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Contents

Happy New Year, and welcome to Issue 13 of the *AMEDD Historian!* This issues authors have done a great job in bringing AMEDD history to you. We in ACHH love our jobs because we get to tell the story of the AMEDD, but we want you to embrace that legacy of AMEDD history and help us tell the AMEDD history, so please send us your AMEDD history article for the Issue 14. Authors like you have made the major contributions to this issue.

In this issue, LTC (Ret) Bill Emerson, a preeminent expert on Army insignia has continued his series on AMEDD insignia. Bob Ampula from ACHH wrote the story of CPT Pete Suer, DC, who received two Silver Stars in World War II. Major John Downs, MC has sent us an article on CPT James C. Fisher, 6th Rangers Surgeon who was one of two Rangers killed in the raid on Cabanatuan to recover American POWs. The *AMEDD Historian* is reaching a wide audience, as CW5 Roger Wheatley, at USA Human Recourses Command submitted an article on the beginning of the Army substance abuse treatment. Last is a book review from a just released 2015 book on a World War I medic, Private Ralph Heller, Army Ambulance Service.

(continued on page 10)

The Caduceus as an Army Insignia

LTC (Ret) William K. Emerson

Army officers did not wear collar insignia on uniforms until the introduction of a high collared sack coat in 1892. Until then staff and combat arms assignments were shown by trouser stripe and shoulder straps colors, and by epaulettes. Before 1902 officers had a variety of devices to show their arm or staff position but in that year, for the first time, medical officers began to use the caduceus as their emblem. Enlisted men of the Hospital Corps used a wide range of emblems to show their assignment to medical duties, with the caduceus one of various designs. Finally in 1902 enlisted personnel also adopted the caduceus as their insignia.

But why the caduceus rather than the staff of Asclepius or some different device? The answer is hidden in these early twentieth century uniform and insignia changes. Many of these changes are still with us, including the caduceus.

Early "insignia" often were simply letters. Doctors' epaulettes carried the old English letters MS (originally for Medical Service) until 1872. Knots replaced epaulettes in 1872 and doctors used the old English letters MD (for Medical Department) until 1890. The wool pad at the end of knots were dark blue for the Regular Army, but in some state militias they were branch colored and then embroidered with a regimental number to indicate where officers served.

Medical Corps Insignia

(From left) 1. A dress uniform epaulette for a medical captain, 1851-1872. In the crescent are the old English initials MS for Medical Service. (Image cropped to retain MS detail.) 2. A physician's dress uniform shoulder knot for a state militia's 1st infantry regiment. The MD stood for Medical Department. Regular army 1872-1890 knots were similar except no regimental number was shown and the wool pad was dark blue for all officers except cavalry, infantry, and artillery. 3. A Regular Army medical major's dress coat shoulder knot, 1890-1896. 4. In 1896 a gold colored Maltese cross replaced the federal shield as medical officers' insignia. This imitation metal device had small loops for sewing to a coat's standing collar.

(Left) Collar insignia for a state's Fourth Infantry regiment, circa 1900. The small Maltese cross in the lower angle shows it was worn by the regiment's doctor.

(Right) A World War I doctor's collar insignia. Colonel John Van Rensselaer Hoff convinced the 1902 Uniform Board to use the caduceus as the new medical insignia for both officers and enlisted personnel, since it had been an ancient symbol of neutrality and commerce.

In 1892 the army introduced branch insignia for non-combatant officers to use on the new coat. For doctors the insignia was a gold colored shield that had been adopted in October 1890 for shoulder knots. The medical shield lasted until 1896. In 1892 cavalry, infantry, and artillery officers simply placed the number of their regiment on coat collars. Finally in 1895 they went to crossed sabers, rifles, and cannons.

The gold colored shield was replaced in 1896 by a gilt Maltese cross, as shown in Figure Four. By the Spanish American War this insignia was well established, even to the point that in several state militias doctors wore small medical insignia below their regimental insignia, the same way regimental adjutants and other staff officers showed their assignments.

In 1902 the army created a special uniform board to design a set of totally new uniforms. The medical member was Colonel John Van Rensselaer Hoff, an experienced officer who had joined the army in November 1874. Hoff recommended the adoption of the caduceus as the medical insignia since it was the emblem flown on ancient merchant ships. At that time merchants were considered noncombatants and Hoff's rationale was that at times of piracy in the Mediterranean vessels proclaimed their nature by flying a flag which bore the emblem of Mercury, the god of the merchant and symbol of commerce. In this context the caduceus indicated neutrality. Hoff had ruled out using the Geneva cross as the medical insignia since it was also the emblem of Switzerland and he considered it inappropriate to use a national symbol. He considered the red cross

brassard a symbol of neutrality in wartime rather than a medical device.

Colonel Hoff evidently did not bring up the point that enlisted men had intermittently used the caduceus as their emblem since 1851. Hospital Stewards used it on their chevrons between 1851 and 1887. Between 1881 and 1887 a German silver caduceus was an overlay on hospital stewards' dress helmet eagles, and a similar device in a wreath went on their forage caps between 1882 and 1887. Starting in 1887 enlisted medical personnel used a silver Geneva cross on caps and as overlays on helmet eagles. Cap insignia worn by hospital stewards and other enlisted medical personnel included a silver Geneva cross, a Maltese cross (1901-1903), and a caduceus (1903-1917).

Hospital Corps Insignia

In 1896 hospital stewards wore a silver Geneva cross in a silver wreath as their cap insignia. Lower rank enlisted men wore the cross without the wreath.

A cap insignia for hospital stewards, 1902. In 1903 the army changed the title of hospital stewards for sergeants first class. Lower ranking enlisted personnel wore only the caduceus.

While early Twentieth Century doctors and enlisted medical personnel used the gold colored caduceus on their dress uniforms and subdued on field uniforms, other medical officers added letters on their caduceus. The first was for the Medical Reserve Corps that started in 1908. Today's US Army Reserves trace their history to this Medical Reserve Corps. Officers in the Medical Reserve Corps adopted an RC monogram on a caduceus as their insignia. This insignia became obsolete in June 1917 when congress eliminated the Medical Reserve Corps, but in the meantime, other reserves had been founded.

Contract surgeons began to use a silver caduceus in 1902 but in 1918, when all insignia were in the World War I version of subdued, they switched to a gilt CS monogram on a dark caduceus. In 1920 a single C on a caduceus became their insignia.

Other physician insignia

(From left) 1. Insignia for Medical Reserve Corps member, 1908-1917. This was the first medical insignia to add letters to a caduceus to distinguish the wearer from a Regular Army physician. 2. Contract surgeons used a CS monogram on a caduceus as their insignia during World War I. 3. Rather than the "U.S." letters worn by Regular Army officers, contract surgeons added silver "C.S." letters on their coat collar next to a silver caduceus.

Congress first provided for contract dental surgeons in April 1901. The army gave them large block silver letters D.S. for their coat collar. In 1911 these men became acting dental surgeons and replaced the block letters with a caduceus that carried a DS monogram, which in 1916, was replaced by a DC (Dental Corps) monogram. The current single D on a caduceus replaced the DC monogram in December 1917.

Dentists' Insignia

(From left) 1. Contract dental surgeons wore these silver "D.S." letters on their coat collar between 1901 and 1911, when they received a caduceus with a superimposed DS (Dental Surgeon) monogram. 2. Dental Corps officers used a monogram of their corps superimposed on a caduceus at their insignia in 1916 and 1917. 3. In 1918 dental officers switched to a single letter on a caduceus, the same general design used today.

Veterinarians used a winged horseshoe in the lower angle of either cavalry or field artillery insignia from 1902 until 1916 when Congress formed the Veterinary Corps. With that change officers' insignia switched to a VC monograph on a caduceus, which lasted until December 1917 when a lone V replaced the two letters.

Collar insignia for the veterinarian, 11th Cavalry Regiment, circa 1902-1904.

Civilian nurses served under contract during the Spanish American War. Congress authorized permanent nurses on February 2, 1901. Nurses placed a single green Maltese cross on their white ward uniform collar as their insignia. This was replaced in 1907 by a gilt caduceus with a white ANC monogram. When nurses went overseas in World War I on their outdoor uniforms they wore a similar insignia but in dark metal with a gilt ANC monogram. The N on a caduceus used today became the nurse insignia in 1920.

In May 1918 the Secretary of War approved the establishment of the Army School of Nursing. Through the fall of 1918 the army established 33 schools across the United States. Students at these schools wore blue nurse uniforms and in September 1918 an insignia for the Army School of Nursing was created—a caduceus bearing a lamp of knowledge. The two remaining post-war schools were consolidated at Walter Reed in the fall of 1923. In 1931 the War Department decided to close that one school, which occurred in 1932.

Nurse Insignia

(From left) 1. Between 1901 and 1907 army nurses wore an enameled green cross on their white ward uniform. They had no prescribed uniforms for wear outside hospitals. 2. Starting in 1907 a white monogram representing the Army Nurse Corps replaced the green cross on white ward uniforms. 3. The army had a varying number of Army Schools of Nursing between 1918 and 1932. Students wore a caduceus bearing a lamp of knowledge. This post-1924 insignia was worn when the army had only one school that was at the Army Medical Center.

Other medical insignia that used a caduceus appeared immediately before and during World War I, including those for the Sanitary Corps, the Ambulance Service, and Reconstruction Aides (equivalent to physical therapists). With this basis well established, during World War II and later as various corps in the Army Medical Department came and went, and some civilian employees (mainly those that later became the Women's Medical Specialist Corps) also wore insignia. One or two letters distinguished the corps, but in all cases Colonel Hoff's caduceus was the basic insignia.

All images from the author's collection.

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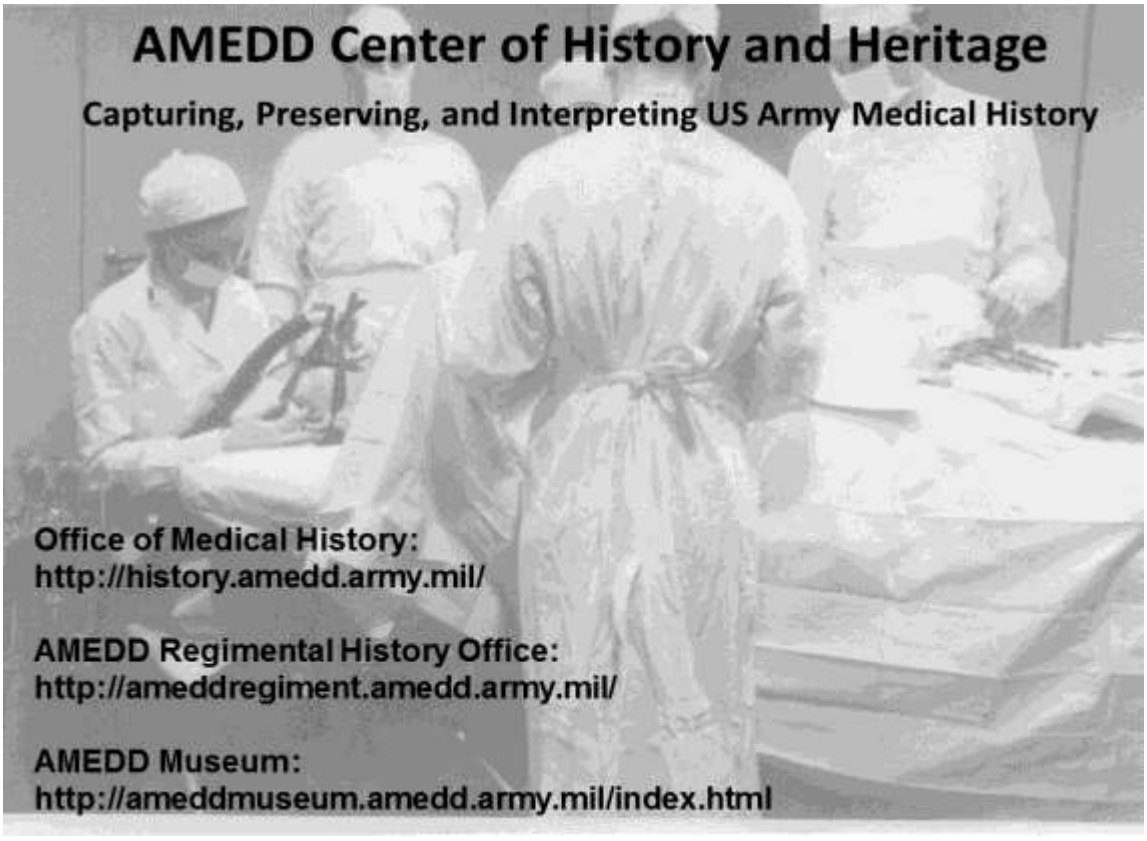

WWII Airborne Dentist, CPT Alexander "Pete" Suer

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

During an intense firefight in Sicily between members of the famed 82d Airborne Division's 505th Parachute Infantry Regiment and German defenders, wounded soldiers from both sides lay in the No-Man's-Land between the adversaries. Suddenly a lone figure rose up waving a large Red Cross flag paying no attention to the hail of bullets between the belligerents; he rushed out to give lifesaving aid to the wounded. He moved from man to man treating the wounded regardless of nationality and then moved them to relative safety. The battle raged all around him but he apparently was not targeted by the Germans. This fearless action was performed by one of the two Dental Corps officers assigned to the 505th, Captain Alexander Suer. (Captain Donat L. Savoie was the other dentist assigned to the 505th.)

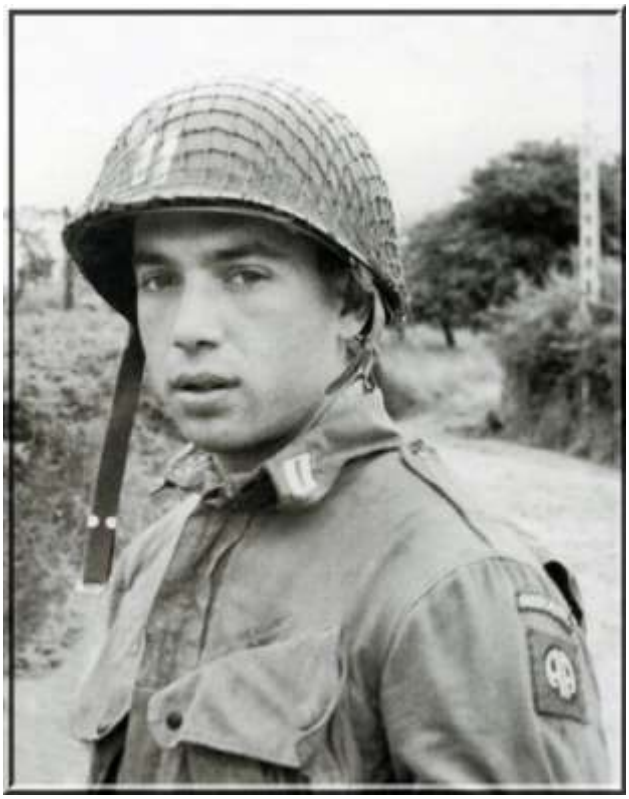

Photo Courtesy of the 505th Regimental Combat Team website.

Alexander Suer, "Pete" to his friends, a native of Philadelphia, attended Temple University and graduated from its dental school in 1938. He went into private practice, but with war looming he joined the Army Reserve in 1939. Pete subsequently joined the Army Dental Corps in early 1941 and after the United States entered the war he decided to attend airborne training and joined the 505th after its formation. The new organization endured rigorous training at Fort Benning before moving to Fort Bragg where they became part of the 82d Airborne Division. In late April 1943, the 505th departed from New York on transport ships bound for North Africa.

Arriving in Casablanca in early May the unit began training for Operation HUSKY, the invasion of Sicily. On the night of 9/10 July 1943, CPT Suer and the 505th were on their way to Sicily in support of the 1st Infantry Division's landings. Strong winds scattered the 505th over a large area but the regiment fought in small groups while moving to the rallying points and cutting communication lines along the way, which hampered German defensive operations. CPT Suer seemed to be everywhere and medics commented that he was intent on saving lives, often at the risk of his own. In addition to these actions, Pete also commandeered a vehicle from the infantry and used it to evacuate casualties back to a Navy beach battalion for further care and evacuation. CPT Suer continued his courageous concern for the wounded when the 505th jumped into the Italian mainland at Salerno.

On D-Day, the 505th jumped into Normandy and although scattered, regrouped and made their way to Sainte-Mere-Eglise. While in Normandy, CPT Suer modified his method of rescuing soldiers lying in exposed areas between the two forces. He would mount the bumper of his jeep, wave the Red Cross flag and drive out into the thick of the fighting, collect any wounded, and return to friendly lines to render aid. On another occasion Assistant Regimental Surgeon CPT Robert Franco (who would himself receive the Soldier's Medal and Silver Star) recounted how he and CPT Suer were walking and noticed some movement in the shadows. CPT Suer called out in German that they were surrounded by heavily armed Americans. Fifteen Germans laid down their arms and Pete ordered them to get down on the ground. While Pete went to radio for help, CPT Franco guarded the Germans, worring they would look up and see his Red Cross armband. Luckily, they didn't.

The 505th next jumped into Holland as part of Operation MARKET GARDEN. After a few moves, the regimental aid station set up in the city of Nijmegen. CPT Suer resumed his tactic of riding the jeep bumper to rescue wounded soldiers. He now added another brave action of swapping wounded soldiers. Pete would load his Red Cross flagged jeep with German wounded, drive to the German lines, and negotiate a swap of German

wounded for American wounded. Quite a brave feat, especially considering that CPT Suer was Jewish.

After a brief R & R in France, the 82d and the 505th were called to blunt the German offensive now known as the Battle of the Bulge. During the battle the medics of the 505th were performing their lifesaving duties under the harshest of conditions against a determined foe. On 26 December 1944, near the German occupied town of Trois Ponts, CPT Suer received word that two men had been wounded. Under full enemy observation, within 200 yards of enemy positions, CPT Suer went forward at the risk of his personal safety. En route forward his group was spotted in open terrain and a mortar barrage came down. CPT Suer was seriously and painfully wounded, but asked that the others be treated and evacuated first.

Ludwig J. Cibelli (POW doctor), Byford I. Hall, Pete Suer and Dan McIlvoy at Ste-Mere-Eglise Regimental Aid Station.
Courtesy Collection D-Day Paratroopers Historical Center, Saint-Come-du-Mont, France

CPT Suer was stabilized and evacuated, eventually making his way to Walter Reed General Hospital. Both of his feet had to be amputated. During secondary surgery to prepare his legs for prosthesis, CPT Suer developed a pulmonary embolism and died on February 1st 1945. Later, Major Daniel B. McIlvoy, regimental surgeon, received a letter from Pete Suer written while he was at Walter Reed explaining his injuries. He said he regretted being back in the States, but not because of his legs – he said he was sorry he was missing out on the end after participating in everything else. The letter was sent to MAJ McIlvoy by Pete's father, Ben Suer. Ben added "Dear Major: This letter was sent to me from Walter Reed Hospital. Al died at 9:00 p.m. in some way from pulmonary embolus. We are heartbroken, but I guess this is the price of war. I only hope that the fight you guys are waging, and Al died from, will not be in vain. At least his boy and all of your children will not have to go through the same mess. Good luck and safe return home to all of you."

Captain Alexander "Pete" Suer earned two Silver Stars in World War II.
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CPT James C. Fisher, MD, 6th Rangers Surgeon

John W. Downs, MD, Major, Medical Corps, US Army

The 6th Ranger Infantry Battalion was formed 25 September 1944 from men of the 98th Field Artillery Battalion (Pack), a pack mule artillery battalion that became virtually useless after their mules were reallocated to other U.S. Army units. The battalion's birth can be attributed to the 6th U.S. Army commander, General Walter Krueger, who was interested in the capabilities of small, highly trained units given very specific missions. As a result of his interest, combined with the success of Ranger units in the Mediterranean and European theaters, General Krueger called for the formation of the 6th Army Special Reconnaissance Unit (Alamo Scouts), and later the 6th Ranger Infantry Battalion. The 6th Ranger Battalion landed as an advanced force on Dinagat, Suluan, and Homonhan Islands three days prior to the major invasion of Leyte Island in the Philippines in October 1944. The battalion has best been remembered primarily for the successful liberation of over 500 American, Australian, and British prisoners of war from a Japanese prison camp in the Philippine city of Cabanatuan on 30 January 1945.

CPT James Canfield Fisher, MD, served as battalion surgeon and medical detachment officer in charge for most of the existence of the 6th Ranger Battalion. Dr. Fisher was the son of American author and educator Dorothy Canfield Fisher. Prior to the war, he attended medical school at Harvard University, and worked as a surgeon at Boston City Hospital for two and a half years. Due to his surgical experience and his fluency in French, Dr. Fisher expected to be assigned to a surgical hospital in Europe; however, he was assigned to the 98th Field Artillery Battalion (Pack) as the unit surgeon and shipped with the unit to New Guinea in the Pacific theater. When the 98th Pack Battalion became reorganized as the 6th Ranger Infantry Battalion, Dr. Fisher volunteered to remain with the battalion, and participate in its Ranger training. Fisher insisted on participating in the full Ranger training, venturing out on training patrols and foot marches that many other surgeons would have avoided. He became endeared to the 6th Rangers who knew him simply as "Doctor Jimmy."

Ranger CPT James Fisher, MD (left) with Ranger CPT Bob Prince a few hours before the raid on Cabanatuan.
Courtesy Alamo Scouts Historical Foundation.

As the 98th Pack Battalion surgeon in New Guinea, Dr. Fisher established and ran a stationary unit health clinic, which he maintained after the battalion was reflagged as a Ranger unit. Dr. Fisher also provided medical care for the native populations of New Guinea and the Philippines. During operations on the island of Luzon, Dr. Fisher helped a young Filipino woman deliver her first child. The mother was so moved by Dr. Fisher's compassion that she asked him to be the godfather of the child. Later during the Cabanatuan operation, Dr. Fisher met with a Filipino guerilla physician, Dr. Carlos Layug, to establish a forward surgical station in the village of Platero for the treatment of rescued prisoners and battle casualties after the liberation of the camp. (At the time it was referred to as "Pangatian Prison Camp" but in recent years Cabanatuan has been used more often.) Dr. Layug's wife later recalled Dr. Fisher's interest in caring for the native Filipino people after the hostilities ended by assisting Filipino physicians in acquiring the equipment and medicines necessary for proper treatment. Sadly, Dr. Fisher was never able to see through on this promise.

Although it appears puzzling why Dr. Fisher was not assigned to a surgical hospital in Europe, in retrospect, it was a great benefit to the battalion. The unconventional operations of the Rangers sometimes prevented wounded soldiers from receiving rapid surgical intervention at a rear-area hospital. Dr. Fisher's skill as a surgeon likely helped to make up for that lack of direct surgical support. Dr. Fisher and his medical detachment landed with the first wave of assault troops during the invasion of Homonhan Island several days prior to the larger Leyte landings. He also argued for the opportunity to go forward with the assaulting rifle company during the Cabanatuan raid so that he could treat wounded soldiers as close to the point of injury as possible, rather than awaiting casualties with Dr. Layug a few miles away in Platero. Ironically, Dr. Fisher would become one of only two Rangers killed during the operation. However, the treatment and evacuation plan that he coordinated for the raid would prove effective and become a major factor in the overall success of the operation.

Medical planning for the Cabanatuan operation was not initially concrete, but became an integral part of the operation, particularly getting the rescued prisoners back to medical attention. No reference was made in battalion operational records as to the planning of medical operations. However, after the operation, the battalion commander, LTC Henry Mucci, wrote several journal articles describing how the medical treatment and evacuation plans were developed and instituted en route to the prison camp. After initial movements had begun, but prior to the actual raid, the battalion's radio transmission records show that contact was made with the 92d Evacuation Hospital to coordinate for food and transportation of the prisoners after their rescue. The day before the raid was conducted the Rangers were bivouacked around the village of Balingcari awaiting intelligence from the 6th Army's Alamo Scouts regarding the situation at the Cabanatuan camp. During this time, Dr. Fisher made contact with a local Filipino doctor, Dr. Carlos Layug and his wife, also a physician, and made plans to establish a forward aid station in an abandoned schoolhouse in the nearby village of Platero so that the most seriously injured prisoners could receive forward trauma management. Dr. Fisher also volunteered to go forward to the prison camp with the assaulting element in order to treat serious medical cases "on the spot" so that they could at least get back to Dr. Layug's aid station. LTC Mucci and Dr. Fisher made arrangements with local Filipino guerillas to help evacuate wounded and injured prisoners by gathering pack animals and carts. He also allowed unarmed guerillas to help the operation as litter bearers for the prisoners who were unable to walk. Local Filipinos staged roughly 25 carabao carts about 2 miles away from the prison camp, near the south bank of the Pampanga River. To reach the site, however, those prisoners who were unable to walk independently were carried on Rangers' backs. When the column reached Platero, roughly another 20 carabao carts joined. As the column passed through additional villages along its exfiltration route, still more carabao carts were donated by the Filipino population. Over one hundred carts were eventually included in the column by some estimates, in addition to the food and water provided by sympathetic locals throughout the march. In this manner, the battalion command element coordinated for the complete evacuation of over 500 malnourished prisoners over a distance of greater than 30 miles.

Within minutes of initiation of the Cabanatuan raid, nearly all Japanese resistance had been overcome. However, a lone Japanese mortarman managed to fire three rounds toward the main gate of the camp, sending fragments into Dr. Fisher's abdomen. During the exfiltration to friendly lines, Dr. Fisher was taken to the same surgical station that he had established with Dr. Layug in Platero. By now, the Layugs were joined by two American surgeons recently liberated from the camp, Dr. James Duckworth and Dr. Merle Musselman. Dr. Fisher was severely hemorrhaging from liver wounds, his intestines were riddled with shrapnel, and he was lapsing in and out of consciousness. Dr. Layug and Dr. Musselman worked desperately to control the liver hemorrhage and remove shrapnel from Dr. Fisher's abdomen, but the surgeons realized that Fisher's wounds were too dire for their limited resources and circumstances and would ultimately need the full resources of an American surgical hospital if he were to survive. The Ranger column had to depart Platero to continue its march back to friendly lines, but Fisher's condition was felt to be too severe to survive the entire march. Understanding this, the decision was made to leave a small guard force of Alamo Scouts, Rangers, and guerillas in Platero, in order to allow Dr. Fisher to continue to receive care from the Layugs and Musselman.

LTC Mucci then radioed 6th Army headquarters to arrange for fixed-wing evacuation for Dr. Fisher. Fisher's condition continued to deteriorate throughout the evening and early morning. During this time, Fisher was transported by the Scouts and Rangers on a makeshift litter created from a large door to the nearby village of Balincarin where his evacuation aircraft was expected. The Alamo Scout detachment gathered local workers and worked throughout the evening to create a primitive landing strip, but the aircraft never arrived. Dr. Musselman remained at Dr. Fisher's side throughout this time, but Musselman realized that Fisher would likely not survive even if immediately evacuated to a surgical hospital. Musselman went as far as conducting a direct vein-to-vein blood transfusion using an Alamo Scout donor who shared Dr. Fisher's blood type. Despite Layug's and Musselman's valiant efforts, Dr. Fisher perished approximately 15 hours after the start of the raid on 31 January 1945. Dr. Fisher was buried near Platero by members of the Filipino guerilla teams. His body was later moved to the Manila American Cemetery.

This is an excerpt of an article previously published in *The Journal of Special Operations Medicine*, summer 2014. It is re-published with permission.

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(continued from front page)

As reminder, the AMEDD Center of History and Heritage, AMEDD Museum Foundation, Uniformed Services University of the Health Sciences, and the Vietnam Center and Archive of Texas Tech University are conducting a Medical Symposium on the Vietnam War, March 10 to 12, 2016 at the Holiday Inn San Antonio Airport. For information, please contact us through **usarmy.jbsa.medcom.mbx.hq-medcom-office-of-medical-history@mail.mil**.

Finally, between issues of the *AMEDD Historian*, you can follow AMEDD history on our Facebook page at: https://www.facebook.com/medhistory/?ref=bookmarks.

Bob Driscoll
Chief, ACHH

Benning House: The Beginning of Army Substance Abuse Treatment

CW5 Roger Wheatley, US Army Human Resources Command

The history of substance abuse in the Army likely began shortly after the first gill of whiskey rations were issued to Continental Army soldiers. Concerns about alcohol and other drug problems within the military were magnified in the late 1960s with rising national concern about drug use among service members. The roots of today's Army Substance Abuse Program began with Benning House, a community-based program that opened in March 1970 providing the first residential treatment in the Army. Benning House became a model program which was replicated throughout the force, growing to 50 similar houses. The community based program, peer recovery support services, and community leader support bear similarities to evidence-based approaches and the recovery advocacy movements of today. Program leaders from Fort Benning provided the Army voice during Senate testimony helping create the modern program, which ultimately subsumed Benning House itself.

Army halfway houses served as the primary treatment model throughout the 1970s, eventually replaced by hospital-based residential facilities. The grassroots, community-based program found success and substantial influence within a bureaucratic system through a team who understood the power of community recovery support. The story provides historical perspective on the military reaction to addiction that historians may find fascinating as well as lessons to support clinicians on the front line of addiction treatment today.

The seed was planted with an Army physician during a psychiatry rotation as an intern. Carl Segal encountered a patient reduced from Master Sergeant (E8) to Private (E1) for alcohol related behavior, yet was caught drinking aftershave in the psychiatric ward. This experience shaped his interest in alcoholism and his specialty of psychiatry. Awarded a Harvard Fellowship, Segal studied community psychiatry under addiction researcher Dr. Jack Mendelson. As Chief of Psychiatry at Fort Benning, he continued to have similar experiences, concluding there was an alarming alcoholism rate at Fort Benning and probably in the Army. He developed the concept for a community-based solution that ultimately became Benning House.

James Adelman, a Social Work Officer, began developing a passion for helping alcoholics at age 7 when his grandfather came to live in his home. After losing job and family to alcoholism, his grandfather was sent to Akron, Ohio in 1951 with hope that Alcoholics Anonymous could help him. Upon return to Pennsylvania, Jim's grandfather came to live with the Adelman family, so Jim grew up attending A.A. gatherings and open meetings. Captain Adelman arrived at Fort Benning just in time to lend his passion to Benning House.

Jim Henry and George Trick.
Author's collection.

Sergeant First Class Jim Henry was the NCOIC of the Mental Hygiene Clinic who assumed responsibility for daily operations of Benning House. Described as the "Radar O'Reilly" of Benning House for his resourcefulness, he acquired needed beds and supplies to open the program before they had a budget.

Daryl Conner became an enlisted Mental Hygiene Specialist after enlisting in 1968 with an undergraduate degree in psychology. Daryl found himself a training "holdover" because his advanced training class was delayed following basic training. Quickly realizing he would pick up cigarette butts until he shipped to training, he sought a clerical job. Wartime demand for mental hygiene professionals was huge and Daryl was an educated enlisted man, so they gave him a patient load immediately. Describing the experience as "both exciting and petrifying," Daryl Conner became the first Mental Hygiene Specialist at Benning House.

Dr. Segal formed a working group consisting of every command and community agency on post, which produced the "Alcoholism and Related Problems Study" for General Talbott, the installation commander. Talbott approved their recommendations and Benning House opened as the first Army treatment program for alcohol and other drug problems.

Benning House began in World War II-era barracks as a 90 day residential halfway house. With no official Army recognition or budget, this grassroots initiative provided the first opportunity for innovation and experimentation treating substance abuse. This grassroots community effort provided the framework for Army substance abuse treatment. Residents lived in the house but reported for duty each morning. Early treatment methods consisted of group and individual therapy, attendance at A.A. meetings, daily devotionals, and chaplain programs. Innovation was encouraged as they struggled to find therapy that worked. Daryl Conner recalled that everyone's ideas were considered regardless of rank, but added that A.A. provided consistency as they experimented with other ideas.

A group therapy session at Benning House.
From Latham, *The modern volunteer army program*

In December 1970, Senator Harold Hughes held hearings of a special sub-committee to address military drug and alcohol abuse. His staff sought experts from the military services and learned about Benning House, inviting Dr. Segal and Captain Adelman to represent the Army at the hearings. Their testimony eventually lead to legislation requiring treatment for service members with alcohol or drug problems. Financing a grassroots program like Benning House without formal recognition was a challenge. When Senator Hughes asked, "How are you financing the program?" Captain Adelman responded, "We have no funds. It is by hook-or-crook methods, begging or borrowing what-have-you." Fortunately Fort Benning was selected to participate in the Volunteer Army Experiment (VOLAR) in November 1970. Along with other quality of life improvements designed to eliminate the draft, VOLAR approved $35,840 to "establish a drug treatment program." These funds came at a critical point, sustaining Benning House which became part of Martin Army Hospital's base budget the following year. During this time, the program grew from fledgling pilot to an established rehabilitative program commended as a model by Continental Army Command.

Favorable inspections, Senate testimony, concern about addiction in the ranks, and VOLAR combined to put Benning House on the map and it became a frequent stop for congressional delegations and their staffs. Medical conferences, including the first Army Worldwide Drug Abuse Conference (September 1971) provided platforms to tout the success of Benning House. Army leaders developed plans to establish 44 halfway houses, providing $4.5 million toward the project. Plans specified details regarding facilities and staff intended to duplicate Benning House. Local differences emerged suggesting innovation and experimentation. For example, Fort Gordon reported a "spit shine" approach with uniform inspections and military style while Fort Eustis staff and residents wore civilian clothing and used first names.

Late in 1971 Major George Trick replaced Captain Adelman as the Clinical Director. George Trick was a drug addict who had been nearly separated from the Army before overcoming addiction through Synanon. Rod Janzen asserted that the Army considered Synanon as they struggled to solve the Vietnam drug problem. It's unknown if Major Trick was assigned coincidentally or deliberately, but his treatment philosophy focused on "The Game" and "hot seat" sessions with residents participating in Interaction Groups three times per week.

George Trick served as clinical director at the peak of military and congressional interest in Benning House. Under his leadership, Benning House continued its influence as similar halfway houses sprang up and army publications codified "halfway houses" as the Army's preferred rehabilitation method.

As the Army program evolved, Benning House itself began to lose its community-based roots, receiving increased guidance from the program they helped establish. Increased professionalization of the addiction field caused friction among some paraprofessionals who were forced to credential or choose administrative jobs. This conflict led to a major turnover at Benning House in 1976 just as Dr. Sidney Levine became the first psychology PhD to lead Benning House. The program began to shift focus to contemporary approaches and away from remaining synanon influences. Benning House continued peer support and residents responsibility for maintenance and conflict resolution while the post hosted Dr. Vernon Johnson and Father Martin lectures at Fort Benning in 1976.

With budget pressures emphasizing "return on investment," a pilot study compared treatment outcome of Benning House to outpatient services. Results suggested outpatient treatment outcomes were "acceptable" with lower costs and Benning House was closed in late 1980. The Army deliberately defunded Army halfway houses in 1981, with medical facilities rather than "non-clinical" halfway houses to treat substance abuse. The first hospital-based program opened in November 1980 at Fort Bliss, Texas.

Benning House led a halfway-house movement providing the foundation for Army substance abuse programs. Program leaders influenced statutory requirements to help uniformed service members suffering from addiction. In the experimental era preceding professionalization, Benning House helped transform lives and provided the Army with productive soldiers. Residents learned personal responsibility through continued military service while receiving therapeutic help each evening. The program leveraged peer support and provided a safe recovery community. The military community and its leaders supported the program and invested in program success.

The current Army Substance Abuse Program has evolved to meet the needs of the modern Army. Benning House and the halfway houses that followed laid the foundation as the Army version of community based treatment similar to Harold Mulford a decade earlier. William White suggested of Mulford's work, that something may have been lost as we shifted from community toward professionalism. Perhaps there are lessons to learn from the U.S. Army version of "the road not taken."

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What is History?

Sanders Marble, Office of Medical History

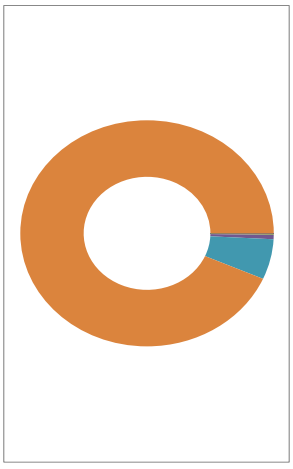
History is the study of part of the past. The past is everything that happened, recorded or not, so historians are only working with part of the past. They also leave things out either inadvertently (because they're human and didn't find something) or deliberately. Leaving things out is not necessarily bad. To keep a story manageable, some details have to be omitted – nobody knows how many bedpans were emptied in WWII, but that doesn't stop writing a history of the AMEDD in WWII. Historians also work with conflicting material, so they have to choose what to believe. For instance, two accounts of the same events may well differ and a researcher will have to evaluate them to see which is more credible. By selecting what information to include other information is left out. None of Tom Brokaw's stories in The Greatest Generation was of a deserter or black marketer; just as some soldiers demonstrated valor above and beyond the call of duty, some demonstrated humanity's less desirable traits.

Historians also deal with gaps. We don't know where George Pickett was during "Pickett's Charge" on 3 July 1863. We don't know why Robert E. Lee ordered that charge. At one level, neither of those gaps matters, because we know the outcome – the Confederates lost that battle – but it's easy to want more details. Gaps don't stop informed speculation, but the percentages of information and speculation will vary, and readers will agree or disagree.

Historians also apply their own interpretations and view the same events in the past differently. George Washington can plausibly be presented as a traitor to his king, a farmer and businessman, a slave owner, a general, and a politician. He did all of those things, and which is most important depends on the point the author is trying to make. No wonder there are multiple biographies of the same people and multiple accounts of the same battle – probably more ink has been spilled about Little Big Horn than blood was shed there. New information also calls for new interpretations. There were lots of WWII generals who wrote memoirs in the 50s and 60s. In 1975, the previously-classified information was revealed that the Allies were reading German signals; all of a sudden claims by generals that they had wonderful intuition were suspect because of new information. New events also cause new interpretations. Were the Barbary Pirates state-sponsored terrorists? It was not a big question before 9/11 but afterwards it was worth exploring if you were looking for how the US had historically responded to terrorism.

But our immediate past is not yet history; not all of the past is ripe for historical analysis. We do not have perspective on what is important on what was not, or as full a set of facts as we should later. A book published in 2004 about the war in Iraq would look different than one published in 2008, or one published in 2020.

So, we don't get to choose the past but we do get to choose the interpretation of it because the interpreter, their priorities, and methods shape the *interpretation* that is history.



This is the rank structure of the Army Nurse Corps in December 1943:

COL: 1 (.003%)
LTC: 22 (.06%)
MAJ: 54 (.15%)
CPT: 222 (.60%)
1LT: 2,056 (6.24%)
2LT: 33,363 (93.42%)

And you were not promoted on seniority, there had to be a vacancy in a TDA/TO&E!

Battling the Unseen Foe, Influenza 1918-1919

Chuck Franson and Paula Ussery, AMEDD Museum

By the time of the First World War, military medicine had made sweeping advances in the prevention of diseases. The Army's approach including inoculation against such killers as typhoid, along with a strong emphasis on sanitation (water treatment, vector control etc.) that resulted in a far healthier military.

With the United States' entry into WWI in April of 1917, the small army of 127,588 regulars was augmented by the 80,000 Guardsmen and thousands of conscripts and volunteers, reaching by war's end over 4,000,000 soldiers. These new soldiers from throughout the US were crowded into 32 large training centers, creating a fertile ground for disease transmission. Trainees suffered outbreaks of measles, scarlet fever, and other diseases, as well as influenza, a fairly common viral infection. Generally these communicable diseases ran their course without major incident. It was inevitable, however, that some soldiers infected with influenza shipped out for Europe and acted as carriers into the war zone. The virus then re-appeared in a virulent strain in the late summer and autumn of 1918.

By spring of 1918, hundreds of thousands of Doughboys were arriving in France each month, going into training and quiet sections of the front. By late spring a few divisions were thrown into battle to stop German offensives. Medical officers saw the usual range of battlefield trauma and routine illness including a little flu. In mid-summer, however, there was widespread and severe influenza – but cases would be short lived and there were almost no fatalities. This was first noticed by physicians such as Captain Alan Chesney of the AEF hospital at Valdehon who witnessed an increase in virulence between June and September of 1918. Alma Larsen, an Army Nurse, was transferred from Base Hospital #66 to Camp Hospital #12 in Valdehon, France because of this increase. The number of admissions of influenza at Camp Hospital #12 was so great that line officers and non-AMEDD enlisted men were assigned duties in the hospital.

By late August, the influenza was making its way to seaports around the world, as sailors and returning soldiers carried the deadly virus. It was a pandemic. This virus was most deadly for those between the ages of 20-40, the prime age for those serving in the armies of the world.

Identification discs and World War I Victory Medal from Alma Larsen

The epidemic reached the port of Boston in late August of 1918, and struck at nearby Camp Devens within days. It spread to the city of Boston almost immediately, beginning a massive epidemic in the US. Medical facilities were overwhelmed. The AMEDD responded quickly. Acting Surgeon General Charles Richard sent his best epidemiologists to Camp Devens to investigate. The team was: Victor Vaughn, from the University of Michigan School of Medicine and director of the Office of Communicable Disease; Dr. William Henry Welch, pathologist from Johns Hopkins; and Dr. Rufus Cole, Director of the Rockefeller Institute for Medical Research. Cole, a leading pulmonologist, received his MD from Johns Hopkins in 1899, and then continued his studies at the Koch Institute in Berlin. In 1909 he was appointed the first director of the Hospital of the Rockefeller Institute for Medical Research in New York City. There he developed a serum for the treatment and prevention of lobar pneumonia. In February, 1918, Cole had been commissioned as a lieutenant colonel in the Medical Corps, inspected the hospital at Ft Sam Houston TX for the Surgeon General in response to increased incidence of pneumonia. He discovered that a streptococcus hemolyticus infection, originating with measles patients, was being spread to influenza patients due to overcrowding in the facility. This

resulted in a severe pneumonia, which caused the patients' lungs to fill with fluids, literally drowning them.

Drs. Cole, Vaughn, and Welch investigated the flu epidemic at Camp Devens, Massachusetts. What they found shocked them. In a 1936 letter, Cole recalled that upon arrival they toured the wards, and observed "…a continuous line of men coming in from the various barracks carrying their blankets, many of the men looking extremely ill, most of them cyanosed [blue complexion] and coughing. There were not enough nurses, and the poor boys were putting themselves to bed on cots, which overflowed out of the wards on [to] the porches." Worse was to come.

After gathering information on some of the cases, and visiting the pathology lab, they made their way to the morgue, where the dead were "… due to the rush and the great number of bodies coming in to the morgue, placed on the floor without any order or system." The team had to step over and around the dead to reach the autopsy room. There, Cole reports "When the chest was opened, and the blue swollen lungs were removed and opened, and Dr. Welch saw the wet foamy surface with little real consolidation, he turned and said 'This must be some new kind of infection or plague,' and he was quite excited and obviously very nervous." Cole and Vaughn were very surprised to see such a reaction from the otherwise imperturbable Dr. Welch.

Olive drab service coat from LTC Rufus Cole

The team made recommendations that included a freeze of troops in or out of the camp, an increase in the square footage allowed per man in quarters and hospitals to alleviate overcrowding, an increase of 20 additional medical officers and 200 additional Army nurses, soldier instruction in proper sanitary measures to eliminate spray-borne diseases, and separation of beds in the wards by hanging curtains.

Despite all attempts to contain it, the pandemic continued to spread through military camps and the civilian population. Army Nursing School student Rhea Hunt served at Camp Grant, Illinois, arriving on September 18, 1918. The influenza arrived at Camp Grant on September 21 and the student nurses were pressed into service, working from 0700 until 1900. Her feet "swelled up something terrible and I couldn't get my shoes on" so she served her shifts in bedroom slippers, with the permission of the Chief Nurse.

Experimental treatments, including transfusions of blood from patients who had recovered from pneumonia offered some promise, but overall 26% of the Army contracted influenza during the pandemic, and lost 8,743,102 days to this horrific event that finally tapered off in 1919. Later research has determined that what actually killed most of the victims of the influenza pandemic of 1918-1919 were the secondary pneumonia infections which attacked the weakened and vulnerable patients.

Influenza patients at Ft Riley.

The Medical Officer's Responsibility, 1898

On 25 April, 1898 the United States declared war on Spain. That afternoon, Surgeon General George Miller Sternberg wrote this letter to his medical officers. As you will see, he focused almost completely on keeping the Army healthy – conserving the fighting strength – rather than on casualty care. That is ironic, because the Spanish -American war is better known for disease (more soldiers died of disease in Army camps in the US than died from fighting or overseas disease) than for efforts to improve casualty care such as deploying X-ray machines and hiring nurses.

Sternberg was writing at a time when medical science was far more limited than today; he certainly had empirical evidence that flies spread disease, but until the Reed-Vaughn-Shakespeare Typhoid Board proved the method of transmission (as a result of the Spanish-American War) he lacked scientific evidence. Sternberg wrote this letter as a circular, something we would now call technical lines of communication since he did not command medical officers in line units.

Surgeon General Sternberg

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Circular No. 1

Surgeon General's Office
Washington, April 25, 1898

In time of war a great responsibility rests upon medical officers of the Army, for the result of a campaign may depend upon the sanitary measures adopted or neglected by commanding generals of armies in the field. The medical officer is responsible for proper recommendations relating to the protection of the health of troops in camp or in garrison, and it is believed that as a rule, medical officers of the United States Army are well informed as to the necessary measures of prophylaxis and the serious results which invariably follow a neglect of these measures especially when unacclimated troops are called upon for service in a tropical or semi-tropical country during the sickly season. In Cuba our armies will have to contend not only with malarial fevers, and the usual camp diseases-typhoid fever, diarrhea and dysentery- but they will be more or less exposed in localities where yellow fever is endemic and under conditions extremely favorable for the development of an epidemic among unacclimated troops. In view of this danger, the attention of medical officers and of all others responsible for the health of our troops in the field, is invited to the recommendations:

When practicable camps should be established on high and well drained ground not having been previously occupied.

Sinks [latrines] should be dug before a camp is occupied, or as soon after as practicable.

The surface of fecal matter should be covered with fresh earth or quicklime or ashes three times a day.

New sinks should be dug and old ones filled when the contents of the old ones are two feet from the surface of the ground.

Every man should be punished who fails to make use of the sinks.

All kitchen refuse should be promptly buried and perfect sanitary police [sanitation] maintained.

Troops should drink only boiled or filtered water, coffee or tea (hot, not cold) except when spring water can be obtained which is pronounced to be wholesome by a medical officer.

Every case of fever should receive prompt attention. If albumin is found in the urine of a patient with fever it should be considered suspicious (of yellow fever) and he should be placed in an isolated tent. The discharge of patients with fever should always be disinfected at once with a solution of carbolic acid (5 per cent) or of chlorid of lime (6 ounces to the gallon of water) or with milk or lime, made from fresh quicklime.

Whenever a case of yellow fever occurs in camp, the troops should be promptly moved to a fresh camping ground located a mile or more form the infected camp.

No doubt typhoid fever, camp diarrhea, and probably yellow fever are frequently communicated to soldiers in camp through the agency of flies, which swarm about fecal matter and filth of all kinds deposited upon the ground or in shallow pits, and directly convey infectious material, attached to their feet or contained in their excreta, to the food which is exposed, while being prepared at the company kitchens or while being served in the mess tent. It is for this reason that a strict sanitary police is so important. Also, because the water supply may be contaminated in the same way, or by the surface drainage.

If it can be avoided, marches should not be made in the hottest part of the day – from 10:00 A.M. to 5:00 P.M.

When called upon for duty at night or early in the morning a cup of hot coffee should be taken. It is unsafe to eat heartily or drink freely when greatly fatigued or overheated.

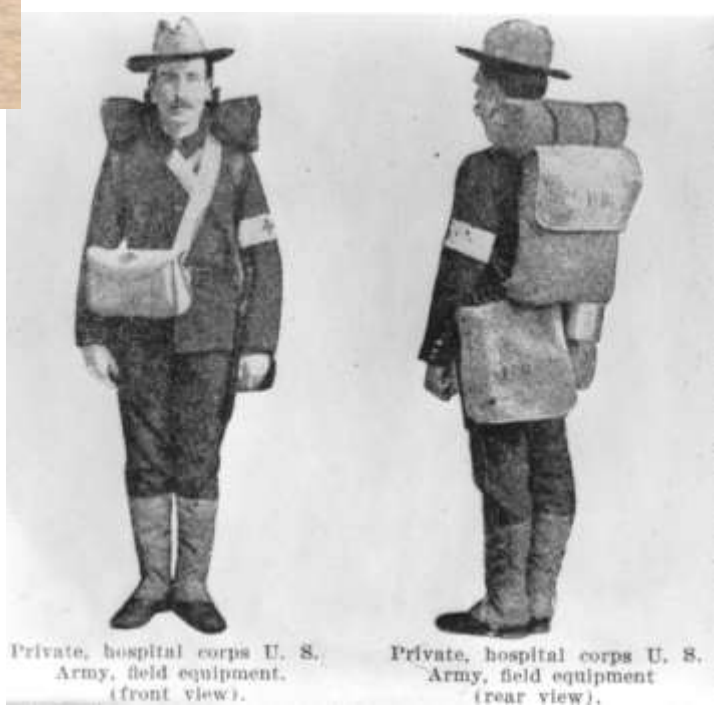
Ripe fruit may be eaten in moderation, but green or overripe fruit will give rise to bowel complaints. Food should be thoroughly cooked and free from fermentation or putrefactive changes.

In decidedly malarious localities from 3 to 5 grains of quinine may be taken in the early morning as a prophylactic, but the taking of quinine as a routine practice should only be recommended under exceptional circumstances.

Light woolen underclothing should be worn and when a soldier's clothing or bedding becomes damp from exposure to rain or heavy dew the first opportunity should be taken to dry it in the sun or by the fires.

Above: The target of this letter - a unit's surgeon, assistant surgeon, and sanitary detachment.

Right: Hospital Corpsman of the Spanish-American War era in field equipment.



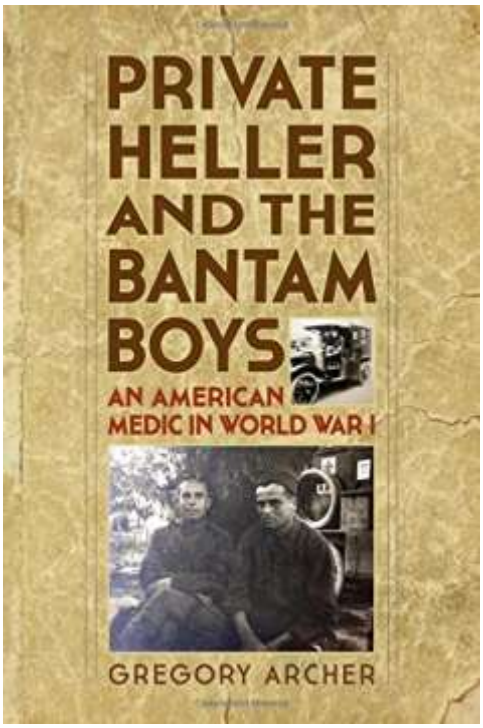
Private, hospital corps U. S. Army, field equipment. (front view).

Private, hospital corps U. S. Army, field equipment (rear view).

Private Heller and the Bantam Boys: An American Medic in World War I

Gregory Archer; Lyons Press, 2015. 320 pages, illustrations.

The German Empire and the Republic of France ground each other's armies to dust for four disastrous years near the Marne River. The tragedy continued. The 1918 German spring offensive entered its tenth vicious day. Retreating from the firestorm was Private Ralph Heller, a volunteer American medical student detailed to the French Army as a medic and ambulance driver. He was twenty-six years old, but looked forty-six. A shell of his once 205 pounds of farm-raised muscle, he struggled to steer his M1917 Ford Model T ambulance. His road was not a road. It was a muddy cow path. German storm troopers continued to machinegun his vehicle. The composite on the ambulance shredded and his "Frenchie" wounded were dying. Seeing no way out, Ralph mumbled a final goodbye to his girlfriend. "Love ya Edyth…"



Private Heller and the Bantam Boys: An American Medic in World War 1—based on Heller's long-hidden diary—tells the tale of a group of privileged yet naïve Princeton University students, the S.S.U 523 Ambulance Corps, and their big, brawny Midwestern farm boy interloper, Ralph Heller. To them, war is a grand adventure not to be missed. They volunteer to make sure they can get to France before the war ends. These college boys go about their training filled with idealism and bravado and, despite constant marching and drilling, absolutely no combat preparation for what they're about to face.

When their transport ship comes under U-boat attack off the Welsh coast, the idea that they could get killed before they reach the front begins to sink in. Once in France, and with a seemingly unlimited supply of red wine (water is for crops and animals), and youthful high spirits, the Bantam Boys are ready for anything. Or so they think.

Devastation touches all, as they enter a hell of mud, rats, poison gas, flying lead, and rotting corpses where they're just as likely in the confusion of No Man's Land to end up heading *toward* the Germans rather than away from them. From the comic to the horrific, *Private Heller and the Bantam Boys* will touch readers of all ages.

The Bantam Boys were one of the most highly decorated units of the United State Army Ambulance Corps. Ralph Heller was a first-rate medic, skilled driver and excellent mechanic. He saved hundreds of lives and won numerous medals. Ralph received two French Croix de Guerres (Cross of War) with Bronze Palms, the American Purple Heart (awarded in 1932), a French Citation for Valor, the Victory Medal with four Battle Claps, and a citation signed by President Woodrow Wilson. He also won a dramatic, color illustrated French combat scroll for bravery.

Unfortunately Ralph suffered PTSD after the war. Perhaps this book will help others to understand PTSD and inspire them to help our war fighters come home. The author, Ralph's grandson and a clinical psychologist, dedicated this book to every Medical Corps man or woman who has ever gone to war to save lives.

The 777th Field Artillery Battalion was one of nine African-American artillery battalions; all served in the European Theater. Here soldiers of the 777th await firing orders in a dugout near Ubach, Germany (just north of Aachen) on 7 January 1945. Their medic is PVT Vreeland Thompson of Newport News, VA.

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 (with a 500 word minimum), which must have sources listed if not footnotes/endnotes

Book reviews and news of books about AMEDD history

Technical requirements:

Photos will need to be at least 96dpi; contact us about file format. Text should be in Microsoft Word (.doc or .docx) format. Please do NOT send text with footnotes/endnotes in .pdf format.

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

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