The AMEDD Historian

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Welcome to Issue #51 of *The AMEDD Historian*! This issue skips ahead from the Revolutionary War in our last issue to the end of World War II. After years of fighting, millions of American Soldiers were finally able to consider their life "when the war is over", but there was still more work to be done. War is often characterized by destruction and confusion, with armies in generally organized groups, but not the citizens of destroyed countries. After World War II, there was a tremendous task of creating order from chaos while managing the demobilization of a massive army. For Army medical personnel, civil government support and public health issues grew in importance as battles faded. They would assist with initial phases as countries and governments recovered.

Battleground countries in Europe and the Pacific had misplaced citizens from other lands, newly freed peoples, military prisoners, and concentration camp survivors to sort through for assistance. The term "Displaced Person" or "DP" was accurate in describing the huge mass of people that needed to be organized and helped. Getting DPs registered, healthy (and non-contagious) as well as transported to their place of origin took time. For concentration camp and prisoner of war survivors, nutrition and conquering even "minor" illnesses were of utmost importance. Their recovery took longer, but it was a daily struggle back to health.

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Mustering Out the Medics: AMEDD Downsizing After WWII

Wayne R. Austerman, PhD

Between the time of the formal close of WWI in Europe on 7 May 1945, and the end of 1946, the AMEDD laid aside the burdens of war and assumed those of an uneasy peace in a stressful period of transition. As the U.S. Army as a whole began the process of demobilization in earnest in the wake of the German and Japanese surrenders in the late summer of 1945, it found it increasingly difficult to sustain the capabilities of a medical component which was in itself an essential key to the success of that larger demobilization effort.

As the Army turned to the task of fully demobilizing 7 million troops from a wartime peak strength of 8 million men, it tasked its shrinking Medical Department with solving problems which "seemed to press for an even quicker settlement than those of worldwide war itself." The climax of the AMEDD's war lay behind them at Remagen and Shuri Ridge. Ahead lay the bleak prospect of lean budgets, declining resources, and global commitments.

The AMEDD of late 1945 had much of which to be justifiably proud. During the war, a force of 45,000 Army physicians, a like number of nurses, and over 500,000 other specialists and enlisted personnel had sustained the fighting strength on every front. During 1943-45, the Medical Department had treated 9 million patients in its hospitals, another 2 million in quarters, and over 80 million cases were handled by the

dispensaries as recipients of outpatient treatment. Despite the service's deployment to some of the most disease-ridden quadrants of the globe, the death rate from nonbattle causes during the climactic final 2 years of the war averaged only 3 per thousand per year, approximately equal to that of corresponding age groups in civilian life. If a wounded man survived to reach a battalion aid station or other medical facility, the odds for his continued survival were nearly 97% favorable. Nearly three out of every four soldiers were returned to duty after treatment. The rate of death from wounds was half of that recorded for American troops during WWI. No Army in the history of warfare had ever received finer medical support than that provided to the American forces during WWII.

The coming of peace in Europe in the early spring of 1945 marked the immediate aftermath of the peak period for American casualties in all theaters of the global conflict, which crested at 81,000 per month in December 1944. The end of the fighting in Europe marked the close of mass casualty situations for those forces, but the then-impending invasion and conquest of the Japanese home islands were expected to produce a bloodbath. The AMEDD had to marshal its personnel and materiel resources to confront the challenges of both partial demobilization and the terrible losses anticipated to come from offensive operations in the Pacific Theater which were expected to continue into 1946.

As early as June 1943, the Plans Coordination Branch of the Plans Division of the Operations Service, Office of The Surgeon General (OTSG), was tasked with planning for the reduction of medical operations as hostilities ceased. Renamed the Demobilization Branch, this organization was concerned not only with planning for reduction in personnel, but infacilities and supplies as well, while it also worked on medical procedures to be used in demobilizing nonmedical personnel. Since demobilization affected virtually every element of The Surgeon General's office, the Resources Analysis Division was given the added responsibility of coordinating all demobilization and redeployment planning and all matters pertaining to civil affairs.

Headed by a civilian, Dr Eli Ginzburg, the Resources Analysis Division received the tasking for unified personnel planning for redeployment and allied planning problems only 8 days before the German surrender. The division had authority to call upon any other elements of OTSG, including the Demobilization Branch, for assistance in these matters. Although some previous coordination had been made with the Army Service Forces headquarters to define basic principles, no adequate "logistical plan" for redeploying and reducing personnel had been worked out to cope with the "tremendous difficulty of which doctors and in what numbers you would be able to let out at what rate from which places," confessed Dr Ginzburg.

The assembly of detailed data concerning the distribution and other aspects of medical personnel (age, efficiency, length of service, etc), the estimating of future personnel needs as medical operations declined and shifted geographically or in relation to the types of patient care required, and the periodic defining and refinement of criteria for discharge in the light of assembled data and estimates, became the function primarily of the Resources Analysis Division, and was closely related to its work in planning the reduction of hospital facilities. All the plans emanating from OTSG had to mesh smoothly with the master redeployment and demobilization plans being drafted by the Army Service Forces, War Department, and National Resources Planning Board.

The plans approved prior to the German capitulation envisioned a complex and leisurely process of demobilization and/or redeployment of American forces as the war in the Pacific continued. The War Department demobilization policy rested upon the guiding concept of fairness to all who had bone the burdens of service and battle. For a partial demobilization after the German surrender, the Army planned to discharge enlisted personnel who had compiled a high Adjusted Service Rating a numerical score which took into account each soldier's length of service, time overseas, combat experience, decorations, and number of dependents. Similar standards governed the selection of officers for discharge to the greatest extent possible.

The AMEDD was thus expected to provide quality health care for all troops remaining on active duty on a global basis, while supporting the demobilization effort, confronting the problems of caring for both occupation troops and hordes of civilian refugees in war-shattered Europe, and preparing for the carnage yet to come in the Pacific, where out of the 767,000 troops earmarked for the planned invasion of Japan in early 1946, fully 268,000 were expected to become casualties. All of these responsibilities were to be met while the Medical Department simultaneously presided over its own partial demobilization. In many ways, the post -VE Day mission was more daunting than the wartime one.

The collapse of Nazi Germany found the AMEDD with approximately 35% of its strength serving in

continental United States (CONUS), with the balance overseas. During the March-June 1945 period, a total of 185,000 patients had been evacuated from overseas to CONUS medical facilities. Each was expected to require a further 5-6 months of care prior to discharge to civilian life or a VA hospital for further treatment. This meant that although only the Pacific Theater of Operations could be expected to generate another major influx of CONUS-bound casualties, there would be a sufficient number on hand to keep the general and convalescent hospitals operating at or near peak capacity until late autumn of 1945.

The situation in Europe demanded the existence of a strong medical support system even after the fighting had ceased, for the normal health needs and peculiar afflictions of a restless veteran army engaged in occupation duty continued to furnish ample work for the medics. In January 1945, for example, the venereal disease infection rate had stood at 50 cases per each 1,000 troops in the European Theater of Operations. By the end of the year, it had soared to 250 cases per each 1,000 GIs as the bored and resentful troops flouted the non-fraternization regulations or sought canal solace with the legion of desperate female displaced persons and refugees who willingly exchanged their favors for food and tobacco.

Other troops fell victim to their own enthusiasm and poor judgment. The distillation of illicit liquors and their resultant consumption killed 31 soldiers within a single week in Germany. In July 1945, General George S. Patton reported that his third Army had lost 50 men killed and 500 wounded in shooting incidents which all too frequently stemmed from drinking bouts, as did many of the frequent road accidents. Patton himself would die as the result of an automobile accident in December 1945.

The demobilization process, as fair as it was intended to be, still imposed horrendous administrative burdens upon the units in Europe, and medical units, which had to perform pre-discharge physical examinations on a steadily mounting number of troops as the weeks passed. Although the Japanese surrender on 2 September simplified things by removing one mission, Surgeon General Kirk and his staff still faced a formidable task, which forced them to "reorganize, and indeed rethink, the basic structure and character of their organization." The department's leadership soon found that events were rapidly overtaking and rendering useless even the most recently conceived plans for a fair and rational demobilization process.

In July 1945, Medical Department planners had anticipated that Medical Corps strength could be reduced only by some 7,000 officers over the next 10 months. On the same day that the first atomic weapon was detonated over Hiroshima, the department reaffirmed a policy that discounted a quick end to the Pacific war while failing to foresee the political firestorm which would erupt in Congress following the Japanese surrender, as servicemen-constituents petitioned their representatives to speed their demobilization. In the wake of Hiroshima and Nagasaki, immediate pressure fell upon the War Department to expedite the demobilization effort with all possible speed. The AMEDD's enlisted component began to melt away. Despite the formulation of an elaborate scheme for awarding points toward qualifying men for separation based upon a wide variety of factors, rapid changes in policy in response to Congressional protests reduced the entire discharge process to a muddle by late summer of 1945.

The resultant situation pleased no one. The point scores necessary for separation had been rapidly and repeatedly adjusted downward, but news of the changes did not always reach everyone in a timely manner. The situation became so chaotic that the chief of OTSG's Enlisted Branch learned of one change only by reading it in a newspaper. Some separation centers were discharging men under one set of criteria while others followed entirely different standards. By whatever criteria, just under 5,000 AMEDD enlisted men had returned to civilian life by the end of 1945, and thereafter the flow of discharges became a flood.

The demobilization effort took on a life of its own as it accrued both political and procedural momentum even before the Japanese surrender. By the end of 1945, fully half of the 8,300,000 men on active duty 7 months before had returned to private life, and by mid-1946, the Army's strength would be halved again. Well before the enlisted exodus had peaked, every Army doctor understandably anticipated that his own estimated date of discharge could be reasonably expected to advance by at least 5 months due to the Japanese collapse. When the pace of demobilization did not appear to be accelerating as expected, the Medical Department confronted serious morale problems among its physicians.

The Lowest Ebb. The majority of the service's wartime physicians were drawn from the 45,000 civilian practitioners who had been inducted for the duration in the months following Pearl Harbor. They had done a superb job throughout the war, but with the end of the fighting on all fronts, they wanted only to go home and resume their private medical careers. Three years later, a new Surgeon General looked back on the imme-

diate period following the Japanese surrender and confessed that "the morale of the Medical Corps was at a low ebb on V-J Day. I refer to the manner in which Army Reserve, Army National Guard, and U.S. Army officers appraised their military experiences. They were dissatisfied; in fact, they were disgruntled ... the extreme negativism of these civilian doctors, and it really was extreme, greatly complicated the postwar readjustment of the AMEDD."

The restive physicians would complain to anyone who would listen. As the leaves changed on the trees lining the banks of the Potomac, the Surgeon General and his staff felt continued pressure from Congress, the public, the Adjutant General, and the War Department General Staff for the swift release of personnel. Facing an increasingly irascible officer corps and Congress, the Assistant Surgeon General, Brigadier General R.W. Bliss, assured a Senate subcommittee in October 1945 that "separations are now one of our important missions." He pointed out that the 7,213 doctors released from service since V-E Day represented about 16% of total Medical Corps strength, while total separations represented only 15% of the Army as a whole to that date. General Bliss promised that every doctor except regulars, volunteers, and those with statutory duty obligations to fulfill would be returned to civilian life by the end of summer 1946. In the interim, he reminded the senators that the Medical Department still needed doctors to deal with a patient load of nearly 400,000 and the processing of nearly 1 million separations per month.

General Bliss' assurances were ignored in some quarters. On 6 November 1945, Senator Clyde M. Reed of Kansas publicly charged that the AMEDD had retained more doctors on active duty by that September than it had on its rosters in January 1945, when global war still raged. The senator further criticized the service for what he termed "an incredible degree of incompetency, inefficiency, and general neglect on the part of the OTSG of the Army, in dealing with the return of the doctors and surgeons from the Army service where they are not needed, to communities where the civilian need for proper medical attention is very great." Reed further called for the Secretary of War to conduct a formal investigation of the situation and take the necessary corrective action.

Critics such as Reed were articulating genuinely felt grievances among the doctors still serving and their civilian constituents in many communities. The truth of the matter was not that the medical demobilization process was going badly, but rather that it was proceeding far more smoothly than had ever been anticipated prior to Japan's abrupt surrender. Over 11,000 physicians had been discharged by the time Senator Reed voiced his charges. What the public and many uniformed malcontents failed to realize was that, in addition to the medical skills still needed to provide definitive treatment in peacetime Army hospitals, 2,000 doctors were required just to staff the separation centers processing all troops for release. Even so, the ranks of the military surgeons were shrinking rapidly. By mid-November 1945, over 25% of them had been discharged, with separations running two months ahead of schedule in some cases. Fully 18,385 nurses out of a total of 57,000 had also been discharged by Thanksgiving. These separations were expedited by a declining patient load, which was expected to total no more than 220,000 by the end of 1945, and with only 70,000 estimated to require further treatment by mid-1947. This development allowed the department to schedule 25 hospitals for closure or transfer to the Veterans Administration by the start of 1946.

Although the threat of a congressional or War Department investigation "did not change basic medical demobilization plans, it probably hastened the execution of them," observed the official historical account of the effort, for by the end of December, 22,000 doctors had been released from active duty. The period September 1945 - March 1946 marked the peak phase of medical demobilization; by the end of that time, 32,900 doctors had been released, along with nearly 10,000 dentists and 40,000 nurses. Within another 9 months, the ranks had been thinned by 45,000 doctors, 14,000 dentists, and over 50,000 nurses as 1946 closed with the AMEDD reduced to a pale shadow of its wartime strength. July 1946 saw the department struggling to provide care with a force of only 8,500 doctors, 3,500 dentists, and 9,000 nurses. "Although the demobilization of critical category personnel, including shipment from overseas theaters, was an outstanding achievement," stressed the official account of the process, "it was undoubtedly too rapid from the standpoint of good medical care."

This is abridged from Dr. Austerman's article of the same title in the April-June 2003 issue of the AMEDD Journal, pages 15-20.

Experiences at a Concentration Camp
Colonel Abner Zehm MC

COL Abner Zehm was a Regular Army officer, born in North Dakota to parents who had emigrated from Germany. In January 1945 he had taken command of the 45th Evacuation Hospital. His selection for this assignment may have been influenced by several years in the mid-1930s at the Army's main tuberculosis treatment hospital, outside Denver CO.

As commanding officer of an evacuation hospital, I received a call from the Surgeon, First Army, on 26 April 1945 informing me that the Chief of Staff, First Army, had directed that an evacuation hospital be dispatched to Buchenwald Concentration Camp, since this camp had recently been liberated and created a considerable medical problem. The Surgeon selected my evacuation hospital to perform what might be termed a threefold mission at Buchenwald; namely (1) to clean the camp up from a sanitary standpoint, (2) to supervise the medical care of all inmate patients, and (3) to screen all confirmed or suspected tuberculosis cases for subsequent evacuation to more desirable and permanent quarters, It was realized that the first mission was of importance since the camp was in a deplorable sanitary condition. To accomplish this a separate headquarters designated as the "Medical Director" was established in conjunction with Headquarters, where close liaison and cooperation could be held with the other offices of Camp Headquarters.

Having received my mission, I decided to make a reconnaissance of the Buchenwald Concentration Camp and develop plans for the establishment of my hospital either under tentage or in already existing buildings. It was a beautiful drive through the hilly, wooded country, on a clear spring day. I noted the singing of the birds and the beauty of the flowers at the roadside, and felt that this type of atmosphere surely would not hide anything really bad. But as I rounded a curve in the road, a different picture caught my eye, a gate shrouded in barbed wire, then electrified. There were enclosures of bombed out rubble which formerly was the factories in which the slaves from the camp labored. Little was left now but the wire and it too had done its work and was cold and lifeless. One could touch it and live, what a change a few days had made.

Having taken care of hundreds of wounded German prisoners since the invasion, having interviewed a good many other prisoners of war, and having discussed Germany and its problems with many of the civilian population, I felt I had a good idea of what is Germany and the philosophy of life practiced by the Germans. That was a mistaken assumption on my part; one does not become so wise so easily. A concentration camp is but one illustration of the moral rottenness and degradation to which Germany sank, but it is a good one. It is more than a detention camp, it is a basic change in a philosophy of life. It is for those who do not believe what they are told to believe, or do not do what they are told to do, and concentration camps have done business which all but exceeds the wildest imagination. Such a large-scale endeavor could never occur in a land in which the majority refused to indorse the measures undertaken.

As I passed through the inner gate to the camp itself, I noted an inscription "Recht oder Unrecht, mein Vaterland" (Right or Wrong, My Fatherland) over the gate. A soldier on guard checked identity but I had no trouble gaining entrance. In this respect, that is as it was before. Upon first entering the camp, I sensed rather than saw the difference in atmosphere. I immediately proceeded to the camp hospital area to see what was available in hospital space and how many patients were present. I found two separate hospital areas referred to as the "great" hospital and the "little" hospital. The "great" hospital was a fairly respectable looking building, relatively new, and impressed one as not being too bad. But upon entering the various wards, they were filthy and reeking of stench. There were double-deck bunks with two patients in each bunk, bare mattresses with no linen and merely a blanket to cover the patients.

The "little" hospital was a series of one-story wooden buildings similar to a barracks, and indescribably crowded and filthy place, in which patients lay on dirty shelves arranged in a long series of triple decked compartments, five feet long and two feet high, six patients to one compartment. I hesitate to call this a hospital for can one call a room no bigger than a bathroom, spattered and caked with blood almost to the ceiling with a wooden table in the center, an operating room? Can one call a hard wooden shelf with no mattress and only a blanket for six patients a bed? Is this the most recent advance in medical science achieved by a country to which no more than a generation ago our own medical men went on a pilgrimage to complete their education? One can plainly see why this mission was not too. eagerly received by my personnel.

The survey of both hospital areas revealed approximately 4600 patients at Buchenwald of which 244 were known cases of tuberculosis.

The one mission assigned to my hospital which involved the bulk of my personnel was the processing and evacuation of all cases of tuberculosis to a hospital appropriate for their continued care. It. was recognized that these cases were a source of dissemination of the disease and from the point of view of medical care, represented a long range problem.

As a background of the tuberculosis problem at Buchenwald it is pointed out that the conditions under which the prisoners lived were conducive in every way to the development and spread of tuberculosis. The malnutrition from which most inmates suffered, together with heavy labor and harsh treatment, inevitably led to the progression of tuberculous lesions in men previously infected, whether these were originally of serious or minor character, and the intense crowding and lack of sanitary precautions led to dissemination of infection throughout the barracks. Little food was available, and that of the worst quality so that the mortality from tuberculosis in both the "great," but particularly in the "little" hospital, was tremendous. No accurate estimate can be made but it is probable that many thousands of the 50,000 known to have died in this camp succumbed to tuberculosis.

The survey revealed that following the liberation, Dr Horn, an eminent Czech surgeon, had promptly put into effect a medical organization, utilizing the hostage physicians in various capacities throughout the camp. Dr. Horn, originally arrested as a supporter of Dr. Benes, had been in this camp six years and was generally familiar with medical conditions in the camp. In the "great" hospital, two wards were set aside for the care of tuberculous patients. Dr. Gerhard Arnstein, an Austrian doctor, was in charge of the treatment ward which housed 116 cases, essentially all under pneumothorax treatment. The ward was crowded and malodorous, X-ray was rarely available and pneumothorax apparatus was of the home-made variety. It is quite remarkable to think that pneumothorax should even be attempted under such conditions.

In another section of the "great hospital was a ward with 32 cases of advanced tuberculosis under the supervision of Dr. Edmund Adams, a German political prisoner. This was simply a death room. In the "little" hospital, 96 patients were housed in a former stable, improved by the patients themselves by construction of windows. These patients were mostly bilateral cases, not suitable for specific therapy but not hopelessly advanced. This area was highly crowded, with patients crammed into the three-decker bunks at night. There was a total lack of discipline and the most that could be said for this group was that this area served to isolate these ambulant patients with infectious sputum. This group was under the supervision of Dr. Paul Heller, a young Czech doctor, who had a fairly good knowledge of the English language. I asked Dr. Heller why he was an inmate at this camp and he replied, "According to the Germans, I am here because I was a member of a subversive organization as a student, but actually I am here because I am a Jew." Incidentally, I was able to help Dr. Heller get a visa to England. He later migrated to the United States and a recent letter from him indicates that he has married an American girl and has just been granted his American citizenship.

The principle accomplishments of these inmate doctors was discovery, isolation and classification of patients. This greatly facilitated our procedure of evacuation. Much succeed in treatment could not be expected under the existing conditions.

Although I had been informed that there were 244 positively diagnosed tuberculous patients in the camp, I anticipated considerably more than this number and planned my hospital accordingly.

The critical condition of most of the patients made it necessary for me to select a site on the camp grounds as closely as possible to the prison compound in order to shorten the ambulance haul. The atmosphere of the area was a most depressing one. The state of the available buildings was so deplorable that at first glance it seemed that one could not be made suitable as a hospital dwelling. I sought a site to set up our tentage but there was nowhere sufficient space to accommodate them. I was therefore compelled to select two buildings (three-story) which were previously used as SS Barracks. These had been made almost unusable by the guards before they left, and had been fouled by liberated prisoners who swarmed into the buildings after their liberation. Dead bodies were in the corridors and excrement all over the floors. Because of these conditions, and the lack of suitable housing, I did not take my nurses with me but arranged a billet for them in nearby Weimar, and promptly made arrangements for a period of rest and recreation for them in the French Riviera while we were accomplishing this mission.

Here again, as before, my men energetically undertook their task of cleaning the buildings and two days

later, when evacuation operations commenced, the place was clean and normal operation was in progress. One building was used as the hospital proper and the other provided housing and messing for the personnel. DDT was amply used throughout the billets and all personnel received an additional inoculation of typhus vaccine. In fact, my room was so energetically powdered with DDT that my little Dachshund lapped up some of the excess powder and promptly died several days later.

The problem here was essentially a medical one so only two operating tables were set up. The ground floor was utilized for administrative offices, Receiving, X-ray, Pharmacy, Laboratory and Surgery. Our procedure in processing patients after admission was altered from our usual SOP. Most of the patients had not been bathed in months and many were infested with lice. Typhus was prevalent in the camp and means had to be taken to prevent its spread. We arranged to space out admissions over the entire day and to receive for processing from 10 to 15 patients every hour. After their records were initiated, this group was taken to the bathroom where all clothes were removed and burned. Each patient was bathed, sprayed with DDT powder, and clothed in clean pajamas. Those who were unable to stand were bathed under the shower while on a wheeled litter. Then they were taken to the X-ray where a chest plate was made on each patient, and from there they were assigned to a ward. By this method only clean, deloused patients entered the wards and subsequent movement for diagnostic procedures was essentially eliminated. Examinations of blood, sputum, and urine were done routinely on all patients. Sedimentation rates were done where patients were afebrile. Laryngeal and bronchoscopic examinations were done where indicated.

Five wards of 40 beds each were set up on the second floor, and a similar arrangement was made on the third floor. One officer was assigned to each ward. Since I did not have ten internists or medical officers, general duty (MOS 3100), some of my surgeons became tuberculosis specialists “by order of the Commanding Officer.” Each ward had four enlisted men during the day and three during the night. Excellent sanatorium atmosphere and procedure was meticulously maintained and it was a credit to the hospital personnel to be able to adopt so quickly to a rather unusual type of operation for most of them. Although clean linens for all cots was scarce, we managed to get enough by making demands on the Burgermeister of Weimar who came through without too much pressure. The Mess Officer provided three high caloric high vitamin meals daily and, in addition, three in-between feedings of chocolate milk, malted milk, and eggnog were served.

Multi-vitamin pills and candy bars further supplemented the diet. It is difficult to describe the reaction of these patients to their new-found freedom and the solicitous care which they received at our hospital.

Never before had we seen patients in such deplorable physical state. The ravages of their illnesses and the long state of severe malnutrition induced by starvation, combined to form a clinical picture which is rarely, if ever, seen in our country. Under the condition which the prison physicians worked, it was inevitable that many cases should be mistakenly diagnosed. Of the 600 patients admitted in a period of twelve days, 433 were found to be ill with tuberculosis or about 10% of the patient population of the entire camp. Many had: pulmonary pathology which was non-tuberculous. There were ten cases of atypical pneumonia, four of lobar pneumonia, two of lung abscesses, one neoplasm, one thoracic empyema and one atelectasis of the lung resulting from an aneurysm of the aorta. Malnutrition in some degree was present in all; in 223 cases it was unusually severe and in 22 cases there was evidence of marked vitamin deficiency. Most of the cases with tuberculosis had wide-spread involvement of both lungs, with exudative lesions and cavitation predominating the X-ray findings.

Sixty-three patients had pneumothoraxes artificially induced before they came to us. In certain instances too much air was introduced and in others not enough. In some the procedure was a failure because adhesions prevented collapse of the lung and closure of the cavity. But considering the circumstances under which the procedure was done, the home-made apparatus used and the lack of X-ray facilities under which the `Inmate physicians labored, the work they did can be considered truly remarkable.

The ultimate prognosis in most of these cases was extremely poor. The large majority would succumb to tuberculosis in a shorter or longer period - a few possibly could be rehabilitated. By removing them as a source of infection to the other malnourished prisoners of the camp and by making them comfortable, we had accomplished one of our. missions. The relief which these patients showed after their long periods of torture and filth in a concentration camp was ample reward to all of us for the difficulties we encountered during this unusual phase of operations.

From Medical Bulletin of the European Command, Vol. 6, no. 5-6, May-June 1949, p. 5-10.COL Zehm concluded his account with another article in volume 6, number 7, July 1949, pages 33-38.

Medical Care of Repatriated POWs
Scott C. 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. The prisoner experience could be brutal. Starvation, poor to nonexistent medical care, death marches, execution, and torture happened (Fig. 1). Army medicine had, and has, a key role in recovery after captivity. Just as each combat experience is different, so also are the resulting medical conditions dependent on individual health, diet, location, physical, and mental treatment during captivity. This article looks at Army care provided to released American prisoners in World War II.

American POWs receiving medical care after forced marches, May 1945. U.S. Army photo

European Theater

The major regulation 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. There were several supplemental regulations and memorandums throughout the theater, primarily U.S. Army European Theater of Operations Standard Operating Procedure No. 58 dated April 3, 1945. Priority of evacuation from forward areas was for the sick and wounded via air, or train if air assets were not available. 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 in SOP No. 58 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 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 exacerbated 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

January 26, 1945. Like her nursing sisters in Asia (see below), she continued to treat the sick and wounded. Unlike her counterparts in the Philippines, minor weight loss occurred. Her captives supplemented rations with Red Cross food packages at Stalag Luft IX. 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.

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. Specific implementation directions were in a more detailed regulation on April 21, 1945 based on the earlier directive. 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 ears, 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 were provided care enroute: "vermifuging (de-worming), chemotherapy, and whole blood and plasma transfusions." Like European Theater American POWs, the Pacific Theater American POWs were sent to debarkation hospitals followed by reception and redistribution centers. After reception center processing, they were given 60 days leave. Administrative disposition from the redistribution stations was given after leave. 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, neuropsychiatrists, dentists, and clinical pathologist were positioned at varying debarkation hospitals in the United States, but actually saw patients at Madigan, Letterman, and Halloran General Hospitals. BG Hugh J. Morgan, chief Medical Consultant to the Army Surgeon General, chaired the group producing the "Morgan Board" report. The board focused on a health survey that would provide research and treatment for the newly freed prisoners by collecting information for future care, disease prevention, and physical changes. 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. The average weight loss ranged from 20 to 110 pounds. Many had lost 30 to 50 pounds before capture due to the reductions in rations before the fall of the Philippines. Without the dire circumstances before surrender, much more weight may have been lost within first 6 months of captivity. The Morgan Board report indicated "pellagra; 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 the population. 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 serious enough to be classified as dysentery. 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 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 bacte-

ria." The 66 Army nurses, 1 dietician, and 1 physical therapist were in pitiful shape when they reached the 126th Army General Hospital in Leyte. Three years of captivity and a starvation diet had taken its toll. Ailments ranged from intestinal obstructions, beriberi, limb infections, malaria, dengue fever, tuberculosis, dysentery, dental problems, low body weight, and dehydration. After an onslaught of press, most were moved to the more secluded location of the 1st Convalescent Hospital followed by flights eventually leading back to the United States. At Letterman Army Hospital, they received a battery of tests and examinations. They were given 60 days 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.

Army nurses in Manila after being recovered from the Santo Tomas Internment Camp, 1945. U.S. Army photo.

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.

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While written and implemented before the actual release of prisoners, the procedures for administratively and medically examining former prisoners in WWII were not always followed. Repatriation procedures were not fully implemented, and there was a lack of thorough medical review and follow-up after WWII repatriation. The most prevalent service-connected disability since repatriation noted by the Veterans Administration was anxiety. Anxiety issues plagued former POWs were much more than other wartime veterans. The eagerness to return former POWs home resulted in little documentation or diagnosis connecting follow-on complications.

The National Academy of Sciences and VA agreed to a Medical Follow-Up Agency (MFUA) that would use the medical data the services had gathered as the start of longitudinal health studies. One of the first studies was about POWs, and there were repeated re-examinations, with the veterans surveyed into the 1990s to find how their health had been affected. This was one of the first studies that looked at environmental effects on health rather than a particular disease process.

The standard procedure on release now is a time for debriefing (i.e., 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.

This article is based on Mr. Woodard's series of articles, "Healing the Wounds After the Fight: Army Medical Care to Repatriated Captives," in *Military Medicine*, July-October 2016.

This was the shoulder patch worn by the more than 1,000 Army medical personnel assigned to Veterans Administration hospitals during WWII. The phoenix emerging from the flames was meant to represent "the restoration of the veteran as a new and vigorous citizen free to engage in his useful pursuits."

In 1940, with war already raging in Europe and Asia, VA began preparing for potential American involvement in the conflict. VA Administrator Frank T. Hines informed Congress that the agency was coordinating with the War Department to assist in the event of a national emergency with both hospital bed space and highly trained medical staff.

Following the Japanese attack on Pearl Harbor and America's entry into WWII, the U.S. Army's need for physicians and other healthcare professionals was acute. As Army Surgeon General MG Norman T. Kirk, bluntly reported, "It was difficult during the past year to secure the additional Medical Corps officers needed to meet the requirements of the increasing Army since there are not sufficient physicians available to meet both military and civilian medical needs."

The military's demand for healthcare professionals drained staff from the civilian medical community and VA alike. Between 1942 and mid-1944, 16 percent of VA employees were furloughed for military service. Draft deferments were rare for those supporting national health: well into the war, only 23 deferments for VA employees had been issued by civilian authorities.

The loss of so many skilled medical workers created problems for VA, especially as newly discharged Veterans filled VA hospitals. A December 1943 agreement between Secretary of War Henry L. Stimson and Hines paved the way for collaborative use of limited medical personnel. Their solution included inducting select VA doctors and dentists into the Army but allowing them to remain at VA facilities. Kirk reported "984 physicians ... on duty with the Veterans Administration were commissioned in the Medical Corps of the Army in grades commensurate with their former civil service ratings and placed on duty with that organization." By December 1944, the Army listed 1,622 Medical Corps and 149 Dental Corps officers assigned to VA.

In addition to physicians and dentists, demand was also high for nurses, orderlies, and related positions. Later in the war, VA had creatively adjusted to these personnel shortages. To fill nursing vacancies, hospitals were authorized to recruit locally, using a variety of sources including nursing assistants and volunteer nurse aides. Hospitals also utilized detachments of enlisted men assigned to limited service, conscientious objectors, and even prisoners of war as hospital attendants.

The rapid demobilization of the U.S. armed forces following Japan's surrender in September 1945 created an unprecedented demand for VA benefits and medical services. But the return of millions of Americans to the civilian workforce also presented a solution to VA's staffing challenges. VA launched a massive hiring effort after the war, increasing its staff size from 64,639 in July 1945 to 168,603 in July 1946. The new hires included over 1,000 doctors, raising the total number of physicians and dentists employed at VA from 2,700 to 4,000. Fewer than 400 were on active duty in the military. At the same time, by mid-1946, the agency replaced most of the enlisted soldiers loaned to VA and other temporary workers with regular full-time employees.

Courtesy VA history office, vahistoryoffice@va.gov

The most notable soldier to affix this patch to his uniform was GEN Omar N. Bradley. After Germany surrendered, President Harry S. Truman appointed Bradley to serve as the head of VA on August 15, 1945. Bradley proudly wore the shoulder insignia throughout his time at VA, as seen in various photo portraits in both his summer and winter uniforms. General Bradley departed VA a little over a year later. He relinquished his position as VA Administrator to become the Chief of Staff of the U.S. Army in November 1947. U.S. Army photo.

The Medical Field Service School Moves to Fort Sam Houston – February 1946

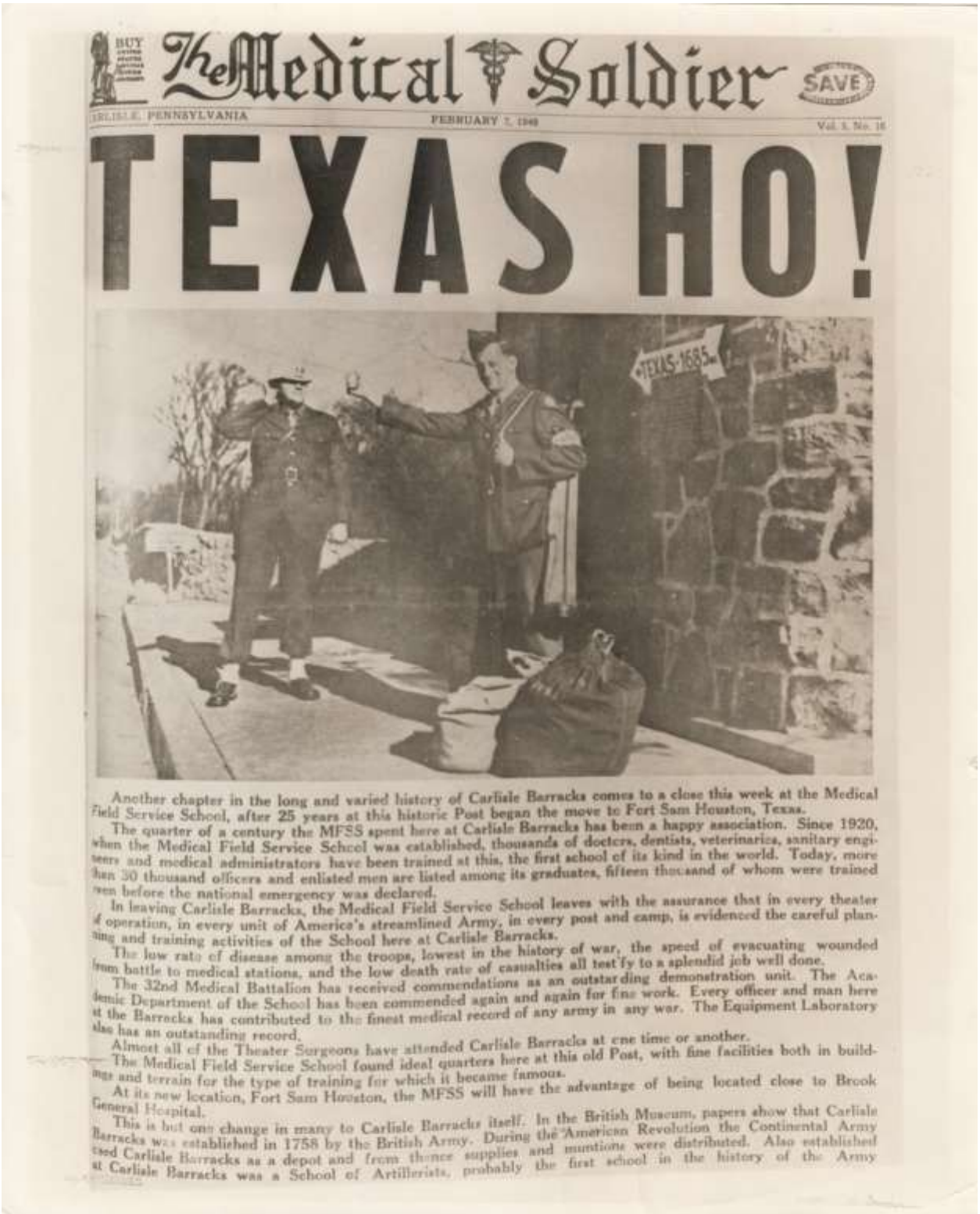
Late in WWII, Surgeon General Norman Kirk had asked to consolidate several AMEDD schools at Fort Sam Houston. The largest of the schools, the Medical Field Service School (MFSS), needed more space, and Texas had space. The other schools would benefit from co-location near Brooke General Hospital, where they would have access to the hospital's clinics and patients. Fort Sam had once been a large post, but it was too small to be useful for mechanized units. It also had a milder climate than Carlisle, PA, where bitterly cold winters had limited the quality of outdoor training.

Surgeon General Kirk obtained permission to move the MFSS, the School of Military Neuropsychiatry, and the Army School of Roentgenology (X-ray) to Fort Sam Houston. In early 1946 the three schools began movement to San Antonio where they were consolidated to form the Army Medical Department Schools (AMEDS), organized under the newly established Brooke Army Medical Center with the headquarters of the MFSS serving as the new headquarters for the AMEDS. Fort Sam Houston was designated as the Army Service Forces Training Center (Medical), and Fort Sam Houston became the "Home of Army Medicine." In 1947 the AMEDS was redesignated as the Medical Field Service School.

When it arrived at Fort Sam Houston, the MFSS occupied what formerly had been the 9th Infantry Regiment's barracks, built in 1928. Substantial renovation was required to transform rooms into classrooms and much of the work was performed by the school's staff. Lecterns, platforms, training aids, and chart boards were built out of scrap wood from packing crates. Beds and wall lockers were removed and stored, and soundproofing, ventilation (although not air conditioning), and seating were constructed rapidly in anticipation of the arrival of new classes. At the same time crews worked to build a demonstration area near Salado Creek on the southeast side of post. Areas were laid out to demonstrate equipment and procedures for field kitchen sanitation, personal hygiene, field latrines, disposal of animal waste, and obtaining and treating water in the field. A sixth area was left in its natural state to demonstrate insect control measures.

While the barracks were being renovated, school staff also completely rewrote the curriculum for the Officers' Basic Course focusing on preparing officers for garrison duty or occupation duty overseas in Germany and Japan. Less time was devoted to battlefield surgery, the medical aspects of chemical warfare, medical evacuation, or the psychological stresses of warfare. Instead, greater emphasis was placed on definitive surgery in the rear echelon, tropical medicine, and the psychological problems associated with occupation duty. Less than two months after the school's personnel arrived from Carlisle Barracks the first class of 500 student officers arrived, followed four weeks later by a second class.

The MFSS would be redesignated, but from 1946 to 1973 it operated in the same building.



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The Medical Soldier

SAVE

CARLISLE, PENNSYLVANIA FEBRUARY 7, 1946 Vol. 1, No. 16

TEXAS HO!

Another chapter in the long and varied history of Carlisle Barracks comes to a close this week at the Medical Field Service School, after 25 years at this historic Post began the move to Fort Sam Houston, Texas.

The quarter of a century the MFSS spent here at Carlisle Barracks has been a happy association. Since 1920, when the Medical Field Service School was established, thousands of doctors, dentists, veterinarics, sanitary engineers and medical administrators have been trained at this, the first school of its kind in the world. Today, more than 30 thousand officers and enlisted men are listed among its graduates, fifteen thousand of whom were trained even before the national emergency was declared.

In leaving Carlisle Barracks, the Medical Field Service School leaves with the assurance that in every theater of operation, in every unit of America's streamlined Army, in every post and camp, is evidenced the careful planning and training activities of the School here at Carlisle Barracks.

The low rate of disease among the troops, lowest in the history of war, the speed of evacuating wounded from battle to medical stations, and the low death rate of casualties all testify to a splendid job well done.

The 32nd Medical Battalion has received commendations as an outstanding demonstration unit. The Academic Department of the School has been commended again and again for fine work. Every officer and man here at the Barracks has contributed to the finest medical record of any army in any war. The Equipment Laboratory also has an outstanding record.

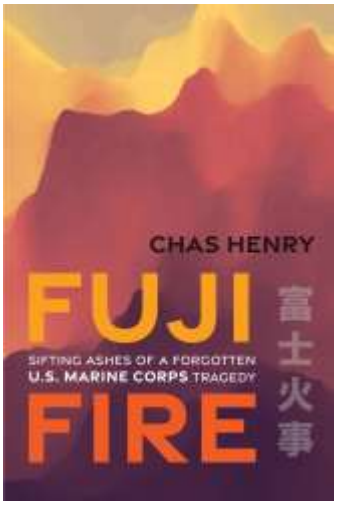
Almost all of the Theater Surgeons have attended Carlisle Barracks at one time or another.

The Medical Field Service School found ideal quarters here at this old Post, with fine facilities both in buildings and terrain for the type of training for which it became famous.

At its new location, Fort Sam Houston, the MFSS will have the advantage of being located close to Brooke General Hospital.

This is but one change in many to Carlisle Barracks itself. In the British Museum, papers show that Carlisle Barracks was established in 1758 by the British Army. During the American Revolution the Continental Army used Carlisle Barracks as a depot and from thence supplies and munitions were distributed. Also established at Carlisle Barracks was a School of Artillerists, probably the first school in the history of the Army

Final edition of the Carlisle Barracks *The Medical Soldier*, February 7, 1946. AMEDD Center of History & Heritage archive.



When 73 individuals, most of them young Marines, were injured in an October 1979 typhoon, fuel spill and fire at Camp Fuji, Japan, 38 were evacuated to Institute of Surgical Research wards at Brooke Army Medical Center. The MEDEVAC and same-day admission of so many critically-burned patients were unprecedented. The events are recounted in ***Fuji Fire: Sifting Ashes of a U. S. Marine Corps Tragedy***, released June 1 by the University of Nebraska Press. This excerpt is drawn from the book's longest chapter, *Brooke*, courtesy of the author, Chas Henry.

In the 14A cube, a corpsman was assigned to each Marine. A registered nurse would track one or two patients, depending on their health status. A surgeon was always on hand. The work was nonstop. Fluids were replenished, urine output measured. At half-hour intervals corpsmen and nurses would suction the airways of patients on ventilators, checking for carbon in their sputum. Every hour or two, patients were turned; the seemingly simple task could take fifteen to twenty minutes.

Those Marines in the ICU space who could speak, did. They learned which of their fellow Marines were nearby. Issac Williams—severely burned and cinched tightly into a Stryker bed, Ron Hilliard remembered—"was always the positive one, giving these guys support, encouragement."

The greatest danger the Marines faced at that moment was infection, which research had shown became a particular risk seventy-two to ninety-six hours postburn. "You need to do everything you possibly can," Dr. Roger Yurt explained, "to keep any invasive organisms from getting into the body."

Key to the preventive effort were the antibiotic creams constantly smeared over the Marines' wounds as they lay unclothed in what doctors described as "open treatment." BAMC spokesperson Audrey Urbancyzk explained: "The patients are completely naked and covered with just the cream," Though gauze was still placed over some burn wounds, the practice of constant, heavy bandaging, she understood, had been abandoned because "bacteria can accumulate in them." A small cloth—"their fig leaf," one visiting Marine officer called it—covered their genitals. Steve Haishuk recalled that he and others able to walk the ward, "wore just a towel around our waist."

From the day they were injured, the Camp Fuji Marines had become familiar with Silvadene. At Brooke they encountered another, quite different, medicated ointment. While Silvadene exemplified the definition of a salve—it smoothed, mollified, and relieved—the second ointment did not. "It should be noted," a medical text of the time cautioned, "that Sulfamylon causes pain on application."

Burning hut at Camp Fuji. Courtesy of the author.

While both topical agents fought infection, Silvadene's effectiveness remained primarily on the skin surface. Sulfamylon could penetrate thick-as-leather eschar—battling infectious agents below and softening the hard tissue.

"I remember it was in a little white round tube," Mike Cummings said. "When you put it on, it was like they was sticking you with a hot poker." He would ask for pain medication before it was applied. "Oh! It hurt like for half an hour, like unbelievable," Jon Jurgen declarad. "You'd just sit there and moan."

Twice daily ISR nurses and corpsmen would remove gauze dressings that lay over not skin, but deeper tissue with exposed nerve endings. Sulfamylon was applied after the day's first change. Usually it was rubbed on as a cream. Sometimes a powdered form would be diluted in sterile water; gauze dressings would be soaked in the milky chemotherapeutic, then affixed over wounds. "At least for the evening," Glenn Roberts remembered, "you got a little relief— they used to put on Silvadene, which I always likened to Noxzema. ... Then you got the morphine. I mean, this was every frickin' day, I forget for how long."

The major effort to remove patients' dead skin tissue occurred in an operating room. Excising the hard-cooked eschar, in which no fatty tissue remained, was a fundamental first step in facilitating a burn patient's

recovery. Until all such debridement was completed, surgeons could not begin grafting skin to permanently heal in place over the Marines' wounds.

The work was different from other types of surgery. "In any standard operating room," ISR surgical nurse David Berry explained, "the patient comes in, hopefully you fix what's wrong with them, they go out and you never see them again. In the burn unit, they come back. Depending on how acute their burns are, they come back many times over a period of months."

The debridements—surgical removal of burned skin—were intricate and bloody. Hard charred tissue was excised to the greatest extent possible at that moment in the patient's healing. While harsh the cutting away was far from indiscriminate. "We were fanatical about protecting the good skin," Berry emphasized. Later, a thin layer of skin surgically harvested from nonburned areas would be needed to graft over each patient's own wounds.

Initially, the increasingly uncovered wounds—until they could withstand further debridement—would be cloaked with gauze. As healing continued surgeons would begin overlaying other materials.

The BAMC of 1979. Ward 14A was on the left of the building, second floor from the top. Photo by Dr. Hani Mansour, courtesy of the author.

Some of the temporary coverings applied were synthetic, infused with honey ointments or impregnated with antiseptic silver. Others were such "biological dressings" as sterile pigskin or human skin harvested from deceased donors. A sizable stock of the latter was shipped to San Antonio from the Navy Tissue Bank in Bethesda, Maryland. There surgically trained corpsmen routinely retrieved transplantable skin from cadavers. The skin had been freeze dried, a process the Navy had pioneered. That allowed it to be stored and transported at room temperature. Its collagen and scaffolding made it an effective natural bandage. All that was necessary before its surgical application was to soak the freeze-dried skin for thirty minutes in sterile saline. "You literally add water," Basil Pruitt explained to reporters, displaying a rolled sheet of the stretchable biologic material in a small glass tube. "It's kind of like instant skin." The delivery to San Antonio, recalled Commander Michael Strong, the Bethesda tissue bank director, "used up our entire inventory." The temporary dressings helped patients retain heat and curb fluid loss. They would be replaced five to thirty days after application—before provoking immune system rejection in patients' bodies, or beginning to fuse with healthy tissue.

Patients undergoing surgery in the ISR operating room were provided anesthesia unlike that used for most patients in surgery. Ketamine, a hallucinogen, was the agent of choice. Under its influence, ISR surgeon Hani Mansour maintained, patients "were still breathing on their own, but not in pain." They did not need to be intubated, they could react to instructions during a procedure, and they could be returned to wards after surgery without layover in a recovery room. Calibrating ketamine levels was both science and art. "Sometimes [patients] would start getting light," surgical nurse David Berry remembered, "and we'd know it right away because they'd start screaming because they would feel it. That always gave me a case of the horrors. 'What are they going to remember?'" On the whole the Marines' hallucinogenic experiences seemed "good trips." One Marine told Berry that the drug had caused him to be "fixated on the lights, and he was part of the lights."

Frequently, Dr. Anton Jirka would be at the head of the operating table monitoring the patient's breathing and administering the hallucinogen. Dr. Mansour regarded the career Army physician "a genius in anesthesia," and remembered Jirka frequently showing up without prompting when a seriously injured patient arrived at the BAMC ambulance entrance. If the receiving surgeon perceived an immediate need to operate, Jirka was ready.

Operating room schedules were fluid. Urgent procedures moved front of line when infections took hold. About a week after the Marines' arrival, surgeons amputated one of Lance Corporal Willie Davis Jr.'s arms. Germs had penetrated burns on the limb; their spread could prove fatal. Chunks of tissue were cut from other Marines for similar reasons.

On Wards 14A and 14B, daily care began each morning with the cleaning of patient's teeth and mouths. The young men would then be weighed. Morphine or Percocet was administered. Those who could get out of bed were then taken to shower stalls to be washed—or to the tank room at the rear of Ward 14A.

Mark Bedwell remembered the two warm-water Hubbard tanks as being "about two feet deep, in the shape of a large cross. ... You're spread out like Jesus." A lifting device was used to lower patients into the tubs. The maneuvering was not easy for those on ventilators and bearing intrusive IV tubing and catheters. Sunlamps would be pulled close to try to keep patients warm.

While skin impacted by third-degree burns had been completely consumed, tissue burned to the second degree remained living, if raw, flesh. It leaked a protein-rich blood serum. The gelatin-like film—attractive to deadly bacteria—adhered to the Marines' wounds, hardening into a dense, waxy crust. In the tanks nurses and corpsmen had to pull, cut, and scrub the scabs away.

Patients were administered painkillers before each tank session. "They would give you whatever the maximum [safe] dose of morphine was at the time," Glenn Roberts recalled. "Pffft. Didn't matter. Oh my God, didn't matter. A lot of times, you'd go in there, two of them would hold the arm down, pour the Hibiclens"—an antiseptic Roberts thought looked like red dish soap. Abrasive washcloths would be used to scrub away the protein scabs. "They'd take that towel, and—you couldn't be gentle about it." The removed substance—"a sickening green and yellow," he recalled, "had to come off every day." The process was messy; at times blood weeped into the tub water. "You felt," Roberts cringed, "like you were being skinned alive."

"A lot of them would buck on the ventilator," then-corpsman Robert Marchi recalled.

Water from hoses in the tanks flushed away the grisly runoff. Tanks were drained, sterilized, and made ready for the next patient in queue.

The obvious misery borne by those undergoing daily scrubbing wore on those whose job it was to carry out the ultimately beneficial procedures. "The nurses," Issac Williams remembered, "were scared to touch me. They knew they was hurting people when they took them to that tub." Glenn Roberts recalled an older medical staff member decamping to a nurses' station after assisting with such a session. "You could hear him sob in the next room."

Nurses watched, impressed, as Marines would walk as far as they could alongside buddies headed to the tank room. "Until you see it, and experience it firsthand," Ron Hilliard said, "you don't really understand what that Marine esprit de corps is all about."

After Issac Williams found his first tank sessions unbearable, he racked his brain. How could he divert his attention from the scrubbing and cutting? As a child he had constantly serenaded his mother; music still brought him joy. In the ward spaces, shared with fellow patients in agony or trying to sleep, it was generally not allowed. "I just decided I needed a radio," he said. Williams's mother, Joan, brought him one. In the tank room, nurses tuned it to San Antonio hit music stations. "If I started singing first—before they started scraping me, before I knew it, they'd been scraping me, I'm still singing and it wasn't bothering me," he remembered. Irrespective of what song came on, he added loud vocals. In lyrical irony, hits airing frequently at the time included Michael Jackson's "Don't Stop 'Til You Get Enough" and Nick Lowe's (You've Gotta Be) Cruel to Be Kind." Williams attested: "I started looking forward to going to the tub, you know, because I had the music."

The fortitude of the young man from Alexandria, Louisiana, astonished his fellow Marines. "For me, Issac was courage itself," affirmed Gust Miller, who spent three weeks alongside him in the cube. "He suffered worse than the rest of us," Mark Bedwell remembered, "but he did it with a dignity that - it was remarkable."

Williams' stamina was buoyed by a strong spiritual faith and the constant presence of a loving mother. He admitted, though, having "had the strength and the willpower to do certain things for myself." That seemingly included selecting his own surgeon. Soon after arriving in San Antonio, the lance corporal heard the doctor first assigned his case talking with someone else: "He made a comment that he didn't think I was going to make it." Williams did not share that view. Soon after, he encountered another, younger physician at the foot of his bed: Issac Williams met Isaac William Goldfarb. "It just so happened," Williams laughed, "his first two names the same as my name."

The two clicked.

"You know, I had a good interaction with my surgeon," Mark Bedwell remembered, "but the interaction with Dr. Goldfarb and Issac was a tremendously personal thing. There was something about saving Issac—nothing else mattered more to Dr. Goldfarb. In the middle of the night, here comes Dr. Goldfarb looking at Issac. In the morning. In the middle of the day, there's Dr. Goldfarb checking Issac."

Bill Goldfarb, thirty-three years old at the time, could not turn away from the Marine who displayed such determination. "Anywhere along the line," the surgeon said, "it would have been easy for him to quit, and die. But he would not quit."

Similarly close relationships developed between other patients who persevered and the surgeons assigned their care. Mark Bedwell and his family developed a friendship with Dr. Hector Benitez.

Surgeon Hani Mansour bonded with Steve Dye, and Steve's father, James. Even decades later Mansour could close his eyes and picture the location of Steve's bed in the cube: "He was next to the exit door on the right." The cutoff jeans Dye had been wearing when he rushed from his hut, the doctor remembered, had prevented burns "from the waist to the upper third of the thighs." The rest of his body, however—82 percent was the estimate—had been scorched. "I kept him very sedated," related the doctor who had treated combat burn casualties in his native Lebanon before migrating and being commissioned into the U.S. Army. The procedure was the thirty-two-year-old's norm. "It was always my fear that the patient would be in pain." Over time Dye's treatment would involve a good deal of skin grafting. "I operated on him maybe six, seven times," Mansour recalled. For months and months, the Marine's survival was not a foregone conclusion. "He fought very hard," Mansour said.

In some respects, the young men of BLT 2/4 and LSU 3/9 differed from most burn patients. Roger Yurt recalled seeing first evidence of that soon after their admission. He watched as two young men, burns over 80 percent of their bodies, climbed out of their ICU beds and began to exercise. "They were doing push-ups," he remembered. "It was something I had just never seen and didn't think was possible. It made me really wonder whether people who are in extremely good shape, and take care of themselves and so forth, can survive these injuries and do so much more than the normal patients can."

He would learn, over the next several months, that the answer was sometimes yes, sometimes no. To a then-young surgeon, the latter instances were "sort of devastating," Yurt revealed—when "those Marines, even though they were really fighting the battle very strong, didn't survive their injuries."

Ward 14A 'Cube' with Dr. Hector Benitez (center, with glasses) and others. Photo by Dr. Hani Mansour, courtesy of the author.

From Austria to Iowa: the demobilization journey of combat medic Richard L. Sanner

Paula Ussery and Charles Franson, AMEDD Museum

With the surrender of Nazi forces on 8 May 1945, the three million soldiers in Europe began wondering when they would go home or if they would be transferred to the Pacific, where war still raged and the invasion of the Japanese islands was scheduled for autumn 1945.

One of those soldiers was PFC Richrd Sanner, a combat medic with the 71st Infantry Regiment, 44th Infantry Division, the 'Jersey Blues'. On 10 May 1945, "somewhere in Austria" he wrote to his parents with news of how demobilization would be organized. "The point values were just announced over the radio and a total of 85 points is needed-at the present-for discharge in the very near future. I figured up mine and have a possible chance for 57... I feel personally that the men who have fought on the front here should not be made to fight in the C.B.I. [against the Japanese] I believe that the best thing to do would be to make them service troops and make the now service troops-who are eligible-front line troops for the C.B.I."

PFC Richard Sanner, in his muddy boots, in the spring of 1945.

Ribbons issued Richard L. Sanner for his service in the European Theater. Top row Bronze Star with Oak Leaf Cluster; middle row: Purple Heart; Good Conduct, American Campaign; bottom row: North African, European, Middle Eastern Campaign with three campaign stars; World War II Victory; Army of Occupation.

The Point System that Sanner refers to was devised in 1944 but shelved when the fighting dragged on into 1945. In May 1945 new regulations were published. The theater commander was to assign each unit to one of the following categories:(I) units to occupy areas of Europe; (II) units to be used in the war against Japan; (III) units to be inactivated within the theater; and (IV) units to be returned to the United States for inactivation. Category II was broken down into (A) units to be shipped to the Pacific direct; (B) units to be shipped to the Pacific by way of the United States; and (C) units to be shipped to the United States to be placed in strategic reserve.

At the same time, each officer and enlisted man in the theater was given an Adjusted Service Rating Score (ASR) based on a point for each month of service since 16 September 1940, a point for each month overseas, 12 points for each child under 18 years of age up to a limit of three, and 5 points for each combat decoration and battle participation award. For enlisted men the critical score was tentatively set as 85 points. Critical scores for Medical Department officers varied with the corps. For hygienists and dietitians, the figure was 62; for dentists, 63; for physical therapists, 65; for nurses, 71; for Medical Administrative Corps officers, 88; and for Medical Corps officers 85 plus, according to specialty.

The AMEDD had not only to demobilize its own personnel but prepare for the expected heavy casualties during the invasion of Japan, treat soldiers remaining in Europe for the occupation, and provide medical care for thousands of displaced civilians. With the surrender of Nazi forces the AMEDD was required to perform a pre-discharge physical for each individual soldier or officer. On the day of surrender, the AMEDD had about 65% of its personnel overseas.

Sanner's journey after the surrender through demobilization was documented in his letters to his fami-

ly. On 20 May he wrote "It is surely a great relief to have the war over in the E.T.O. We aren't doing much except the usual training like in the States standing guard, guarding roads, etc. Most of us now are sweating out the C.B.I."

After spending a short time in Austria and backtracking through Germany, Sanner and his unit traveled by Army truck and WWI-era railroad cars to Camp Pittsburgh. Camp Pittsburgh was one of 17 staging camps located around Reims, France, named for cities in the United States. Each camp had a capacity from 15,000 to 17,250 men. It was here that the point system was applied. "We were told we would return to the States, have furloughs, and go into training before going into battle again, the Pacific theater, probably invading Japan itself. However, not all of us would go… [T]hose with the magic 85 points or more were not to return with us but to stay in Europe…"

Richard Sanner's 'Jacket, Field, Wool,' or Ike Jacket. The jacket has Sanner's division shoulder sleeve insignia; the 44th Infantry Division and his rank of Technician 5th Grade as well as his ribbons and Combat Medic Badge.

Sanner had a brief furlough in Paris in late June, which he described to his parents; "Paris, to me is famous for two very distinct things, music and beautiful structures. I went up in the Eiffel Tower… and went to an opera this evening. The opera was 'Faust' and was the most wonderful stage show I have ever seen. … The acting was wonderful, the music grand, the singing superb." His unit then climbed onto trucks to go to Le Havre, the embarkation point. After crossing the English Channel, Sanner spent a few days at Camp Tidworth which he noted had real brick barracks rather than tents!

On 15 July 1945 "The whole division of nearly 15,000 plus several others, crowded on the *Queen Elizabeth* for the voyage to New York City. We had rotational bunks for resting, in every conceivable part of her, even in the swimming pools. Food was served twice a day." After landing in New York, "we were quickly processed, unloaded and on our way home for that long furlough. The big question on our minds though, was what then? How long would the fighting last in the Pacific?" Sanner returned to Anamosa, Iowa, and was there when the Japanese ceasefire was announced on 15 August 1945. "Rumors were really flying about the possible surrender of the Japanese. It happened and I was home when it did! The town's fire siren was set off, church bells rang, and the whole town went to Main Street to celebrate." No longer did the Army or the AMEDD need to organize a partial demobilization.

In September 1945 Sanner reported to Camp Chaffee, Arkansas, one of over 100 Separation Centers scattered across the United States to await his discharge. During the peak of demobilization these centers operated on a 24-hour basis. Among the required procedures for returning servicemen were: Initial Clothing Shakedown Section at which they were relieved of all unauthorized government clothing and equipment, an orientation lecture to explain the procedures involved in discharge and how the specific center was organized. Soldiers then reported to the Medical Processing Branch for their medical examination that included a complete medical history and a review by four medical officers including a psychiatrist. The next step was to report to the Counseling Branch. Counseling in this instance was focused on informing soldiers about the G.I. Bill of Rights, job opportunities for returning veterans, completing the Separation Qualification Record and other vital forms and the options available through National Service Life Insurance.

Not surprisingly, Sanner found life at Camp Chaffee somewhat dull. He commented "Much of our time was spent drilling, drilling and more drilling. It all seemed so futile." At long last his discharge day ar-

Honorably discharged veterans also received an Honorable Discharge Emblem (nicknamed the "Ruptured Duck.") Designed in 1925 and authorized for federal service between 9 June 1925 and 31 December 1946, it is most closely associated with WWII due to the small size of the Army during the interwar period. Soldiers sewed one onto their jacket as a part of the demobilization process and were authorized to wear their uniform for up to 90 days after their discharge. A gilt metal lapel pin of the same design was issued for veterans to wear on civilian clothing as well. (Leora Stroup Collection)

rived on 11 November 1945. Sanner later wrote "Most of the rainy day was spent getting my physical, taking all kinds of tests, filling out forms and being interviewed by various noncoms and officers … We got our last pay, were given travel funds, all the necessary documents, and finally lined up for our formal discharge. I promptly packed the few remaining items in my duffel bag, and headed home."

Although Sanner doesn't mention it, there was also an Awards and Decorations Section of the Counseling Branch that issued Good Conduct Medals, ribbons, and valor decorations if the soldier had not received them. Due to the need for metal for war production, campaign and service medals were not issued at the time of discharge, only ribbons. The U.S. Army issued three campaign medals for service during World War II and of course a World War II Victory Medal. The American Campaign Medal, the Asiatic-Pacific Campaign Medal and the European-African-Middle Eastern Campaign Medal were established per Executive Order 9265, dated 6 November 1942, by President Franklin D. Roosevelt.

Blue is the dominant color of the American Campaign ribbon, representing the Americas; the central blue, white and red stripes (taken from the American Defense Service Medal ribbon) refer to the continuation of American defense after Pearl Harbor. The white and black stripes represent the German part of the conflict, while the red and white stripes represent the Japanese colors.
On the obverse is a Navy cruiser with a B-24 airplane overhead and a sinking enemy submarine in the foreground. In the background a few buildings representing the arsenal of democracy are depicted and above the words "AMERICAN CAMPAIGN." The first medal was presented to General of the Army George C. Marshall on 17 December 1947. (Kenneth Tallman Collection)

The Asiatic-Pacific Campaign ribbon is predominantly yellow, with white and red on each side representing the Japanese colors. The center blue, white, and red stripes were taken from the American Defense Service Medal ribbon and refer to the continuance of American Defense after Pearl Harbor.
The obverse of the medal depicts a tropical landing scene with a battleship, aircraft carrier, submarine and an aircraft in the background with landing troops and palm trees in the foreground. The first medal was presented to General of the Army Douglas MacArthur on 17 December 1947. (Tallman Collection)

The World War II Victory Medal design was authorized by Congress on 6 July 1945 but not approved until February 1946. There is a female figure of liberation on the obverse and the "Four Freedoms" from a speech given by President Franklin D. Roosevelt on the reverse. The center of the ribbon is "Old Glory Red" with the ends repeating the rainbow colors found on the World War I Victory Medal.
(James Wier Collection)

The European-African-Middle Eastern Campaign Medal was also established by EO 9265 but the ribbon design was approved one month later. The green bands represent the fields of Europe and brown the sands of Africa and the Middle East. The center blue, white, and red stripes were taken from the American Defense Service Medal ribbon. The colors of Italy and Germany are represented by green, white and red and white and black. The obverse includes an invasion scene of men embarking with an LST in the background. General Eisenhower was presented the first medal on 24 July 1947. (John Halseth Collection)

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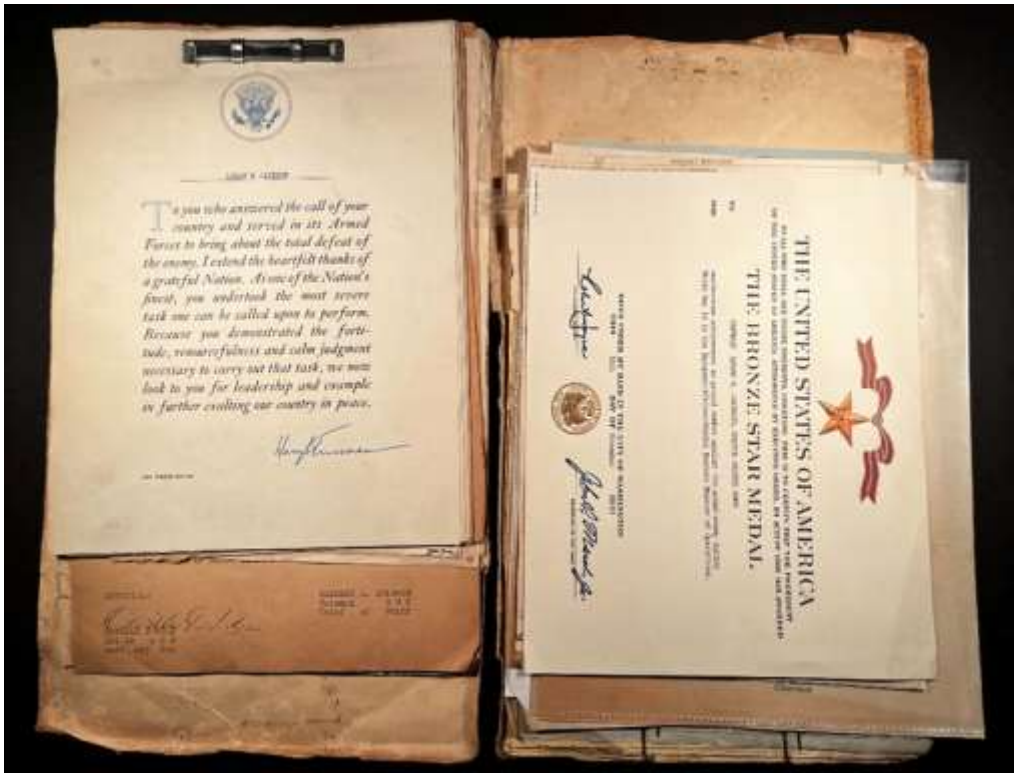
Aging WWII Documents
Carlos Alvarado, ACHH

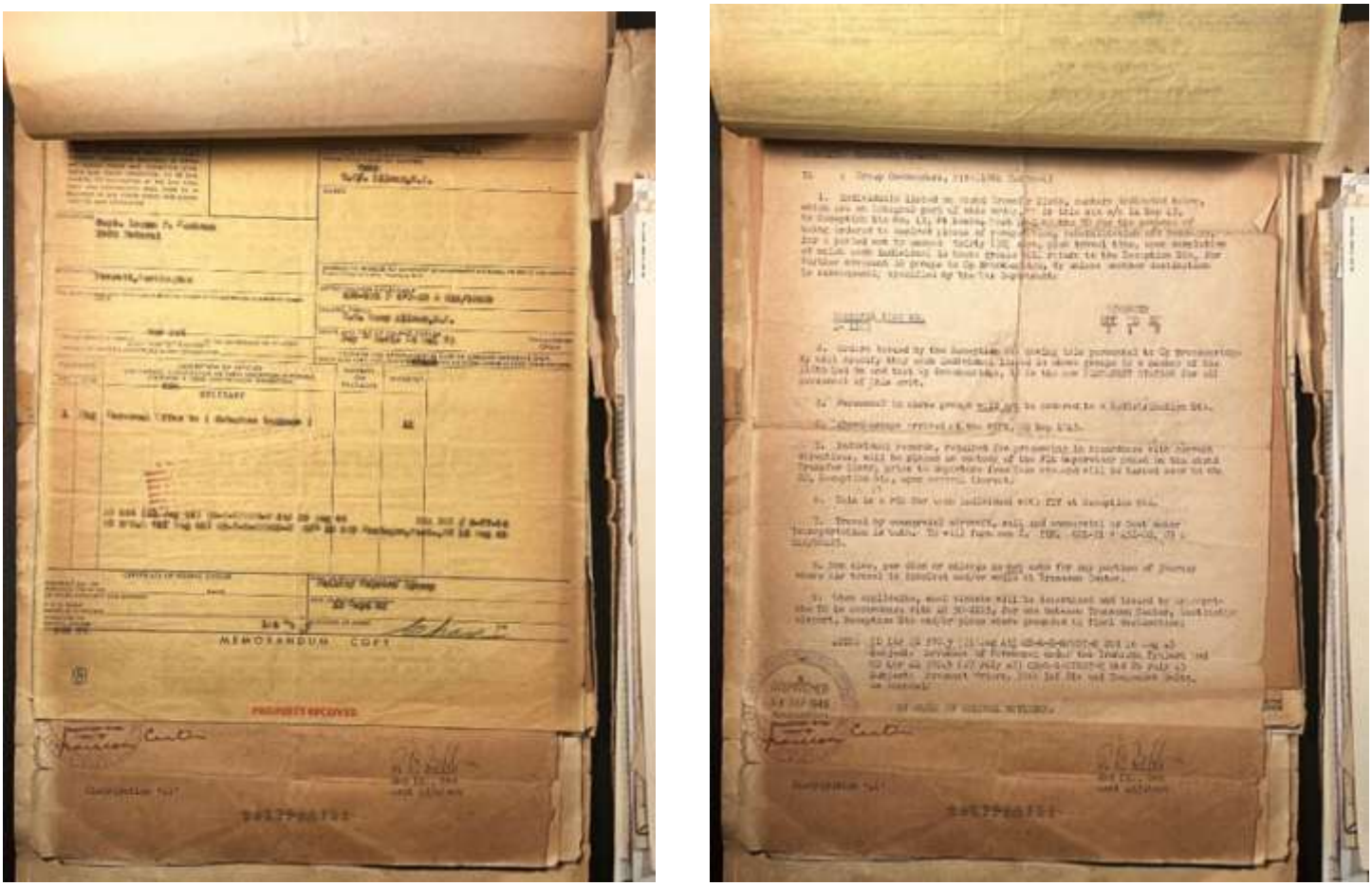
The AMEDD Center of History and Heritage (ACHH) maintains a historical research collection that is comprised of nearly 7,000 linear feet of books, documents, and photographs. They are kept in three buildings located across JBSA-Fort Sam Houston. The majority of these items are paper-based and are unfortunately prone to deterioration because of environmental factors. Deterioration is generally defined as a change from an item's original state to one that had begun the process of decay. As custodians of material dating back to the mid-1800s, we are acutely aware of the issues surrounding their durability and permanence and take steps to mitigate this decline. Surprisingly, some of the more sensitive items that we deal with are documents produced during the 20th Century and specifically during World War II.



Major Logan Edward Jackson served as a battalion surgeon with the 110th Medical Battalion (35th Infantry Division) during World War II. His papers and scrapbook are currently preserved by the AMEDD Center of History and Heritage.

For example, inside Army Major Logan Edward Jackson's tattered and discolored personal copy of his 201 File are copies of award and training certificates, promotion orders, pay and travel vouchers, and separation papers. The documents themselves are over 80 years old and of various sizes and physical composition, held together in two sections by a metal two-hole fastener on the left side and metal paper clips on the right, both of which have become oxidized and slightly rusty. Some of the documents are brittle, some are torn along the creases where they have repeatedly been folded and unfolded, and all show signs of deterioration. The main reason for concern is that the wood pulp paper used to document much of World War II is inherently vulnerable.

Paper made from wood pulp contains lignin which is sensitive to excessive levels of light and fluctuations in temperature and relative humidity. Over time and under the right (or incorrect) conditions, this organic material begins to break down the wood pulp's cellulose fibers, initiating a process of acidification that causes paper to become discolored, embrittled, and aromatic. If left unchecked, the acidic papers can begin to transfer their acid to neighboring materials, even those that have minimal or no acidic levels. This was certainly the case with Major Jackson's papers and most other World War II documents in our research collection. It is evident from these examples that deterioration is steady, cumulative, and irreversible. So, an argument can be made as to why bother collecting and preserving historical documents at all if they are destined to slowly fail.



The images above show how a less acidic paper acted as a buffer between two more acidic ones. When the yellow carbon paper (left) is lifted, levels of discoloration are revealed on the document below (right).

First, there are practical methods to mitigate deterioration. Choosing proper document storage materials is one solution. Boxes, file folders, and interleaving papers that are acid- and lignin-free, pH neutral, or have an alkaline buffering substance can slow the rate of acidification. Housing paper documents in storage facilities that operate within consistent temperature and relative humidity tolerances is another. The primary research collection maintained by the ACHH is fortunately co-located within the AMEDD Museum where these conditions can mostly be met. Finally, using the original documents can promote preservation. It is counterintuitive to think that the more historical documents are used the less susceptible they are to damage. But the careful handling of documents in a controlled environment allows archivists and historians to examine the materials during the course of their research and identify potential areas of concern.

Preserving these documents and extending their lifecycle is worth our best efforts because they enhance historical awareness and support decision making for the Command and key leaders. They also aid in the development of museum exhibitions, staff rides, and military history educational training. They offer important contextual information necessary in telling a unit's history and in preserving its institutional memory. Ultimately, they are necessary for the study of history and in the case of AMEDD Soldiers like Major Jackson, the study of their contributions to the history of Army Medicine. And even though his documents are now relatively stable and accessible to researchers, we have a statutory requirement and professional responsibility to ensure they remain so for future generations.

Medical Logistics Demobilization in World War Two
Scott C. Woodard, ACHH

Planning for the end of World War Two and demobilization began in August 1943. The Plans Coordination Branch within the Plans Division of the Operations Service, Office of the Surgeon General (OTSG) was established in June 1943. Later it became the Demobilization Branch and moved to the Special Planning Division Branch in February 1944. Demobilization included reduction in personnel, facilities, and supplies. Upon final victory in the Second World War in 1945, the US Army began demobilizing 7 million soldiers from its highest of 8 million soldiers during the war. Along with those numbers of personnel, the supplies, equipment, and facilities used in their mission were also reduced.

Considerations included revising contracts; disposing of products already in the materiel management chain; prioritizing which research and development projects to continue; adjusting spare parts lists; and handling medical lend-lease products. There were requirements beyond just the smaller peacetime Army. Agencies such as the American Red Cross were also considered, and material needed to be set aside for war reserve stocks. Also weighing on the minds of medical logistics planners was the understanding that flooding the market with excess medical stores would adversely affect the civilian economy. Another 'big picture' factor was enabling health and sanitary institutions in the United States to receive products they normally could not afford.

With the United States' policy focus on "Europe First," plans for demobilization started in the European Theater of Operations before Victory in Europe, 8 May 1945. OTSG had very specific directives and exact procedures to be activated following Germany's defeat. These actions were contained in specialized instructions published in February 1945, promptly revised in March 1945.

The supply chain went all the way back to factories, so the demobilization planning included all phases of production. Changing the quantity of production would involve cutting the workforce; revising quantities of critical materials needed; factory construction and modification contracts; railway distribution to depots and warehouses; and how many warehouses would be needed. Long-term planning included how many government-owned factories would be needed active, and how many should be mothballed for reserve. Material on hand would need to be assessed for repair, or disposal. Material on the move had to be diverted, including returned to shipper. And all this had to be done without bar-codes or en-route visibility.

Additionally in overseas theaters, the Chief, Supply Service was to determine which items should be given priority for redistribution for active combat operations, determine sources of supply (US, or inactive theaters), and disposal of returned property. Meanwhile the Director, Mobilization and Overseas Operations Division, was to determine which operational projects would be terminated. Overall, the objective was "to make the necessary adjustments to meet the continuing medical needs for the effective and efficient prosecution of the war against Japan."

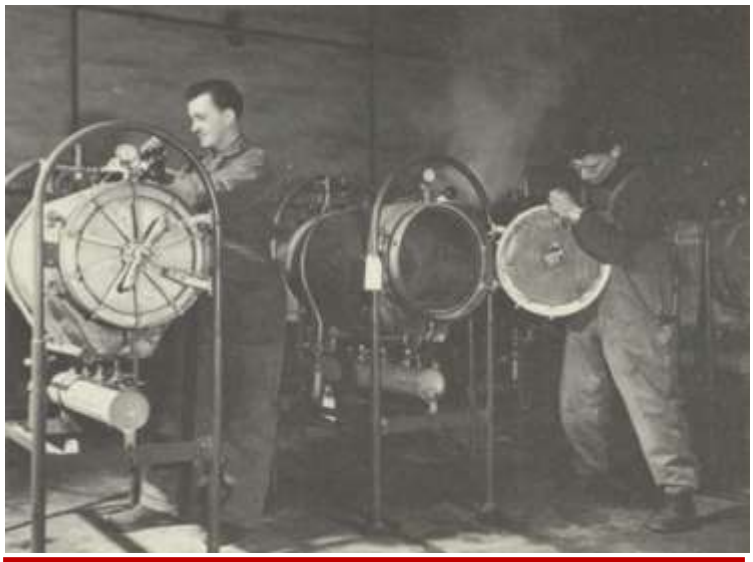
Soldiers assigned to Medical Depot M-418 in Mourmelon-le-Petit, France disassemble medical chests in preparation for restocking for shipment to the Pacific Theater. (From Anderson, Medical Supply)

Once the Third Reich was defeated, plans for redeployment began in earnest. Units were placed in three classifications: (Category I) occupation; (Category II) transfer to another theater; and (Category III) demobilization in the United States. The war was still raging in the Pacific, so European units not heading directly to that theater turned-in most medical supplies and equipment which were eventually

shipped to Asia. For materiel consolidated in Europe, priority was instituted to modify packing requirements to meet the requirements of combat in a tropical environment. Category I units redeploying to the Pacific collected newly stocked sets at depots for further movement. Surprisingly 75 to 90 percent of the hospital equipment was found serviceable or repairable. Excess was sold as surplus. The challenge became packaging material, which created a bottle neck until crates and packing material were received from the US. Some mitigation came from centralizing all box-making activities in France. Adding to the challenge, those same soldiers doing the job were also demobilizing, leaving the work to those left behind in Europe. The large numbers of soldiers separating from the service provided a unique challenge for medical maintenance technicians tasked to service the consolidated stocks. Work hours were reduced, yet technical expertise was still required to assist in closing military operations, and units still required emergency repairs at permanent hospital stations.

Europe was divided into occupation zones and AMEDD depots transferred stocks to the countries responsible, France, the United Kingdom, and the Soviet Union. Additionally, medical commodities were utilized in caring for displaced persons and prisoners of war. Medical depots in zones under United States authority supported American occupation forces.

Upon Victory over Japan (2 September 1945), the medical materiel flow to the Pacific stopped and became surplus; medical depots in the Pacific consolidated stocks in the Philippines. Before victory, the Manila area already contained the largest medical depot system in the Pacific. The depots supported Army forces and the Philippines Commonwealth Government for eventual civilian usage. Most of the equipment bound for the Pacific Theater had reached the Philippines or was already enroute. A concerted effort was made to prevent a buildup of excess materiel in Japan. Unless the medical stores were essential in occupied Japan, ships in the harbor and requisitions enroute were returned to the United States. Supplies and equipment coming from the European and Mediterranean Theaters of Operation were downloaded if they arrived in the Philippines. Officials then delineated surplus and stocks required for War Reserve Stock onsite. However, if medical materiel arrived at a Japanese port, they were forwarded to the United States before debarkation. Of note for the depots in the Philippines,



Repairing field autoclaves at the Medical Maintenance and Repair Shop, Depot M-407 in Europe. (From Anderson, Medical Supply)

Receiving section and warehouse, 49th Medical Depot Company, Quezon City (Near Manilla), Philippines. (From Anderson, Medical Supply)

there was extensive pilferage of medical supplies. Unlike the typical shoplifting normally occurring at depots, the Philippines saw organized armed raids that hijacked shipments to the extent that penicillin was in short supply by 1946.

In 1946 the War Assets Administration was formed to dispose of surplus government goods in the US and its territories. The WAA dealt with all supply categories, and medical examples included notifications to the public that "medical, surgical and dental apparatus and equipment" sets were set aside for the exclusive sale to veterans. In one example of enabling institutions normally unable to afford equipment, a 150-bed hospital on Fort Raymond (in Seward, Alaska) was given to the Territorial Government to eventually serve as a tuberculosis sanitarium.

Optical Section Shop, 49th Medical Depot Company, Manila. (From Anderson, Medical Supply)

View of the front of the Seward General Hospital, 1945. The sign above the front entrance reads "Hospital." (Courtesy Alaska's Digital Archives, Hans and Margaret Hafemeister papers, Archives and Special Collections, Consortium Library, University of Alaska Anchorage)

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Demobilization following WW2 was an immense undertaking. Long before the required execution timeline, Army medical planners and logisticians in OTSG developed a detailed plan that met the national strategy of winning in Europe first and continuing to support the effort to win eventual victory in Asia. Future conflict will require thoughtful effort on the part of medical personnel to win our next war while also planning how to scale down mobilization. The plan and execution, as well as challenges, of medical demobilization in WW2 may foreshadow requirements in the future.

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Long-term Research

After the atomic bombs at Hiroshima and Nagasaki, the thread-bare Japanese medical system had to handle the burned and radiation-sickened survivors, as well as those suffering from secondary missiles such as broken glass or wood. However, the U.S. would soon have medical teams on site. The first, an Army team, arrived after a month. Led by COL Ashley Oughterson, MC, they did rapid surveys and found that (as the physicists had suspected) there was little residual radiation, but the Japanese needed medical supplies. Oughterson's first supply order included 100 million units of penicillin. Once Japan surrendered, and the U.S. was the occupying power, providing supplies was part of the U.S. responsibility. The medical researchers also established whether it would be safe to re-occupy the city. Soon a U.S. Navy hospital ship arrived, and a research team (including medical researchers) from the Manhattan District. Rather than have three American teams and various Japanese efforts, MacArthur's headquarters organized a Joint Commission for the Investigation of the Effects of the Atomic Bomb in Japan.

Initially the research was classified, but Oughterson pushed to get it declassified, which it was in 1951, and then published in 1956 for all to read about the effects of atomic weapons. By then, physicists had created the hydrogen bomb. However, the Atomic Bomb Casualty Commission (1947-75) and Radiation Research Effects Foundation (ongoing from 1975) have continued the research.

As Dr. William Mayo said after World War I, "medicine is the only victor in war."

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Photos to document and begin clinical understanding of atomic bomb effects. Left: thermal burns based on the dark portions of the kimono pattern. Right: study of keloids (raised scar tissue) outside an area protected by a shoulder belt. Images courtesy National Archives.

With the lack of governmental infrastructure and destroyed utility systems, sanitation was a problem in most of the battleground countries.

The end of the war and leaving the military was long awaited by service members. Soldiers in Europe pondered if they would be moved to the Pacific. Soldiers in all theaters anticipated their return home. Although America maintained a sizable standing Army and occupation force in Europe and Japan, demobilization of its enormous Army was methodical utilizing numerous stations and depots from the war. Still, medical support meant that certain medical units and personnel had to remain on duty.

Once out of uniform, with a glut of fellow job seekers, many former troops took advantage of benefits from the original G.I. Bill (1944-1956), receiving higher education or business and farm loans. Former service personnel recovering from war injuries received care from the greatly increased Veterans Administration's hospitals and physicians. After personnel were mostly transitioned into civilian life, the materiel of the war (including medical equipment) was also transitioned. Determinations were made of what could be utilized, sold, and scrapped. These were just the opening phases in reforming the world after the war. It would of course take years of work and recovery.

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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