicines and other supplies, forced hard labor, inadequate housing as well as harsh discipline created a medically vulnerable population in which any disease or injury could become life threatening.

It was against this backdrop that the captured AMEDD personnel persevered in their duties. One of those captured was CPT Thomas Hewlett. He graduated from the University of Louisville's School of Medicine in 1938 and joined the Army in September 1940.

Stationed on Corregidor, Hewlett spent 14 months there after the surrender as the medical officer for a 500-man labor detail. In July 1943 Hewlett and a group of prisoners were ordered to Japan to Camp 17 located near Omuta, Fukuoka Prefecture. As Hewlett recounted after the war "I was well aware of the need for surgical instruments and the fact that the Japanese did not furnish instruments for use on prisoners. The instrument kit I had put together on Corregidor was minimal at best [but] my friendship with certain enlisted men working in medical supply at Cabanatuan [POW camp] made it possible to supplement my kit to the point that at least we would be able to handle emergency surgery while en route to Japan. The individual instruments were placed in the baggage of a number of prisoners; thus they escaped detection during the inspections we were subjected to."



Captain Hewlett's surgical kit included both professionally manufactured instruments and improvised instruments. The scalpel and circular abdominal retractor in this photo were made by Dutch torpedo technicians in Camp # 17.

"Our only available anesthesia consisted of several vials of dental Novocain tablets. Two of these tablets dissolved in a small amount of the patient's spinal fluid and injected into the spine gave about forty-five minutes of anesthesia. . . ." When the ship stopped at Taipai [sic] Harbor a prisoner became very ill. A request to send the POW to a hospital for emergency surgery was denied. "[S]o utilizing a hatch cover table and dental Novocain in the spine, removal of a ruptured appendix was carried out in bright sunlight."

Prisoners at Camp 17 were forced to work in a mine and a foundry owned by the Mitsui Corporation. Due to the intervention of Baron Mitsui, there was a clinic building and six wards. Hewlett continued to improvise in order to save his patients. He used bicycle spokes to set fractures, maggots to fight gangrene and light bulbs to keep pneumonia patients warm in the winter.

The medical staff at Camp 17 included Australian, American, and a Royal Dutch Army physician. At the end of WWII they compiled a comprehensive report of the category of diseases and frequency encountered and a mortality chart. Among the most frequent diseases were those of the gastro-intestinal tract, pneumonia and other respiratory diseases, dengue-type fevers nick named "Fukuoka Fever" and malaria. 126 men died out of a total population of 1,859, or 6.7%. The largest number of deaths were due to pneumonia, deficiency diseases, and colitis. The five other medical corps officers composed a letter of commendation for Dr. Hewlett. It reads in part, "Dr. Hewlett has throughout this extremely difficult period set a standard of high professional work. His sound technical knowledge and ability is reflected in the excellent results obtained in this camp. ... His ... own personal example and leadership has encouraged us all."

Major Roy Bodine was also captured in the Philippines with the surrender of the United States Army Forces in the Far East. He had graduated from the University of Iowa's College of Dentistry in June 1934, and received a U.S. Army Reserve Commission. In 1936, he was appointed a dental officer in the Regular Army. Bodine was assigned to Sternberg Army Hospital in Manila, Philippine Islands in September 1939. During the fighting retreat down the Bataan peninsula, Bodine served with the 101st Medical Collecting Company. He received a Silver Star for actions on 7 April 1942, "Though the enemy had broken through and threatened to overrun the main line of defense, Bodine continued to devote himself to the wounded in many forward and completely exposed positions."

His first ordeal as a prisoner was surviving the Bataan Death March and Camp O'Donnell. He spent

time at Cabanatuan and a short period at Bilibid Prison in autumn 1944 while waiting to be transferred. As American forces began liberating the Philippines, the Japanese Army began moving the prisoners via sea northward away from American forces. In December, 1944 he and 1,600 other prisoners were put on the Japanese merchant ship *Oryoku Maru*. Not a hospital ship, it was bombed by American aircraft and on 15 December it sank near Olongapo Naval Station, Subic Bay, Luzon. He noted in his diary that the dental instruments he had carried were lost in the sinking. After reaching shore, Bodine swam back to the ship to assist other POWs, an action for which he would be awarded a Bronze Star. Surviving prisoners were assembled nearby at the tennis courts on the Naval Station. Of the 1,619 POWs aboard the ship, only 1,290 answered roll call. For a week the prisoners were held at the tennis courts. On December 21 the POWs were transported from Olongapo Naval Station to San Fernando, Pampanga and eventually to Japan and Korea.

Food was an all consuming obsession for POWs, especially as rations were cut in 1944-1945 due to the Allied advances in the Pacific. Bodine's diary from this journey faithfully records each scrap of food he ate. Although he had a small quantity of hoarded canned food, the issued rations were minimal. "17 December, Sunday. ... the first food issued since Thursday AM. ... Had four cups of rice which amounted to 2 1/3 spoonfuls per man. Very mouldy and full of worms." 18 December "Had our usual sack of raw rice, 2 1/2 sacks this time, 3 spoonfuls per man, an improvement with 1/2 cup salt for 55 men." 21 December. "Wonder of wonders we were fed eight canteen cups of dry cooked rice for 35 men. It made less than one fourth cup per man but issued with a little salt it made about the tastiest thing I have ever eaten." Major Bodine and the other prisoners were put on different ships and he ended up at Jinsen, Korea, in 1945. "It is by far the cleanest and best run camp we have been in." Aside from the issue rations of soup with a few vegetables, salt, white rice, cups of tea or hot water and bread this camp had "Best of all Red Cross Boxes 1/2 every two weeks"



MAJ Roy Bodine inscribed his name on both his canteen and mess kit. A prisoner's mess gear was of critical importance. Lost or stolen equipment was not replaced and prisoners could not afford to miss any of the meager meals.



Army Nurse Corps insignia worn by LT Hattie Brantley.

"This is not just a caduceus with a white 'N' but a very special one. When I went into the service in February 1939, there was no such thing as 'basic training.' I was assigned a room in Reid Hall, Fort Sam Houston, Texas, and told to go on duty. . . . About a week later, the chief nurse cornered me . . . and told me to stop by the Post Exchange sometime and buy a gold (LT) bar and a Nurse Corps caduceus and wear them instead of my school pin. And . . . this is the insignia I bought.

This is the item I wore, even on the coveralls, on duty in Bataan. Of course during imprisonment we did not wear the insignia, but when the Americans arrived in 1945, I brought out my bar and this caduceus and pinned them on the worn old khaki shirt I had. I didn't want to lose my identity at that late date."

Among the AMEDD personnel captured in the Philippines, were 66 members of the Army Nurse Corps, and one female dietician and one female physical therapist, then working as civilian employees. These women had a coveted overseas assignment. The work load was light and there was ample opportunity for socializing. On 8 December 1941 this world vanished when the Philippines were attacked.

They responded quickly and professionally, tending the wounded and dying at their various hospitals until they were ordered to evacuate to either the Bataan Peninsula or Corregidor Island the week of Christmas 1941. On Bataan they cast aside their white hospital dresses for coveralls. They adapted to living in tents, bathing in a river and working in two large unconventional hospital facilities. They adapted to reduced rations and blackout conditions and the monkeys, rats and snakes. After the quinine was exhausted in March they adapted again, "Sally Blaine became bedridden with malaria [and] she set herself on a cot in the middle of her ward and directed the work of her staff from there."

The women were ordered to Corregidor as Major General Edward King was preparing to surrender. There they endured another month of bombings and mass casualties until Corregidor surrendered on 6 May 1942. They remained on Corregidor until July 1942 when they were transferred to the Santo Tomas civilian internment camp in Manila. For the next three years they were held there and staffed the internee hospital on the grounds. At Santo Tomas, the nurses coped with a lack of privacy, steadily dwindling rations, bedbugs, and as their clothing wore out, they re-made it and knitted their own socks. They were on duty, if malnourished, on 3 February 1945 when a column from the 1st Cavalry Division liberated the camp.

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Recent Donations

ACHH Archival Donations:

Research papers belonging to Captain Richard A. Cook, Chief Clinical Psychologist, US Disciplinary Barracks, Fort Leavenworth, Kansas, 1950s and 1960s.

Two black and white panoramic photographs of Walter Reed General Hospital dated 1918 and 1919.

Framed decorated papyrus painting and an aerial photograph of the 115th Field Hospital, Mubarek Military City, Egypt during Operation Bright Star 1997.

Collection of 20 framed photographs taken by David B. Buhr while serving in Vietnam with the 36th Evacuation Hospital.

New to the Research Library:

67th Medical Group yearbook, 1970-1971

Rogers, Larry. Sword and scalpel: a doctor looks back at Vietnam. 2014.

Aptowicz, Cristin O'Keefe. Dr. Mutter's marvels : a true tale of intrigue and innovation at the dawn of modern medicine. 2015

Enemy Prisoners of War in the 20th Century

Donald Hall

During WWI the American Expeditionary Forces took too few prisoners for major medical problems to develop. After WWI there were new international agreements about treatment of prisoners, with specific provisions for medical care. One was that captured medical personnel (and chaplains) were classified as “detained” and were expected to be used in the treatment of their comrades. The capturing country would have to provide any further personnel and supplies needed.

WWII

Millions of Enemy Prisoners of War (EPW) were taken during WWII, most late in the war as Germany collapsed. (For example, in 1944 about 25,000 Germans were captured in Italy; in 1945, over 180,000 were in just April and May.) Most were in Europe, although more Japanese prisoners were taken very late in the war. Over 425,000 EPW were brought to the U.S. (to reduce logistical demands on overseas theaters) and detained, creating unusual conditions for medical support.

The war in Europe saw the number of prisoners increase significantly as the Allied armies moved relentlessly across the continent. In initial operations, EPW casualties, while a significant portion of overall EPW numbers, only moderately affected the overall hospital workload. For example, the Fifth United States Army, fighting its way up the Italian peninsula, found that 8.54% of its German EPWs were wounded in action (WIA). However, those German WIA were a smaller percentage of patients admitted to the Fifth Army’s hospitals. For instance, there were 8,475 Allied WIA admissions and 606 EPW WIA admissions between May 23 and June 1, 1944, when the final drive on Rome began.

As the Allied armies moved into Germany and the Wehrmacht collapsed, the number of EPW captured significantly increased. At the end of the war, U.S. units were telling the Germans to abandon their weapons and head to the rear, where they were rounded up and placed in EPW camps. More challenging to the Americans were the German military hospitals. As the hospitals were overrun by the Allies, they and their staffs were left intact. An American oversaw their operations and American supplies allowed them to continue operations. The staffs and patients were found to be more than compliant with the Allies.

Generally, U.S. personnel were only used to supervise German and Italian medical personnel, who provided the actual care for their own personnel in the camps. In planning for the invasion of Europe, significant effort was spent in planning for preventive medicine measures in detention facilities, based on U.S. experience in World War I and, to a limited extent, U.S. experience in North Africa. Despite their careful planning, however, the number of prisoners quickly exceeded the available space in EPW camps and continued to exceed capabilities throughout the war. Overcrowding was a constant problem, particularly in transient facilities. EPWs were provided adequate rations; supplies were stretched upon the initial capture of most prisoners but they improved over time.

The hundreds of thousands of EPW in the U.S. caused different problems. There were 150 camps, with over 300 branch camps, each of which needed outpatient care. Preventive medicine was a concern, as EPW brought some diseases that could spread to the U.S. population, e.g. malaria and filariasis. Hospital beds were provided for 4% of the prisoner population, some built specially for the prison camps and some wards at existing Army hospitals dedicated to prisoners. Some seriously wounded prisoners were brought to the U.S., and some prisoners developed serious conditions, and two general hospitals were dedicated to EPWs, with a capacity of over 4,000 beds.

Korean War

During the Korean War, large numbers of prisoners were taken by the United Nations Command (UNC). The UNC assigned responsibility for EPW care to the Eighth United States Army. With the UNC’s counteroffensive in September 1950, large numbers of prisoners were taken, and by December 1950, the UN was housing 173,000 prisoners in and around Pusan. For security reasons, the UNC moved their EPW operations to Kojedo Island, building a camp there that would eventually house 220,000 prisoners. Additionally, to establish an EPW hospital, another compound remained on the mainland in the vicinity of Pusan.

The hospital facility, operated by the 3d and 14th Field Hospitals and designated Prisoner of War Compound 10, peaked at 10,800 patients in March 1951 before dropping to a monthly census of 7,500-8,000. To provide the needed care, the U.S. personnel were augmented by South Korean civilians and captured enemy medical personnel. While at first hesitant to accept treatment from UN personnel, prisoners became more receptive to care when the hospital staff began returning patients to the same ward they had been on before surgery, rather than separating them into pre-operative and post-operative wards. Once they could observe that treatment was not injurious, they became accepting, even eager, for treatment; often demanding that they be treated on a “first come, first served” basis, rather than on the severity of their injuries.

The inability of the UN to control security conditions inside the compounds had a direct impact on public health conditions in those compounds. Dysentery and diarrheal diseases were the second largest cause of death of prisoners among prisoners; accounting for 2,299 of 5,013 disease deaths and 7,614 total recorded deaths (45.9% and 30.2%, respectively). The disease data shows that there was an epidemic of diarrheal disease that burned itself out once the UN regained control of security in the compounds. Similarly, deaths due to trauma (817 deaths, 10.7% of the total) showed spikes linked to violent episodes in the compounds. Tuberculosis, the leading cause of death for prisoners, (2,404 deaths), was fairly consistent throughout the war and was also endemic in the general Korean population.

Vietnam

Although neither North nor South Vietnam were signatories to the Geneva Conventions, the U.S. informed the International Committee of the Red Cross (ICRC) on August 10, 1965 that it would follow the provisions of the Geneva Conventions and, on August 11, the Republic of Vietnam (RVN, or South Vietnam) informed the ICRC that it would do the same. The ICRC made it clear to the U.S. that it would hold them responsible for violations of the conventions by the RVN. U.S. efforts to follow the conventions, and to ensure that the RVN did as well, was at least partially an effort to secure more humane treatment of U.S. personnel, particularly pilots, captured by the North Vietnamese and Viet Cong.

To provide a modicum of oversight of RVN detention facilities, the U.S. and RVN governments established a joint oversight committee for EPW operations, with the RVN establishing EPW camps to which all Free World Forces would transfer their prisoners. The camps would be controlled by the Vietnamese, with the U.S. providing advisors; plans called for six camps. The U.S. provided no medical support or medical advisors to the camps; instead, the senior medical advisor to each region oversaw health care at the camp in their region. Each of the camps, divided into multiple compounds, had a dispensary providing outpatient care for EPWs and camp staff. Some camps also organized sick call within their compounds, run by the prisoners themselves. The U.S. goal was to ensure that the RVN ran an end-to-end, convention-compliant detainee system.

For most of the war, wounded EPW taken by the U.S. (and many Free World Forces as well) were evacuated through the U.S. system. Prisoners were picked up by Dustoff aircraft at the point of injury, flown to the nearest hospital capable of best treating their injuries, and, once sufficiently recovered, turned over to the RVN. Prisoners were mixed with other patients on the wards. Following some large battles, a separate ward might be used to segregate large numbers of prisoners from U.S. and Allied personnel if the situation warranted.

After the 1968 Tet offensive, an intermediate level of holding capability was needed, and two medical clearing companies were dedicated to that purpose; each with a capacity to hold 240 patients who required minimal care. Requests were made for the deployment of two additional hospitals to support the EPW mission. Following a call-up of reserve units, two field hospitals were mobilized and deployed to support EPW operations. The 74th and 311th Field Hospitals arrived in country during October 1968. Originally deployed on two-year mobilization orders, both hospitals were redeployed after only one year in-country. Their mission not yet complete, the 44th Medical Brigade utilized the 50th Medical Company (Clearing), with staff augmentation from the 24th Evacuation Hospital, and the 17th Field Hospital. This was only a temporary mission and, by the end of October 1969, the 17th Field Hospital had returned to An Khe. In 1970, after a surge in the Central EPW Camp's population and a particularly harsh ICRC visit, the RVN increased the capabilities of its hospital on Phu Quoc Island. Increasing from a 100-bed hospital which had been staffed to operate only 40 beds in 1969, by 1972 the hospital had 380 operating beds, supporting a detainee population of 26,500 plus support staff and their families.

The two field hospitals to support detainee operations were requested by the U.S. Army, Vietnam Command Surgeon, Brigadier General Glenn J. Collins, because he preferred it to mixing EPWs with Free World Forces. But he also said that it was much harder on the staffs “running the PW hospital day after day. But someone has to run the PW hospital ... [t]he only relief I can think of is ... shifting around periodically and not keep people on that job for prolonged periods of time. This solution also presents problems.”

Operation Desert Storm

Operation Desert Storm was the largest U.S. combat operation between the Vietnam War and Operation Iraqi Freedom. Well planned and aggressively executed, when cease-fire negotiations began at the end of the war, coalition forces were still counting the number of prisoners they had captured, then in excess of sixty thousand. By the time the sand had settled and the counting was completed, coalition forces had captured 86,743 prisoners, and of those, “approximately 69,822 EPWs and displaced civilians” had been processed through U.S. facilities.

To supervise the processing of EPWs, the 800th MP Brigade was mobilized and deployed to Saudi Arabia. There, the brigade and its subordinate battalions established a centralized EPW management system, including four EPW camps capable of housing up to 100,000 EPWs. The ultimate disposition of any EPWs would be their prompt handover to the Saudis for long term detention or repatriation; much as was done with prisoners in Vietnam. At its peak, the 800th MP Brigade had a strength of more than nine thousand providing security, accountability, and life-support for the prisoners.

Medical support for detainee operations was similarly challenging. The 800th MP Brigade issued its initial guidance for medical care on January 13, 1991. As always, EPW patients who were sick, ill, or injured were evacuated through medical channels, returning to MP control when their medical condition warranted it, while always being provided access to the same quality of care as coalition forces. Iraqi EPWs (the first of whom had surrendered in January and the last of whom were transferred to the Saudis in May, 1991) were in poor condition, poorly fed, and ill equipped. They suffered from malnutrition and diseases due to improper sanitation and lack of control of insect vectors in their field locations; conditions which deteriorated as the air campaign isolated forward positions from resupply.

U.S. Central Command anticipated the need for hospitalization support, and gave the EPW camps support mission to the 300th Field Hospital of the 3d MEDCOM. The 300th arrived in theater on January 16th and set up 400 beds at the western of the two camps established by the 800th MP Brigade. On January 23rd and again on the 26th, the 800th MPs requested that three additional hospitals be dedicated to EPW support. On the 26th, the 3d MEDCOM issued guidance on EPW support but did not dedicate additional hospitals to the EPW mission. Instead, EPWs in the eastern camp had to be escorted to one of three supporting, but not dedicated, Evacuation Hospitals. This solution proved more than enough to manage the EPW patient load; despite the concerns of the MP Brigade leadership.

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“The Magic of Oatmeal”: MAJ Arthur L. Ludwick, Jr. and combat medicine in WWII **Peggy Ludwick**

Is there anything quite like a bowl of hot steaming oatmeal to start off the day? My father, the late Dr. Arthur L. “Lud” Ludwick Jr. (1913–2008) was certainly a believer. For as far back as I can remember, in his 50+ years as a family medicine physician in Wenatchee, Washington, hot oatmeal was how he started each day. He regularly touted its health benefits to anyone who would listen, insisting that this “stick-to-your-ribs” breakfast would “get-you-through” to lunch, and beyond. He fervently believed in the power of porridge, not just for its well-known nutritious properties, but for its potential to comfort and calm, as well.

Dad’s ritual of oatmeal was more than just sustenance. Its therapeutic properties dated back to WWII, where Lud was a Battalion/Regimental Surgeon in the celebrated 34th “Red Bulls” Infantry Division (133rd/168th Regiments). Major (later Lieutenant Colonel) Ludwick, M.D. served for 28 months on the front lines of North Africa and Italy in some of the bloodiest battles of the Mediterranean Theater: Kasserine and Fondouk Passes, Hill 609, Monte Pantano, Cassino, and Anzio. He insisted on serving as far forward as possible to ensure that wounded soldiers were quickly treated where they fell and properly evacuated. As a result, he earned both the Purple Heart and Silver Star, unusual combat commendations for an unarmed medical officer.

In context, his 265 eloquent letters home to his wartime bride of just two months were filled with not only observations on the landscapes, cultures, and people he encountered, but also many references to depression and fear —his own *and* his men’s. During interviews with my father in the years before his death, I recorded his many hair-raising, fascinating, and entertaining war stories, of which I write about in my book, *A DOCTOR’S WAR*. Lud was responsible for the physical and emotional well-being of traumatized and wounded soldiers – and this is where the “power of oatmeal” made its debut. One of Lud’s more unusual stories was about the magical powers of oatmeal as a psychological balm for soldiers suffering from what was then called “combat fatigue,” now Post Traumatic Stress Disorder (PTSD).

In February 1943, after their first major skirmishes with German troops in North Africa, many American soldiers suffered from debilitating emotional trauma. Although the 34th Infantry Division had trained in Northern Ireland for nearly ten months prior to engaging with the enemy in North Africa, they were very young, inexperienced, and ill-equipped for actual live combat.

“We experienced our first heavy casualties in the Faid/Kasserine Pass area of Tunisia, North Africa. At that time, I was a Battalion Surgeon in the 133rd Infantry Regiment. There, we deployed into a defensive position because the enemy was up on high ground with entrenched artillery and some ground troops below to defend their position. When we attacked a few days later, it was really rough going because the Germans were so well trained and situated. This was the first major contact we had with the enemy, and it was a disaster.”

“We had many medical casualties, and also the condition known as ‘combat fatigue,’ when the men would get the ‘shakes’ and ‘couldn’t take it anymore.’ Well, they became a real medical problem and liability. Most of them were just evacuated.”

In WWI, this condition was called “shell-shock,” and in previous wars, those soldiers were derided for being “yellow” or cowards in the face of combat. In a well-documented incident during WWII, while General George Patton was inspecting an army field hospital in North Africa, he came upon a whole ward of soldiers diagnosed with “combat fatigue.” When one young soldier confessed “I just couldn’t take it anymore,” Patton slapped him and threw him out of the tent. This “macho” attitude towards emotionally traumatized soldiers eventually became obsolete, even though the very real concern amongst commanding officers was that such behavior could rapidly spread. A soldier would plead ‘combat fatigue,’ be relieved of frontline/active duty, and spend time convalescing in a rear echelon hospital with three hot meals a day.

As my dad noted, “Patton didn’t like the fact that these guys had been evacuated as medical casualties,



MAJ Ludwick, MC, receiving the Silver Star from LTG Mark Clark, 14 March 1944.
Courtesy of the author.

because that becomes contagious. He didn't like that, and frankly, neither did we." According to Albert E. Cowdrey in his book, *Fighting For Life* "... Psychiatric reactions were responsible for 20 percent of all battlefield evacuations, and could even run as high as 34 percent. ... Battles began to last for days, then for weeks or months, forcing men to spend seemingly endless time under fire. The body's 'fight-or-flight' mechanisms, designed by nature for use in brief emergencies, instead were evoked over long periods by the constantly impending danger of injury or death."

My father continues, "My commanding officer, Colonel Ray Fountain, a former federal bankruptcy referee in Des Moines, didn't want a high casualty rate on his record — it wouldn't look good, and if a good portion of these were actually psychiatric casualties, he wanted to avoid that. And so, he said to me, 'Doc, see what you can do with these guys.'"

In a somewhat unconventional approach to the problem, Lud took four to six traumatized soldiers at a time from the front back to his camouflaged aid station, which was about three-quarters of a mile behind the front line.

"I got some pup tents and set up the men there, around the aid station, and I kept them for two or three days — sometimes four days — and I fed them hot homemade oatmeal every morning, with raisins, if I could get them, and canned milk. And then I'd talk to them and say, 'You know, I'm just scared to death myself, and am constantly afraid of being killed. Fear is not uncommon or a bad thing — it's the normal reaction and response in battle to this terrible danger we face every day. But we've all got to do it. And we can't give up, and say 'I just can't make it,' because I know you *can* do it — after all, you're an American soldier.'"

"I'd talk to them from a psychological standpoint and in a gentle voice, and after about three or four days of being on oatmeal and talking about what they were feeling, a modified form of group therapy, I guess, they often went back to their unit — and were not counted as an evacuated casualty."

"Well, the Colonel really liked that and thought I was some kind of miracle worker. But I knew those young guys just needed to know that it was normal to be scared to death in combat and that they could get through it."

Who knew that "The Magic of Oatmeal" could not only comfort and transform young frightened soldiers during combat and, dare I suggest, help win a war?

My father seemed to instinctively know that unlike the physically wounded, soldiers suffering from combat fatigue became worse, not better, as they were moved farther to the rear. To effectively rehabilitate these men, they needed to be treated with compassion at the front lines and kept *with* their unit. It affected the unit too. If they were evacuated and replenished with inexperienced replacement soldiers who lacked emotional ties to their new comrades, the result could make matters worse for the rest of the regiment. Also, because combat replacements were in such high demand, many of these replacements, suddenly shoved forward to the front lines, had not even finished basic training or qualified with their weapons, as well as being in poor physical shape and often, overaged. Therefore, it was in a regiment's best interest to keep as many original unit members together as possible.

Perhaps Lud's novel and compassionate approach to treating PTSD was due, in part, to his own father's influence. Major Arthur L. Ludwick Sr, M.D., who had been trained as a neuro-psychiatrist (or "alienist" as it was then called) and spent more than twenty years in civilian life treating patients with "nervous" and mental disorders. After joining the Army in 1917 during WWI, Ludwick Sr became one of the country's first trained Flight Surgeons in the Army's Air Service and began treating "nerve-shocked" aviators, our nation's earliest and most daring pilots.



CPT Ludwick at his camouflaged battalion aid station in Tunisia, April 1943.
Courtesy of the author.



MAJ Arthur Ludwick, Sr, (center) with pilots and biplane, Carlstrom Field, Florida.
Courtesy of the author.

Ludwick Sr believed that the majority of medical problems these flyers had were related to morale, fear, anxiety, and other emotions that interfered with their performance as pilots. In one of his 1918 hospital reports, Ludwick Sr noted “These ‘Birds’ are hypersensitive, quick-headed, reckless, and superstitious.”

At that time, it was assumed that flyers’ neuropsychiatric disorders were a result of concussions suffered in artillery barrages and/or lack of oxygen in the open-air cockpits of the era’s primitive biplanes. However, this was not always the case. “Stale” aviators, whether they had engaged in actual combat flights or not, often faced terrifying challenges in the open cockpits of their flimsy planes. Captain Ludwick Sr had a sophisticated understanding of stress and how it should be treated, recommending a complete break from military discipline and talking freely with patients about their traumatic experiences.

Over a hundred years ago, Ludwick Sr pioneered the use of a new and unconventional rehabilitation method now referred to as “psycho-drama,” where the distressed pilots wrote, staged, and performed in short re-enactment plays depicting their frightening and dangerous flight experiences. One such play, “The Eyes of the Army,” was presented to neighboring communities in and around Cooperstown, New York during the summer of 1919. In one particularly dramatic scene, an actual fuselage of an old army plane dropped onto the stage from the loft above, and in it were two aviator patients. This “special effect” stunned audiences and became a well-publicized attraction for subsequent performances.

I can’t help but think my dad’s familiarity with his own father’s compassionate and innovative treatment of stress during WWI, laid the foundation for his approach to the “combat fatigue” he treated in North Africa and Italy: taking traumatized young soldiers from the frontlines back to his aid station for a few days, and giving them the personal attention and gentle, non-judgmental counseling they needed.

After the war in 1951, Pulitzer Prize winning journalist and Associated Press Staff writer, Relman Morin, wrote in *The Montana Standard* that “During World War II, 640,000 American soldiers cracked up from mental or emotional causes and became unfit to bear arms. These men were not ‘crazy.’ Nor were they ‘cowards’ in the absolute sense that they were totally incapable of controlling fear. Nevertheless, they were casualties, as surely as though each one had been hit by a bullet.”

In one of the biggest projects conducted by the military to study and investigate why there were so many cases of PTSD during WWII, two distinct factors emerged that led to some major reforms in officer training: about 60 per cent of the emotional breakdowns occurred during training, well before the men were in combat; and there was a direct ratio between the percentage of neurosis cases in a division while it was in combat and the number of men killed and wounded by enemy fire. The Army concluded that good leaders are made, not born.

The report went on to say, that an essential component in command and leadership training had nothing to do with tactics, weaponry, or administration; rather, the relationship between officer, soldier, and the given situation confronting them was what was most important.

In a letter home a few months before leaving Italy in 1944, my father wrote:

“I know that a great many men who are now overseas will be strangers when they return, and their secret need for understanding and companionship will go unheeded. No rough, tough fighting American is going to admit that need, but it’ll be there just the same, and its frustration will come to the surface in a variety of actions, reactions, and behaviors. . . . Darling - I’m going to need you very much when I get home.”

—MAJ Arthur L. Ludwick, Jr, 22 January 1944, Italy

A Doctor’s War: Letters and Reflections From the Frontlines of WWII, is one man’s resolute journey through the minefields of love and war and what he learns about himself along the way. It’s also a daughter’s discovery of the young man she never knew, before he became her father.

<https://mcfarlandbooks.com/product/A-Doctors-War/>

For more information about the book, how it came to be, and select photos and excerpts <https://adoctorswar.com>

Book Review by Scott C. Woodard, Historian, ACHH

Lathrop, Alan K. *A Surgeon with Stilwell: Dr. John H. Grindlay and Combat Medicine in the China-Burma-India Theater of World War II*. McFarland & Company, Inc., Publishers, Jefferson, North Carolina, 2018, 251 pages, bibliography, endnotes, pictures, maps, index.

Alan K. Lathrop, a retired professor from the University of Minnesota Libraries-Twin Cities, tells the story of Dr. John H. Grindlay's experience in the China-Burma-India (CBI) Theater during World War II. Lathrop weaves primary sources (unpublished diary and letters from Grindlay, numerous papers from archives ranging from the US Army Heritage and Education Center and the Mayo Clinic), published works from the period, as well as, a rich collection of secondary sources.

This account from 1941-1944 foreshadows future potential large-scale combat operations in Asia. The personal and medical view reflecting a lesser known theater of operations is valuable. Dr. Grindlay, the central figure of the story, was one of the handful of Americans who walked out of Burma with General Joseph W. Stilwell and later served as chief of surgery in the Seagrave Hospital Unit. He mingled among the more notable men of the war – Generalissimo Chiang Kai-shek, head of the Nationalist Chinese Government, the aforementioned General Joseph W. Stilwell, leader of the “walkout” from Burma to India and builder of the Ledo Road from India to China, and the famous Dr. Gordon S. Seagrave. This close relationship with the “Burma Surgeon” reveals much of the human side of the famed surgeon not relayed by the public relations machine during and immediately after the war.

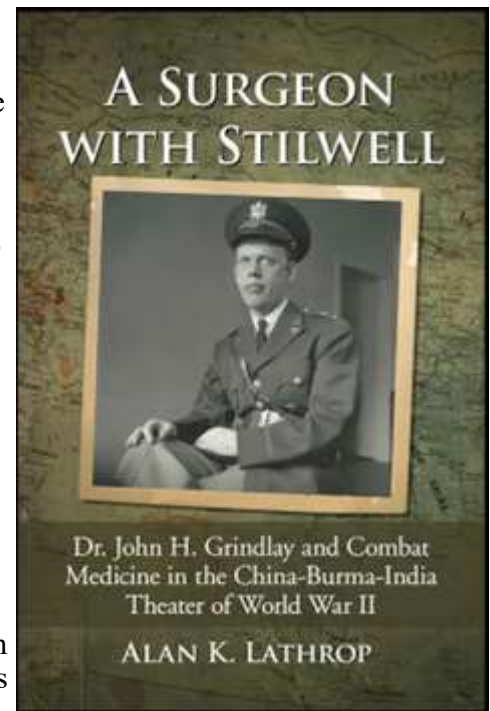
Lathrop's skill is demonstrated through his detailed information and detective work forming the contexts to Grindlay's observations in the often forgotten malarial and starving tropics of the CBI. Of particular note for the reader, the endnotes add incredible background details on the personalities in the book. So much is revealed and these snippets add to the flavor and round out the personalities encountered. Some of the gems in the details of a personal diary are Grindlay's witness to biological warfare carried out by the Japanese (p. 50-51), realization that his diary entries for the “walkout” were used by Seagrave in his book, *Burma Surgeon* (p. 151), and the incredulous reaction of shock displayed by hospital staff to the Theater Commander's obvious familiarity and bond with the surgeon during Stilwell's visit to the Seagrave Hospital Unit (p. 151-152).

Unfortunately a lot of the pictorial snapshots in time are lost because Grindlay's camera was lost, but the richest photos are US Army photographs possessed by the Grindlay family showing scenes not often seen from Stilwell's walkout from Burma. Perhaps in a desire to publish more original material, other photographs seem arbitrary at times. For example, Friends Ambulance Unit (conscientious objector ambulance driver volunteers from England) member Bill Duncombe's photo (p. 155) from 1970 is included, but he is only mentioned three times in relatively minor roles. Additionally, the two maps in the book would be much more helpful with locations of Grindlay's travels better indicated.

As described in the epilogue, medical personnel adopted to the challenges in the CBI Theater relatively quickly.

Grindlay himself is an exemplary case in point: finding himself in Burma during the drought and overpowering heat of the dry season, he learned to conduct surgery without the sterile conditions that prevailed in the operating theaters he was accustomed to in the United States. Insects, rain and often dust fell into the surgical field; blood was removed from patients and recycled; surgery was conducted by lamplight or flashlights; surgeons smoked as they operated; and the constant rush of cases rarely left sufficient time to give them full attention or complete care. It took Grindlay a long time to conquer his compulsion for strict sterility and learn to accommodate less-than-perfect surgical conditions (p. 205).

This excerpt highlights the timely and incredibly important aspects of military medicine in an unforgiving and brutal environment presented in *A Surgeon with Stilwell* that Army Medicine experienced and may face again. It is a worthwhile read to understand the up-close and personal aspects of combat medicine in Asia from yesterday and for tomorrow.





Relatives Await POWs



Pay Call



Processing Line



Typical Reunion

Did You Know?

Operation Big Switch brought 709 repatriated POWs directly from the Fort Mason pier to Letterman . . . 558 of these were Army and 151 were Air Force personnel . . . the returnees made 600 telephone calls to their homes and sent 50 telegrams . . . 1062 extra meals were served to the POWs and members of their families who came to meet them . . . 2000 cups of fresh coffee were dispensed by Red Cross volunteers, 56 of whom worked an average of eight hours each . . . \$1,530,000 in checks and cash was disbursed as travel pay and accumulated pay . . . buses, ambulances and trucks made a total of 774 trips to transport passengers and baggage from the pier to wards in the Crissy area and from Crissy to Travis AFB . . . LAH MPs acted as convoys for the trips and directed traffic . . . mountains of paper work were accomplished by personnel in various sections, many of whom worked until the wee hours . . . yards of film were shot by news photographers and hundreds of questions were asked by reporters . . . No statistics were kept as to the number of smiles and tears, kisses and handshakes exchanged between the returning POWs and their relatives and friends; nor yet of the joy experienced by Letterman duty and volunteer personnel who were privileged to serve the returnees in any way.



Unloading from Busses



Mess Hall Meal

tions. These duties are in addition to the normal POW roles of resisting captors and trying to escape. For consideration think of the tools of a POW surgeon, or the desperation of their patient. Although the circumstances of conflict differ, human perseverance and kindness continues as seen in the treatment of fellow POWs.

Changing gears, can mental well-being be cured by a good oatmeal breakfast? There is more to the story, including understanding and camaraderie during war. Read about MAJ Arthur Ludwick and combat medicine during World War II. Also, a book review on Dr. John H. Grindlay shares his experiences while operating in the China Burma India Theater.

Please let us know your thoughts. We would like to hear your comments and are always seeking new articles for publication.

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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 usarmy.jbsa.medical-coe.mbx.office-of-medical-history@army.mil Please contact us about technical specifications.

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