

Chapter Three

The Vietnam War

POSTWAR DEMOBILIZATION

By the end of 1945, the Army and Navy had demobilized about half their strength, and most of the rest was demobilized in 1946. Millions of men went home, got jobs, took advantage of the new Servicemen's Readjustment Act (commonly known as the "GI Bill," passed in 1944), got married, and started the "baby boom." Just as in the period following victory in World War I, few Americans paid much attention to national defense.

The newly created Department of Defense (formed in the 1947 merger of the War Department and the Navy Department) faced several concurrent tasks: demobilizing the troops; selling off surplus equipment, land, and buildings; and calculating what defense forces the United States actually needed. The government adopted a postwar defense policy of containing communism, centered on supporting the governments of foreign countries struggling against internal communists. In its early stages, containment called for foreign aid (both military and economic) and limited numbers of military advisers. The Army drew down to only a few divisions, mostly serving occupation duty in Germany and Japan, and most at two-thirds strength. So few men were volunteering for the military that, in 1948, Congress restored a peacetime draft. The world began looking like a more dangerous place when the Soviets cut off land access to Berlin and backed a coup in Czechoslovakia that replaced a coalition government with a communist one. Such events, in addition to the campaign led by Senator Joe McCarthy to expose any possible American communists, stoked fears of a worldwide communist movement.

THE KOREAN WAR

Yet it was not until June 1950 that the United States took military action in the Cold War. The invasion of South Korea and the ensuing 3 years of warfare



Figure 3-1. Headquarters sign, 12th Evacuation Hospital, May 1967.

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put the United States and the West on notice that containment needed to be backed up by military force. It took several years to build up the military—partly because so few defense factories were left to equip the available personnel—and in 1952 the Army reactivated the 12th Evacuation Hospital. On January 4, 1952, the unit was renamed the “12th Evacuation Hospital, Semi-mobile,” and a month later the first personnel arrived at Fort Lewis, Washington. There do not appear to have been any plans to send the 12th to Korea, because, by 1952, the front line had stabilized and casualty numbers were low. The unit stayed at Fort Lewis until May 1954, when the 4 officers and 96 enlisted men (less than half of full strength) moved to Fort Hunter Liggett, a large training area in California mid-way between San Francisco and Los Angeles.

The 12th spent the summer at Fort Hunter Liggett training reserve units, and was then permanently relocated to Fort Ord, only a few miles north on Monterey Bay, where it stayed until 1966. The 12th was assigned to the Strategic Army Forces (STRAF), the Army’s strategic reserve. However, the unit never became

ready for action because of constant turnover: STRAF was responsible for training individuals to fill divisions posted abroad, and most soldiers were 2-year draftees or 3-year volunteers. The 12th trained steadily; in summer its members helped reserve units train in the field and the rest of the year most of the men rotated through the post hospital at Fort Ord. In the mid- and late-1950s, the 12th supported two major amphibious training exercises on the California coast, called "Surfboard" and "Rocky Shoals," and also sent men to operate a temporary clinic during atomic bomb testing in Nevada. By 1960 most of the 12th's enlisted roster had been filled, but only a few officers were assigned, and those were administrative officers rather than physicians or nurses.

After the July 1953 truce halted the fighting in Korea, defense spending remained moderate through President Dwight Eisenhower's two terms. Eisenhower was convinced that American economic strength was the foundation of solid national defense, and he was concerned that too much defense spending would damage the economy. To get the most capacity from limited spending, Eisenhower decided that nuclear weapons (plus Air Force bombers and the missiles to deliver them) were the first priority for national defense. The Army would serve as little more than a tripwire for the Air Force's "massive retaliation." Eisenhower also continued the containment policy, helping governments around the world suppress communism.

EARLY US INVOLVEMENT IN SOUTHEAST ASIA

The Eisenhower administration helped fund France's attempt to retain its colonies in Southeast Asia, ultimately providing \$100 million per year. Despite reservations at the highest levels of the US government, aid was continued during the next two administrations, escalating with the addition of advisers and, ultimately, ground troops by President Lyndon Johnson. In late 1966, as the 12th Evac was arriving in Vietnam, Secretary of Defense Robert McNamara worried about a prolonged struggle, and the North Vietnamese understood they could likely outlast the American public. Over time troop morale in Vietnam declined as the American public increasingly came to doubt the war. The men and women of the 12th Evac were part of this national debate during their 4 years in Vietnam; some supported the war, others disliked it, but all of them served in it.

CHANGES IN THE ARMY

Vietnam was not the war the Army expected to fight in the mid-1960s; Army doctrine was written mainly for a war with moving front lines and safe rear areas. In Vietnam the Army had to adapt to guerrilla warfare that relied on raids and ambushes, sweeping through territory but never being sure of holding it, and seeking to win over the loyalty of the local people instead of pushing back an opposing army. Infantry units patrolled and responded to ambushes rather than seizing and

holding ground, and combat support units did not have secure rear areas in which to operate.

Many units also found their roles changing. For the 12th Evacuation Hospital, Semi-mobile, this meant becoming immobile. In a war with no front lines and medical evacuation (MEDEVAC) helicopter ambulances (called "Dustoff" helicopters after the radio call sign given to the first aeromedical helicopter evacuation unit in Vietnam, the 57th Medical Detachment), the hospitals did not need to move, so they gradually built more and more elaborate facilities. Although concrete floors and wooden buildings meant better medical care, they also made quickly packing up and moving impossible, which was a complete reversal of the Army's World War II experience, when hospital equipment was limited for ease in relocation.

Another major change was how units were staffed. In World War II, personnel served for the duration of the war, many of them remaining in one unit for years. In the Vietnam War, the Army rotated individuals overseas for 1-year tours of duty in 2 years of service: draftees trained for about 6 months, served in Vietnam for 12 months, then returned to the states for their remaining time. (Volunteers served 3 years and stood a slight chance of being sent to Vietnam twice.) Thus, although the 12th arrived in Vietnam in 1966 and returned to the United States in 1970, not a single person in the 12th made both moves.

From mid-1967 on, as personnel rotated home, replacements arrived either directly from the states or as transfers from other units in Vietnam (staff were moved among units so no unit had too many inexperienced people at once). This personnel system meant that unit strength fluctuated: in a 3-month period in late 1969 and early 1970, the 12th Evac went from 28% under strength to 20% over strength. Usually there were enough key specialists, except in positions that were important for the static situation in Vietnam but not authorized because the organization structure for mobile warfare was still in effect. But rotation also gave everyone a hard-and-fast end to their time in Vietnam, a psychological target that helped them plan and thus helped sustain morale.

This system also meant that nobody had quite the same experience in Vietnam, even in the same unit, because they arrived and departed at different times, with different colleagues in the unit every few days. Those who were in the hospital years apart could have very different experiences with living conditions and different feelings about the ongoing war. They also returned to the United States individually, not as a unit. The individual rotation policy was a compromise based on experience in World War II and Korea; it had strengths and weaknesses, and in time the Army decided on another way to handle long campaigns, rotating complete units instead of individuals.

Still another change from World War II was that the Army now drafted physicians, dentists, and a small number of male nurses. Male nurses could be drafted as a result of legislation in the 1950s allowing men to serve in the Army Nurse Corps. Some young doctors deferred their 2-year military service until after

completing advanced medical training and became specialists, such as neurosurgeons instead of a general medical officers, or oral surgeons instead of general dentists. Women were not drafted and few nurses were male, so almost all nurses were volunteers. Women could also volunteer to serve as officers or enlisted in the Women's Army Corps (WAC), but no WACs served with the 12th Evac. Nurses were given special service numbers (beginning with "N") to show they were nurses, and male nurses were assigned their own service numbers, with "MN" prefixes.

THE 12TH GOES TO VIETNAM

The major US buildup in Vietnam began in 1965, with roughly 24,000 troops dispatched. American involvement continued expanding through 1966, 1967, and 1968, ultimately peaking at 543,000 troops. The 12th Evac was part of that expansion: in May 1966 it received orders to pack its equipment, ready its staff, and embark to an undisclosed location in the Pacific. Technically the destination was classified, but with the major buildup in Vietnam it must have been an open secret where in the Pacific the 12th was heading.



Figure 3-2. Aerial view of Cu Chi, Vietnam.
Photograph courtesy of Howard Hirsch.

Over the next 6 weeks, the 12th packed its equipment and supplies into containers and gathered its last people. It was authorized 98 officers, 1 warrant officer, and 214 enlisted men, relatively few to run a 400-bed hospital. Many of the enlisted soldiers had been drafted in late 1965 and had time to train in their military and medical duties. In contrast, most of the officers were reservists who had been called up in January and February 1966; however, they needed less preparation time because most already had professional training as nurses, physicians, or dentists.

On August 28, 1966, the 12th departed after a formal parade. An advance party flew to Vietnam, moving up to Cu Chi to start preparing the site. Most of the unit sailed across the Pacific on a large transport ship. Probably the most eventful part of the voyage was crossing the equator, where “traditional ceremonies” were held for those who had never been across the line, including kissing the executive officer’s stomach, which was slathered with cold cream. After a quick stop in the Philippines, the ship docked at Vung Tau, South Vietnam. The main body of the 12th proceeded to the major US supply base at Long Binh and spent about 3 weeks helping establish the 24th Evacuation Hospital there.

By about September 19, all the staff of the 12th Evac had arrived in Cu Chi, the base camp for the 25th Infantry Division. Cu Chi was 30 miles northwest of Saigon and situated along one of the major highways from the Cambodian border to Saigon. Enemy forces were filtering supplies down through Cambodia and then moving them onward for operations around Saigon, putting the Cu Chi base in a busy operational area. The base itself was huge, with perhaps 20,000 Americans. A large enemy tunnel complex with barracks, headquarters, storage, and even underground hospital rooms was later discovered nearby, but had no effect on operations of the 12th.

At Cu Chi, the 12th Evac replaced the 7th Surgical Hospital, a smaller unit with fewer operating tables and ward beds, to support the increasing number of US troops around Saigon. Major operations such as “Cedar Falls” and “Junction City” were in the planning stages, and areas like the “Iron Triangle” would become infamous for repeated battles. Although the 12th Evac was taking over about 20 existing buildings, staff had to construct the remaining 34, with only some limited engineer help in pouring concrete floors. The engineers were too busy to even finish the electrical work. Enlisted men worked in teams to erect the World War II-era Quonset huts—which was heavy manual labor in the tropical climate—and outfit the buildings as a hospital. Beds were moved in and supplies unloaded, again using only manual labor (no forklifts were available to help). Medic Robert Hysko’s team found medicinal alcohol in a pallet they unloaded one day, and a bottle eased their aches and pains that night. Quarters were varied: enlisted soldiers and nurses had barracks-style buildings, while male officers had smaller buildings and more privacy.

The hospital opening was delayed a few days when the wiring of the x-ray machine was overloaded; however, functional facilities left by the 7th Surgical

allowed a few patients to be admitted and surgeons to perform operations ahead of the official opening. Construction work continued for the next few years. Operating rooms (ORs), wards, key storage areas, and other working areas were air conditioned. The 12th was connected into a Cu Chi-wide electrical network, and the hospital's generators were used as backups. Drainage sumps were dug to prevent critical working areas from flooding, and quarters were gradually upgraded. Some of the work improved the quality of life, for instance, carpeting the library. A new laboratory was built and a play area was set up for wounded Vietnamese children.

Lieutenant Colonel Mims Aultman organized an "outdoor recovery unit" because the windows of the normal recovery unit were blocked by air conditioners, and, according to Aultman, patients who stayed several days grew disoriented from lack of daylight. For the outdoor unit, engineers poured a concrete base, rigged a light roof, and put in electric outlets. Bedridden patients could be

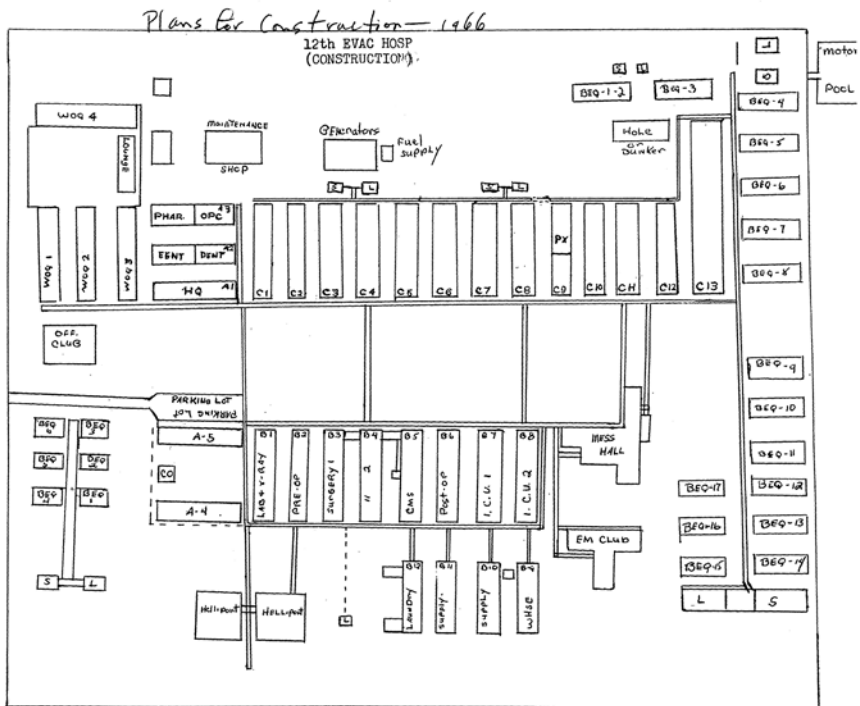


Figure 3-3. Layout of 12th Evacuation Hospital, 1966. Reproduced from: 12th Evacuation Hospital Quarterly Report, 31 October 1966, Army Medical Department Center of History and Heritage, US Army Medical Command, Fort Sam Houston, Texas.

wheeled outside for some fresh air and normal daylight, and Aultman reported the unit was “a big hit.” Only the nurses’ quarters and the commanding officer’s quarters had flush latrines (though a latrine with showers and toilets was completed for C-wing in the final days). One attempted “improvement” was unsuccessful: when volunteers tiled the OR to make it more sanitary and easier to mop, they failed to make the floor smooth, so water remained in cracks, leading to worries about bacteria and wound contamination. By that time, however, the unit was preparing to go home, or they would have had to go back to plain concrete floors. Painting and maintenance were continual processes in Vietnam’s climate, and the Army also had a beautification program for base camps, with whitewashing and tree planting.

Once the hospital was set up and receiving patients, problems arose with supplies. Until 1967, the Defense Supply Agency operated the medical supply chain across the Pacific, but the agency had trouble handling special medical items. In March 1965, for instance, over a quarter of the medical items were out of stock along the Pacific supply chain. Improvements were made in 1966, but the problems were not rectified until 1967. Because the troop buildup in Vietnam proceeded faster than the system could ship equipment, there were shortages of desirable items such as air conditioners. Units scrounged for items, traded favors, and held “midnight requisitions” to get things they wanted but could not get authorized. Sometimes nurses were asked to acquire supplies at parties, as illustrated by the accounts of the following two nurses:

In the early days at Cu Chi, the 12th Evac didn’t always have the supplies and equipment it needed to function properly. Many of the materials had been pilfered or traded away before they ever made it to the hospital. Shortages ranged from blankets and penicillin to an autoclave. The chief nurse in those days, a middle-aged woman named Molly, used common sense and a heap of ingenuity to solve the omnipresent problem of shortages. With thousands of soldiers and only a handful of women at base camp, she knew she possessed a bargaining chip worth its weight in gold. The fact was, the men at Cu Chi and outlying areas would do almost anything to dance with an all-American girl. Molly assessed what she needed for the hospital and nurses’ quarters. Whenever VIPs needed escorting or high-ranking soldiers wanted to hold a party, Molly called upon her nurses to serve the greater good. “Come back with some antibiotics,” she’d mumble to one. To another she’d whisper, “We could really use a refrigerator and some bamboo matting. Don’t come back empty-handed.” It was all in good clean fun, and we got our supplies. When we returned from one party with goods that exceeded her expectations, Molly began referring to the group as “Madam Molly and Her Girls.” She even crafted a stripper’s outfit for me out of three cloth surgical masks, two for the top and one for the bottom, complete with strategically-placed red tassels. I still have it. It’s my favorite piece of memorabilia from that crazy year in Vietnam.

—Lieutenant Beth Parks

Once the chief nurse called us in and said we’d been invited to some general’s party. I got all excited. I thought it sounded good—she told us there would be really good food, plus we’d get to wear civilian clothes, dresses, instead of fatigues. So we get all ready to go and this major comes to pick us up in a helicopter. He has a Styrofoam case with champagne in it. Neat—a champagne flight in a helicopter! So we get to the party. There’s a huge spread of

food and real silverware and real plates. We ate a lot. That was nice after being in the mess hall. But then, afterwards, these generals—and these are big generals I'm talking, commanders of infantry divisions—start trying to put their hands on us. This one guy wanted me to call him Big Daddy. He wanted me to be his girl, sit on his lap and stuff. He was real drunk and gross. Smoking cigarettes and sticking them in his nose and sticking them in his ear. Telling me that whenever he wanted me he'd send a helicopter to come get me. He didn't offer money, but still the whole thing was just sickening, obnoxious. I knew right then I had to get out of there, so I said I had to go to the bathroom and went and found that major and told him to take me back. Well, he says he can't take me back till tomorrow.

Now what am I going to do? So I go outside and walk around the compound. All of a sudden I hear something between the buildings—it scares me. But it turns out to be an enlisted man who worked at the hospital. He seemed OK, was friendly, safe. So finally I told him what was going on, because I'd never been in a situation like this. I didn't know what to do. The guy said, "Well, I have an idea. You can sleep on one of the hospital beds tonight." He took me to the ward where he was on duty and I slept in a hospital bed that night. I was real upset and scared. When I got back to the hospital the next day I told the chief nurse I wasn't going to any more officers' parties, told her I'd rather work. Those guys were just too gross.

—Captain Saralee McGoran

CARING FOR THE WOUNDED FROM AMBULANCE TO WARD

Thousands of men survived the Vietnam War because of the quality of their hospital care. US hospitals in Vietnam were the best that could be deployed, incorporating several improvements from previous field hospitals. Army doctors were better trained, and they had good facilities at the semi-permanent base camps. As a result, more advanced surgical procedures were possible: more laparotomies, thoracotomies, vascular repairs (including even aortic and carotid repairs), advanced neurosurgery for head wounds, and other medical procedures. Blood transfusions were performed, with massive quantities of blood available for seriously wounded patients; some patients received as many as 50 units of blood. Advances in equipment resulted in the development of intensive care units with mechanical ventilators. There were far more medications available for particular diseases than in earlier conflicts.

Although comparing numbers for different time periods is never entirely accurate, only about 2.8% of patients who reached a hospital died in Vietnam, slightly better than the Korean War, and a further improvement over World War II results. The lower death rate is especially impressive because the use of Dustoff evacuation helicopters resulted in more seriously wounded soldiers reaching the hospitals.

With about 30 physicians assigned, the 12th could keep four or five operating tables going all day, and two or three all night. A common practice was delayed primary closure for wounds with a high likelihood of infection. Instead of stitching the wound closed immediately, dirt and contaminants were flushed out, bleeding was controlled, dead flesh was removed (debrided), the wound was packed with sterile gauze, and antibiotics were administered. For a few days the patient healed, while nurses changed the bandages and made sure the wound did

not get worse. Then doctors removed any remaining contaminants or dead flesh and stitched up the wound. This procedure reduced the incidence of infection compared to immediate wound closure at a risk of a larger scar.

Many patients were treated at the 12th, but few statistics survive. In general, most wounds during the Vietnam War were caused by fragments, followed by blast and bullet injuries. Studies found that body armor helped reduce the number of wounds, doing more to stop fragments than to stop bullets. Lower extremity (foot and leg) injuries were more common than upper extremity wounds because of the numbers of mines and booby-traps, and body armor protected the chest more than the abdomen. Obtaining whole blood at Cu Chi was easier than in the United States because soldiers of the 25th Division willingly gave blood to help their buddies.

According to Army doctrine, outpatients should have gone to the 25th Division's medical battalion, but because of a doctor shortage, many were sent instead to the 12th Evac; sometimes general medical officers (GMOs; the Army term for doctors without specialized residency training) were attached to help. GMOs were also extremely useful in triage, allowing experienced surgeons to



Figure 3-4. Interior of the EMT hut, with litter stands and IV rack. Staff were able to work on at least six patients simultaneously.

Photograph courtesy of Howard Hirsch.



Figure 3-5. Staff working on a patient.
Reproduced from: Photo 655418, Record Group 111-SC, National Archives and Records Administration.

remain in the OR instead of having to assist with triage. As a result, however, surgeons were less connected to patients and sometimes never learned their names, although they certainly were involved in postoperative care.

The 12th experienced lulls as well as periods of high intensity, the latter especially during major operations such as the 1968 and 1969 Tet offensives, and the 1970 Cambodian incursion, as well as more attacks on Cu Chi. But unlike during World War II, major operations did not involve the 12th changing location. The surges, especially Tet '68, could temporarily overwhelm the supply system. First Lieutenant Carolyn McLeavey, an OR nurse, had to reuse rubber gloves and sterilize intravenous (IV) tubing. The needle supply was exhausted except for the largest sizes, and pharmacists had to use expired medications from the back shelves when supply convoys could not use the roads to bring in new provisions.

Whether in a major battle or a lull, most patients arrived on the Dustoff medical evacuation helicopters, with a trained medic on board to provide care in flight. At times, ordinary helicopters would be pressed into use, including the large CH-47 "Chinook," which could carry up to 40 wounded at once. Few patients arrived by ground ambulance, although local Vietnamese civilians arrived at the front gate, and injured troops from the Cu Chi base arrived in vehicles. The 12th processed everyone through the standard triage (or emergency medical treatment [EMT]) area, moving them on to ORs, a postoperative ward for observation as they recovered from anesthesia, and then to a postoperative recovery ward. There were separate medical wards for ill patients, a ward for Vietnamese civilians, and another for prisoners. In any given year in Vietnam, about one soldier in three was hospitalized for disease. The main causes for hospitalization were malaria, psychiatric problems, and ordinary fevers. Although many men fell sick, competent care was available and most recovered quickly and returned to duty.

TRIAGE AND THE EMERGENCY MEDICAL TREATMENT AREA

In the EMT everyone was considered equal as a patient, regardless of whether they were civilian or military, American or Vietnamese. Dr Jeriel Beard recalled, "The idea was to have equal care. We didn't neglect the GIs, it's just that if a GI had a few frag wounds that weren't life-threatening or limb-threatening, then—just like anybody else—they could wait."

Many staff helped in the EMT, especially when several casualties arrived at once. Nurses and medics alike shouldered more responsibility than in civilian practice. With the number of serious wounds to treat and the number of minor fragmentation wounds a single weapon could inflict, it was impossible for surgeons to perform all the care. When nurses and enlisted men showed they could handle the work, they were given responsibility. Others helped in various ways; for instance, Lieutenant Colonel Richard Harder (Medical Service Corps), the

executive officer, cut uniforms and boots off the wounded so doctors and nurses could focus on treatment.

Everyone came to Vietnam “trained,” but because draftees served only 2 years, training was limited. Medic Ken Armstrong recalled the emotional force of performing his job for real the first time after training, an effect made even stronger by the smells and sounds of the EMT. Nurse Ann Cunningham was 18 months out of nursing school and had more experience than most of the junior nurses, but her OR experience was with appendectomies rather than major trauma.

Lieutenant Lily (Lee) Adams, a nurse, recalled feeling overwhelmed at first:

I had been assigned to triage for the first three days, recovery for the second three days, and ICU after that. A group of wounded comes in and I just stand there, frozen. What I see is a typical patient: a double amp. No legs, the bones and muscles and everything showing, like a piece of meat in a butcher shop. So I watch. Ten people are doing ten thousand things I can't keep up with—really, they were doing too many things too fast for me to understand. Basically, they were cutting the uniform off, looking to see where the wounds were, making the assessment, getting the IV in, trying to find out if the guy is allergic to penicillin so they can give him a shot right away, and also asking him to give his name, rank, and serial number in case he goes unconscious.

I'm on the other side of the triage room, trying to compose myself so I don't have a shocked look on my face. I'm thinking “This is crazy. They didn't tell me it would be like this.” Then I started thinking “I want my mother. Why did I join? This is a goddamned war zone.” The second batch comes in and I'm feeling awful because I'm not doing anything. I'm frozen. Paralyzed.

The third group comes in. As each group comes more doctors and nurses are going to the OR, to pre-op, to x-ray, and so on. When we're down to about a skeleton staff, one doctor yells, “I need someone to hold this guy's head!” I think, “Hold head . . . Hold head . . . I can do that; I can hold a head.” So I run over and hold the guy's head while they stick a tube down his throat. Finally the doctor says, “Good,” and after that I'm able to get the idea of what needed to be done.

It was overwhelming. I was overwhelmed by the sights, smells, yelling, moaning. . . . It was like a zoo. After I realized I could function, though, I was better.

Staff recall generally good teamwork between experienced personnel and newcomers. Nurse anesthetist Rosemary Sue Smith remembered telling a doctor who had trained at the Mayo Clinic, “You're not at the Mayo Clinic anymore, you're in Vietnam.” She then talked him through what equipment was (and was not) available. Dr Jeriel Beard felt that even surgeons could not really be prepared; medical education simply did not expose students to the massive trauma of war wounds, and even if they had seen such wounds, it would not have been under the pressure of a mass casualty (MASCAL) situation. Lieutenant Colonel Mims Aultman, the commander in 1968–1969, wrote a vivid account of coping with a MASCAL:

The call to the Commander came early one Sunday morning. Heavy fighting had occurred at Dau Tieng, a mountain area north of the hospital. The enemy had waited through Tet '69 without a stir but, several days later, early on this Sunday morning they hit the base camp with everything they had: rockets, mortars, rocket-propelled grenades, AK-47 fire, hand gre-



Figures 3-6 and 3-7. A double-amputee who came in with two shattered legs (above). The large flap of remaining skin shown in image at right is to provide cover for the stump. Photographs courtesy of Howard Hirsch.



nades, satchel charges—all the usual and more rained down on the camp at a former French rubber plantation. The base medical facility was hit, killing a couple of patients and wounding others and some staff. The perimeter had been breached and enemy infiltrated the camp. The defenders exacted a high number of enemy casualties.

There were over 80 wounded GIs. The plan was to start moving them out at first light, so there was no need to alert any of the staff yet. Nurses would be changing their 12-hour shifts at 0700 hours, as staff would be eating breakfast and discussing the day's schedule. Finally, I alerted the Chief of Professional Services (CPS), the Chief Nurse (CN), and the XO. The XO would notify the medical supply personnel, admissions, Red Cross, Chaplain, and the mess hall. I notified the 25th Division Surgeon, the CO of the 25th Medical Battalion, the Dustoff commander, and discussed triage arrangements.

The CPS notified the 1st Call Surgical Team, and perhaps the 2nd and 3rd; the last would just be coming off duty at 0700. The CPS and the CN reviewed the bed situation. Patients scheduled for discharge were moved out. This provided more beds in addition to the "overflow ward," which was readied for operation. Because of the large number of wounded, two Chinook choppers would be used for evacuation. We positioned ambulances at the airfield. As the large choppers landed and opened their doors, we loaded four patients in each ambulance and sent it the short distance to the ER. Our motor pool personnel and soldiers of the support command unit across the street lined up outside the ER to serve as litter-bearers, because they wanted to help and that kept our medics able to do more medical things. As patients were evaluated as to wounds and priority of care, the Chief of Surgery and Chief of Orthopedics signaled litter-bearers to move the patient to x-ray, or holding/pre-op, or even to the OR. On arrival at the ER, patients were given a tetanus booster, marked with a T on their forehead, and an M if morphine was given. Patients had their clothes cut off, and were examined closely all over, turned from side to side to inspect the back for small fragment wounds; if indicated a vein was opened with Ringer's Lactate and whole blood added.

The OR started up and soon was filled. Ophthalmologists and oral surgeons were doing their primary specialty or assisting as needed. An Expectant Unit was opened and staffed for those expected to die. Medical Group HQ was notified and alerted hospitals where ORs and beds were available. Minor wounds were treated at the Med Battalion. Head cases were moved to Long Binh where neurosurgeons were available. Admissions people were busy getting the information for admission. Personal items were placed in labeled paper bags and placed in a safe. Chest tubes were inserted as needed. The enlisted and nursing staff anticipated the doctor's order and had the chest tube cart already in place.

Bilateral leg amputations had pneumatic cuffs attached [to stanch blood loss]. It was also not uncommon to discover a grenade in a patient's pocket; they were carefully taken to a safe holding container outside the Quonset hut. The Chief of Surgery, having just gotten out of the OR, came by checking his list. "Let's see, we've got four closed chests, the double amp[utee], three belly cases, four multiple frags, three genito-urinary and six eye cases. We'll put the double amp in next when Howard gets a look at him. The chests may be all right except one appears shaky. He may have nicked a coronary. I want to check his x-rays. He may have to go in next."

"Medical Regulating wants to know the OR backlog, sir."

"Tell them 20 cases, 15 hours and see if we can move the eye cases to the 24th [Evac in Long Binh]. Can the 159th Dustoff move any patients out?"

"No sir, they're busy in this area but Regulating says they'll get the 45th Dustoff to come up. I'll see what they say on the eye cases. Anything else you want me to tell them, sir?"

By 1300 hours there were 120 patients logged in. Five ORs were going full blast. Some minor procedures were performed in the ER or overflow wards. Some surgical cases were moved to other hospitals. The Air Force Casualty Staging Facility at Tan Son Nhut had sent a representative to make a routine visit and he volunteered to make a larger airplane available to move larger numbers of patients to other hospitals. The OR reported an 18-hour backlog. Over thirty patients were moved by the Air Force. This was helpful because new fighting in several locations was producing more casualties.

The Dustoffs from Long Binh brought whole blood (O-negative or low-titer O-positive) to replace the large amounts being used and to provide the lab a buffer before nightfall. Between cases, surgeons would take off to eat a bite and get some rest. The Mess Hall brought trays of food to the ER and OR. The Red Cross kept the iced Kool-Aid container filled and readily available near the ER. By 0800 the OR closed for awhile for re-stocking and rest. The final tally was 156 patients seen in the ER during the 24-hour period. Only 55 were admitted, nearly all undergoing major surgery. There were record amounts of whole blood used and x-rays taken.

It was the second busiest day recorded by the 12th Evac. In Tet 1968 attacks there were 164 logged in the ER. Still, we didn't care about breaking records. We were proud of the quality of medical care rendered that busy Sunday in Cu Chi.

Surgeon Jeriel Beard commented on the available diagnostic equipment and how it affected the quality of care the surgeons could provide:

We didn't have today's sophisticated machines like CT-scans, MRI, or arteriography. It was mainly just plain x-rays, because the basic question was: has that fragment entered the chest cavity or is it still in subcutaneous tissue? Has that fragment entered the abdominal cavity or not? Is there a fracture or isn't there a fracture? Most of the time we could tell if it was a fracture and we didn't need x-ray to do that. But in some ways, I think that was a benefit to the patients that we didn't have such sophisticated equipment. The tendency of a surgeon is to want to be sure and not operate unnecessarily. If you had a thigh wound, it was obvious that you had to explore that wound and, if there was vascular injury, you would see it when you're there. So if we erred in any respect, it was to operate if there was any doubt at all. If we couldn't tell for sure if the fragment was in or out we operated, and when we operated we

explored everything completely. I think that really resulted in more prompt care and more definitive treatment and you slept better, because you had taken a look and you knew.

Doctors and dentists could postpone their draft service until after advanced training. Ken Bass was a trained oral/maxillofacial surgeon before entering the Army; at the 12th he became the main provider of emergency oral and nasal intubations, as well as handling some minor brain and ophthalmic surgery, such as burr holes through the skull or enucleations. He recounts one day on duty:

I was called to the ER and found a badly injured GI with multiple facial wounds, bleeding profusely from all sites. He needed to be put to sleep before we could work on him, but couldn't lie down since each time the staff tried he'd begin to drown in his own blood. I hadn't done an awake intubation on a patient in a sitting position, but I had no alternative. God was guiding me that day and with a minimum amount of anesthesia, I was able to pass the tube on the first try. We put him to sleep and I began clamping and tying every bleeding point I found. Once he was stabilized (5-6 units of blood) I performed a tracheotomy,



Figures 3-8 through 3-11. These pictures chronicle treatment of a wounded hand of an ARVN soldier. The thumb was preserved by sewing it into functioning blood vessels of the abdomen. Otherwise the thumb would have been amputated because of the extent of damage to the blood vessels in the hand. As the thumb healed, it was cut loose and reattached to the hand. Above: the soldier's left hand, with middle and ring fingers amputated by a blast.

Photographs courtesy of Howard Hirsch.





Top left: right hand of the same soldier. Bottom left: the right hand sewn into an abdominal full-thickness skin flap. Above: results about 3 months after operations.

x-rayed him and began definitive treatment. It was cases like that that made me thankful and appreciative that I was able to be in Nam.

The war spurred advances in surgery and medical trauma research. New surgical techniques allowed limbs that previously would have been amputated to remain functional. Nurse anesthetist Rosemary Sue Smith recalled the development of new blood-handling procedures:

We started separating blood into its components, because we were getting a lot of aggregates that were causing a lot of disseminated intravascular coagulopathy in patients, and causing a lot of blood clots, and pulmonary thrombosis, and a lot of ARDS, Adult Respiratory Distress Syndrome, which started in Da Nang and was called Da Nang Lung initially. It has developed into today being called Adult Respiratory Distress Syndrome, and they did a lot of research on this, and they were having us separate our blood into its components, into fresh frozen plasma and into platelets, and then we started doing blood tests to see which the patients would need. If their platelets were low, or if their blood clotting factors were low, we would just give them the particular products.

We actually started breaking these products down and administering them in the Vietnam War, and it's carried over into civilian life now. They're used today in acute trauma to prevent disseminated intravascular coagulopathy and prevent Adult Respiratory Distress Syndrome on massive traumas that have to be naturally resuscitated with blood and blood products.

CARE ON THE WARDS

The 12th Evac operated a recovery ward for postoperative patients, two intensive care units, and up to thirteen intermediate care wards, depending on how many were needed and how many could be staffed by available personnel. Although an evacuation hospital was equipped with 400 beds and wards were built for all of them, two things usually kept patient numbers far lower: first, the Army's policy was to keep about 40% of hospital beds in Vietnam empty in case of a major offensive or a breakdown in the system for evacuating patients out of Vietnam; second, hospitals were often below strength and could not manage their rated number of beds. They could handle a surge of patients, operating under-staffed and bringing in help from other units, but they could not handle a full load day-in and day-out.

In the 1960s, intensive care was still quite new and the 12th had only one (later two) intensive care wards fully equipped and staffed. A key piece of equipment was the ventilator, then called "respirator." Ventilators worked on pure oxygen until 1969, when research revealed physiological problems from prolonged breathing of pure oxygen. Early ventilators required considerable maintenance; valves needed frequent cleaning or the machines broke down. Senior noncom-



Figure 3-12. Two busloads of litter patients ready to be loaded for evacuation from Vietnam. Photograph courtesy of Howard Hirsch.



Figure 3-13. A nurse talks with a patient at the 12th Evacuation Hospital, 1969. Nurses on the wards saw patients longer than the physicians did, and got to know them better. Reproduced from: Photo 655421, Record Group 111-SC, National Archives and Records Administration.

missioned officers (NCOs) learned how to do quick fixes on the ventilators, and First Lieutenant Carolyn McLeavey, a ward nurse, learned to clean out valves with a cotton swab when she heard them start to whistle.

Antibiotics were important because of the wide variety of bacteria and large number of penetrating wounds; in the face of a possible systemic infection (the development of sepsis), antibiotics were delivered through an IV. Nurse Rosie Parmeter recalled having to prepare antibiotics to be delivered through an IV several times a day for each patient, a necessary but time-consuming task.

On the intermediate care wards, patients still needed regular attention from registered nurses, but the minimal care wards (mainly for minor cases, especially minor diseases) were staffed entirely by enlisted men. All the wards were always busy, but the intensity increased during major combat operations, when the number of patients increased and supplies could run low, forcing improvisation and expedients.

A closer personal connection with patients meant nurses were more affected by their pain. Lieutenant Lily Adams remembered how news from “the world” affected one patient:



Figure 3-14. Captain Ellen Lanzstrum talking with an ARVN patient who lost a leg to a booby trap, mid-June 1967.

Reproduced from: Photo 40504, Record Group 111-SCC, National Archives and Records Administration.

The ICU I ended up in had just been opened. It was half amputations with complications and half severe burns. I was on that ward four months. Four months and I said, “Get me the hell off this ward.” I think the thing that took the cake was a black guy with no legs and a chest wound, who had, I think, pneumonia. He was going to go home in two days, when he went into respiratory distress and died. I called the doctor when he went into cardiac arrest. We did CPR [cardiopulmonary resuscitation] and we worked hard on the guy. [The patient died and, in sorting through his effects, they found a letter.] The guy had gotten a “Dear John” letter that evening—I remembered the Red Cross volunteer giving him a letter. “I’m going to kill her,” I said to Sue. “I am really going to kill her. Goddammit—she should have read the letter first.” Then I just stopped in my tracks and thought, “Right—you’re going to censor letters!” So I realized it wasn’t the Red Cross volunteer’s fault and put my anger onto the girlfriend.

I became very angry at the girls at home who would do such a thing, even if they did not know their boyfriends were in the hospital. When my boyfriend went to Vietnam I wrote him every day of the week. Sure I started growing away from him, started dating other boys, but I never wrote him a “Dear John” letter. Never. My letters started to get less romantic because I didn’t want him to come home thinking I was lying all that time, and of course he knew what was happening. When he came home he said, “I knew it.” But he also said, “You kept

me alive. You saved my life by not writing me a 'Dear John' letter. Even though I knew I was losing you, I was getting your letters, and that kept me alive."

I was really angry at the women back home that they would destroy the guys like that. One day my corpsman came in hysterical. I said, "What's the matter?" He said, "I just got a 'Dear John' letter from my wife, and oh my God, what am I going to do?" So I had guys crying on my shoulder, destroying me with their pain.

CARE FOR THE VIETNAMESE

About two-thirds of patients cared for by the 12th were US military; the other third were mainly Vietnamese but also included nonmilitary Americans and Free World Military Assistance Forces personnel. Staff regularly dealt with the Vietnamese, both military and civilian, enemy and friendly. There were wards set aside for enemy prisoners (who were stabilized, then transferred to hospitals at POW camps) and civilians. Wounded South Vietnamese Army soldiers were also stabilized and transferred to hospitals run by the Army of the Republic of Vietnam (ARVN). Civilian patients often stayed longer because the war swamped the available hospitals for Vietnamese civilians. Some local civilians



Figure 3-15. MEDCAP in Cu Chi town.
Photograph courtesy of Howard Hirsch.

came to the hospital for care of conditions not related to the war.

First Lieutenant Carolyn McLeavey was blunt about her feelings about the prisoners, admitting she “had problems working with POWs.” Her hardest case was a POW and the GI he injured, who were placed in adjacent beds. The GI was young and in critical condition, and McLeavey was torn: “You do what have to do. You don’t have to like it, but you do it.” Nurse anesthetist Larry McBurnett also had a tough situation:

The only time I ever wanted to harm anybody over there was a Viet Cong nurse. She was a hard-core veteran . . . We got some very bad American casualties in, and she was in the recovery room and she leaned up on her bed and pointed and laughed as I came through with one. They kept me off her.

One nurse believed that guards stationed in the postsurgical recovery room were there not to prevent escapes or protect Americans but in case a GI tried to get revenge for a buddy. Nurse Lily Adams was told to nurse a North Vietnamese Army soldier, and she initially refused. Her supervisor got her to reconsider, saying that although “none of us wants to take care of the enemy,” the prisoners had information and by caring for them, the nurses “may end up saving 100 GIs.” She started caring for the patient and soon was treating him like anyone else—squeezing his hand and willing him to survive. When the patient was interrogated by military intelligence, Adams asked some questions through the interpreter, learning that he was 19 years old and did not want to be fighting. There were also disputes between POWs; once a guard had to wrestle a South Vietnamese Army soldier off a Vietcong guerrilla.

When the 12th treated civilians, traditional Vietnamese remedies often clashed with modern medicine, and other problems arose from communication difficulties. Captain Valerie Buchan treated a burned child, who was sent home with medicated cream and sterile bandages. The parents brought him back with clay secured by palm leaves on the burns. She also treated a child for dehydration, setting the IV at the proper rate, only to find when she returned that the mother had opened the valve, thinking that more fluid was better. After staff performed a Cesarean section on a woman whose labor had not progressed, there was a small spate of Cesarean sections as women came in who wanted to avoid labor. Buchan remembered one of them offering her new baby to the chief nurse, who had to decide quickly how to graciously decline. Dr Jeriel Beard recalled three Vietnamese patients. A pregnant woman with a ruptured ectopic pregnancy and internal bleeding became a teaching patient for the OR staff on how to recognize and handle this problem. After treating a second emergency delivery, Beard earned the nickname “Dad.” He recounts the situation:

When I was on second call one night a chopper landed for a few minutes and then flew away. I expected a call from the ER but heard nothing. Out of curiosity I called the ER nurse and asked “What came in on the chopper?” She replied, “Just a pregnant lady with a prolapsed

cord, but the doctor put it back in." Shocked, I ordered, "Get her ready for me to examine and have the OR prepare stat for a C-section."

I ran to the ER where a brief evaluation confirmed my suspicion. The mother was in active labor and much of the umbilical cord was in the vagina. Each uterine contraction compressed the cord between the baby's head and the cervix; that prevented blood flow to the baby. The fetal heart tones were not audible but the cord was still pulsating. I used my gloved right hand to push the baby's head up and relieve the pressure on the cord. This was difficult as we rushed to the OR.

Administering a spinal anesthetic would take too much time. During the rapid induction of a general anesthetic, we splashed Betadine on the abdomen and quickly draped it. So I made the incision, actually nicked the uterus on a skin incision, because I was moving quickly. But we had the baby girl out in about three minutes and she was sedated. I gave her mouth to mouth resuscitation and got her breathing. She pinked up and cried, then we sewed up the uterus and completed the operation. The mother recovered well with no post-operative complications. She was very happy to have a healthy baby.

Beard's third patient underwent open-heart surgery with the benefit of a coronary bypass machine that would have been used in the United States to stop the heart:

I had another child with a small fragment wound in the left flank. The fragment came to rest in the anterior myocardium and Jim Stevenson was great on calling that, because he took different views when that fragment moved. He said, "That's in the heart somewhere." Ken Swan was there from Walter Reed and his job was to take pictures of common cases and develop a slide teaching file for training surgeons in war surgery. He was a fully trained cardiovascular, pulmonary guy and just great. He said, "Yes, you really do have to go." So I went ahead and opened the chest. The fragment was sitting right under the anterior descending coronary artery and vein. They were not injured, but it was right underneath and the problem was to get that out without causing bleeding from the vessels. It was a beating heart, so the idea is to make a horizontal mattress suture, and you put your needle through, into the myocardium, so that it comes out on the other side beneath the coronary vessels. Then you go back through the same way. Then you can reach in, which I did, with a hemostat and extracted the fragment. And then as it starts to bleed, just tie the suture, get the bleeding stopped. The hard part was putting the needle in without piercing the vessels of a beating heart. I hesitated a couple of times, said a prayer, went ahead, and both times went through, didn't injure the vessels. Ken said, "If we don't take that frag out he's going to be out in the rice paddy sometime and it's going to erode the vessels and he's going to exsanguinate." Well, he may not exsanguinate, but he would have bleeding from the coronary vessels. So that was kind of a challenge. The frag had come through the diaphragm and stomach also. We then opened the abdomen, closed the through-and-through wound of the stomach, which was simple, just debrided the kidney and repaired the diaphragm, of course. That kid did real well. That was a great case.

The 12th also treated Vietnamese through the Medical Civic Action Program (MEDCAP), which was intended to win the support of the Vietnamese people by providing healthcare in villages. MEDCAP activities were required for units but were staffed by volunteers who worked during off-duty time. As part of the program, a few personnel from the 12th went into the town of Cu Chi once a week to treat patients (mostly outpatient treatment rather than diagnoses for hospital admission). At first the 12th's MEDCAP volunteers were escorted by

infantry, but the soldiers seemed to draw enemy fire. When the medical personnel went out alone, there was no sniping, leading some Americans to speculate that the Vietcong (or their families) were getting medical attention at the MEDCAPs. MEDCAP personnel treated tuberculosis, a common disease in Vietnam, and also taught prenatal and postnatal care, as well as sanitation and preventive health measures that were routine in developed countries but uncommon in Vietnam. Personnel also administered immunizations when local suspicion of the practice could be overcome.

Captain Garth Holmes thought that health programs were effective: "To relieve the pain from an infected tooth or to clear up a diseased eye on a child or to set a broken leg created a bond of appreciation which could never be measured in dollars or cents." Lieutenant Colonel Richard Harder judged it worthwhile but thought giving Vietnamese "them pills and candy and those sorts of things" was "somewhat superficial," although it did help the population, was useful for public relations, and provided a change of routine for the staff of the 12th. Nurse Ann Cunningham liked that break in routine, going whenever she could. Major Ken Bass, a dentist, participated in a number of Dental Civilian Action Program (DENCAP) missions, mainly doing routine extractions. He even trained a Vietnamese woman to diagnose common problems, give local anesthesia, and extract teeth.

The war left many orphans in Vietnam, both children whose parents were killed by the fighting and Amerasian children abandoned by their American fathers and ostracized by the socially conservative Vietnamese society. Most of these children were placed in orphanages, and wounded orphans were often brought to American hospitals. A young boy, Thach Ri, lost a foot to a landmine and was flown into the 12th Evac for surgery one night. Ken Armstrong worked on Ri's recovery ward and got to know the boy. When Ri had recovered and no longer needed hospitalization, Armstrong tried to find space for him in orphanages, but they were already overwhelmed and did not want another child, especially one with long-term medical problems. The search to find an orphanage for Ri stretched into months, and, although ultimately a place was found, Armstrong decided to adopt the boy. Armstrong worked through immense bureaucratic hurdles, actually being discharged from the Army before securing the adoption, but was eventually able to bring Ri to the United States.

PURPLE HEARTS

Every US soldier wounded in Vietnam received a Purple Heart. It was part of the adjutant's duties to record the wounded soldiers' personal and unit information so they could be properly credited with their medals. Captain Garth Holmes recalled that most of the men were too sick to understand what had happened to them. One soldier, missing a leg, threw the medal back at the commander, saying he wanted his leg back instead.

In World War II, Red Cross workers had been formally assigned to evacuation hospitals, but in Vietnam, even though Red Cross workers were with the 12th at Cu Chi, the table of organization only included military personnel. Lieutenant Colonel Aultman considered these personnel “a valuable part of our team,” especially helpful for writing letters home for the wounded. Aultman was concerned that the Purple Hearts mailed home would arrive without news of the patient’s condition, and the Red Cross volunteered to send the soldier’s letter or take dictation from patients who could not write. Aultman arranged something special for the 20,000th patient:

While it was an honor for the hospital and the staffs over the 2 and a half years of its existence in VN, it wasn’t an honor for patient No. 20,000 in February 1969. Indeed this patient had just been in with chest and abdominal injuries the previous December. He had been evacuated [*sic*] to Japan where he healed and was considered fit for duty and returned to his unit. This 19-year old red-headed, clean-cut young man from West Virginia came in this time with both legs blown off. He quickly recovered from the surgery but would be kept around a few days. I had discussed our thoughts about some recognition with the 25th Division Commander and his staff. They were in favor and even volunteered to buy a watch and have it engraved on the back with “Patient No. 20,000, 12th Evac Hosp RVN.” The Commanding General would present it and pictures be made.

One day shortly after the patient’s admission, my Sergeant Major and I, on my daily “Purple Heart” rounds presented the second Purple Heart to the patient and I told him about his being Patient No. 20,000. I told him that we had planned a recognition of such with the Division Commander being involved, presentation, and all—but that he would determine what would happen, if anything. If he did not want to be recognized, we would still give him the watch but that he did not have to have any ceremony, or I could present it in a low-key ceremony or whatever. He replied that the full ceremony would be all right with him. I told him I did not want a reply right then but in the next day or two when he had time to think about it. On subsequent days he insisted that it was OK with him. We had the ceremony with pictures for the patient and our archives. I still remain in contact with this fine man in West Virginia.

THE DECEASED

Over time, hundreds of the casualties brought to the 12th died. Some had died during evacuation from the battlefield, some were so badly wounded that they were set aside in the triage area as “expectant.” After being cleaned, the bodies were taken to a temporary morgue. The ARVN took care of its casualties, local civilians took care of their dead, and mortuary affairs troops came in a black-painted ambulance to remove the American dead for the trip home. All of the dead left their mark on the people of the 12th who were so busy trying to save lives. Saralee McGoran was suddenly overwhelmed:

One redhead was my breaking point. He was maybe seventeen or eighteen and he was just blasted. The whole bottom half of his body was just blasted to hell. He’d lost part of his penis and scrotum and his two legs. And he’d lost his legs so high that he really will never be able to walk because there was nothing to hook [prostheses] onto. Even the tops of his legs were gone. He was really half a man. So while we were operating on him we were all

sort of looking at each other and crying. The doctors were in tears, too. They were just sort of pleading, “What do we do?” But we weren’t trained to let people die, not mentally, not ethically or emotionally. We couldn’t make that kind of decision. We got guys in like that and even though we could see the damage and the kind of future they were going to have, no one wanted to be the one to make the decision that this guy should die.

We worked furiously on that redheaded guy. We saved him. Even though there was such an enormous amount of blood it was unbelievable—the guy had a million clamps in him. I got through the day OK, but three days later, when he came back for his closure, I walked in and saw this blob on a stretcher. That’s what it looked like to me: a blob with a sheet over it. So I walked over and I looked and it seemed real cold in there all of a sudden. I don’t know why, but it seemed so cold. My body remembers the cold. I picked up the sheet and got a glimpse of his red hair and blue eyes, and I couldn’t look. I had lost it. I screamed and ran out the door. I remember screaming at the top of my lungs—all kinds of obscenities. And I remember being outside and there were helicopters going out on a mission and I was yelling “Kill kill kill!” and all kinds of awful stuff. I just walked around the hospital, screaming and crying. I had lost it, no self-control at all. Couldn’t stop screaming, couldn’t stop crying. Suddenly it dawned on me that the guy was all alone. So I went back to him. But in all honesty I don’t remember a thing after that.

Lily Adams soothed a dying man’s last moments:



Figure 3-16. Perimeter of Cu Chi camp.
Photograph courtesy of Howard Hirsch.

I remember one guy who knew he was dying and kept thinking I was his wife. He was saying, “Mary, Mary—hold my hand!” So I held his hand. “Mary, Mary—I just want to let you know I love you!” At the time I did not know much about dealing with dying people but my instincts told me it would not be right to say, “Hey, you’re dying in muddy fatigues and this is a war zone and I am not your wife.” It was his last time on earth and I did not want to screw up his fantasy, even though I felt guilty that, in a way, I was lying to him. Well, my response was “You’re going to be OK,” meaning either way—you’re going to live or you’re going to die, but you’re going to be OK.

They all died peacefully. I always thought guys in a war zone would die like in an Edgar Allan Poe story. But they always died so peacefully that it gave me a sense of peace.

SECURITY

Life at Cu Chi was a mix of hard work, danger, boredom, discomfort, and the uncertainty of what the war would bring tomorrow. Almost anything could happen any day: an enemy attack, a USO show, a swim in the pool, a drink after duty hours.

Although the 12th was located in the middle of a large American base camp with barbed wire around the perimeter, bunkers, guards, and a reaction force,



Figure 3-17. Officers excavating for a bunker.
Photograph courtesy of Howard Hirsch.

legitimate targets surrounded the hospital and some buildings were hit by fragments. A few patients were wounded again, but there are no records of members of the 12th being killed from enemy action at Cu Chi.

Indirect fire was the main threat, and patients who served in the infantry were more experienced than hospital soldiers at distinguishing between incoming and outgoing fire, as medic Robert Hysko found out. When the EMT was under mortar fire, staff set litters on the floor and worked on their hands and knees to stay below the level of the sandbags. There was no protection in the OR, and operating teams ducked when they heard an explosion. On the wards, patients who could move crawled beneath their beds, where they had better lateral protection from the sandbagged walls as well as the extra protection of the mattress. Nurses and medics put extra mattresses on top of patients who could not be moved.

Attacks on the base perimeter were rare but did happen. Lieutenant Colonel Aultman recalled one enemy raid that started off sounding like nothing more than normal fire nearby. A telephone call from the 25th Division headquarters alerted him to the raid but also brought the reassuring news that patrols were all around the 12th. Aultman checked all occupied buildings, finding everything in



Figure 3-18. Quonset-hut hospital wards at Cu Chi, with sandbag walls against shellfire. Reproduced with permission from: Slide VAS032312, Ivan Dalton Collection, The Vietnam Center and Archive, Texas Tech University.



Figure 3-19. A helicopter gunship firing. “One night an alarm went off that something was trying to penetrate the protective fence and the reaction forces deployed. A group of us climbed up on the water tower above the shower to watch the show. In no time, several gunship helicopters were airborne and began firing thousands of rounds of machine gun fire, laced with tracer bullets. It looked like the 4th of July on a mild summer evening. The battle lasted for twenty or thirty minutes before the all-clear was sounded. We found out the next day that the enemy was the four-legged type when the body count revealed a dozen or so water buffalo had been killed. Of course, the army didn’t know that at the time, it was just another example of the tension everyone had.” —Captain Garth Holmes Photograph courtesy of Howard Hirsch.

order, although one ward nurse refused to take cover until all her patients had their medications. When he got back to his headquarters, Aultman found that the company commander had issued weapons. Aultman knew how little weapons training his medical officers had received and ordered the pistols retrieved and locked up. Several Chinook helicopters were blown up in another raid. The Vietcong either eluded or killed the guards, so the hospital received no patients, but nobody was sure that all the Vietcong soldiers had been accounted for until a daylight sweep.

Saboteurs also slipped into the base. Valerie Buchan had a lingering memory of two incidents:

On two different Sundays we got large numbers of wounded because of incidents on the base. Both times claymore mines exploded, one in the mess hall of an engineer unit and one at the USO Club where a contest of bands was being held. The one in the mess hall had been attached by a wire to one of the mess hall trays. All the soldiers were lined up for the noon

meal. Many died—and many were wounded. I remember a set of twins. One died and one was wounded. The mine at the USO had a wire attached to a doorway and was tripped when someone stepped across the threshold. For a long time I remembered the precautions we took around our area, always on the lookout for wires. When I got back to Ft. Devens, Mass., I stopped dead in my tracks one day as I came up the steps to the BOQ. The wind had blown a string across the steps, but for a few seconds I was back in RVN seeing an unexploded mine.

US military medical personnel were (and still are) allowed to carry weapons, but only to defend themselves and their patients; medical personnel could not guard the perimeter of Cu Chi. Men of the 12th were put on security patrol, but only within the unit. After some “peeping toms” were seen in and around the nurses’ quarters, junior NCOs had rotating guard duty. Two nurses recalled the problems:

There were like 48 females and 25,000 men—we had problems, and we had some severe problems a couple of times. We had a couple of rapes. Two of our nurses were raped. One of them subsequently committed suicide, years later, and the other one, it took her, she says, 30 years to get over it. We did have GIs hiding in our latrines. That was frequent. We were not protected. At the end of my tour we had barriers around us; before then, we were wide open. We always had Peeping Toms. A couple of times you would wake up and there were men in your room. But for the most part all you had to do was scream and for that one guy you’d have 50 come and beat him, take care of him for you.

—First Lieutenant Carolyn McLeavey

We lived in hooches [period slang for a thatched-roof hut] a short walk from the hospital. On two occasions we had intruders. One night I was sitting on my bed reading. I heard a noise at my doorway, looked up and saw a young soldier standing there. I didn’t recognize him. He turned and ran away. One night we heard a scream from the hooch next door. One of the Red Cross staff had awakened to find a young soldier standing next to her bed. That one was caught. As we all jumped up and went into the hallway I met two nurses fully armed, one with a large frying pan and one with a golf club. After that we got a fence and a guard.

—Captain Valerie Buchan

It was also easy for most Americans to get out of Cu Chi. Supply convoys departed regularly, and medic Robert Hysko recalled being checked when he accompanied one: individuals leaving the base had to have a helmet, flak jacket, weapon, and ammunition. Convoys were supposed to stay closed up and not stop. Hysko experienced no ambushes. Driving in Saigon traffic was much less safe, with streets crowded with bicycles, cars, and motor-scooters. It was impossible to tell bicycle or scooter riders who grabbed ahold of a truck for a free ride from those moving alongside to toss a grenade.

Personnel could also get official permission to go into the town of Cu Chi by themselves. Risks in town included enemy action, but other risks were more likely: bad food or water (bars and restaurants had to be approved by food inspectors or they were off limits to Americans); bar fights; or contact with unhealthy locals. Bars sold hard liquor and beer, some imported and some local. Local beer

was different from American beer, stronger, less carbonated, and unpasteurized. Hostesses who might be prostitutes worked in bars. US doctors from a preventive medicine unit inspected known prostitutes, apparently under an agreement with the local Vietnamese government. Infected soldiers were treated by the US staff, while infected prostitutes were referred to the local health system. Nurse Lily Adams, who was Asian-American, was sometimes mistaken for a prostitute when she was off duty and dressed in civilian clothes, even on Cu Chi base. She was angered by things she heard soldiers say that non-Asian staff never heard.

As adjutant, Captain Garth Holmes handled requests to leave the base. He recalled approving a request from the commander's driver to get the jeep washed in town. After the request was repeated several times and the driver began taking some of his buddies along, Holmes became suspicious and investigated. He discovered that in addition to washing the jeep, the soldiers were visiting an anonymous wooden hut with a bar and "bar girls." He had these women undergo venereal inspections as well as the known prostitutes in town.

Environmental health threats in Vietnam were addressed in several ways. Mosquito netting and preventive drugs kept malaria rates low. Dichlorodiphenyltrichloroethane (DDT) was sprayed to reduce the number of insects. Rats were a problem; some of them were large enough to haul off the standard-issue traps. Soldiers kept pets, mainly local dogs but also monkeys. Dogs and monkeys presented a risk of rabies, so there were periodic sweeps to round them up. One soldier wrote home to his mother about losing his pet; she wrote to the president. A White House staffer sent a query to the unit, which caused a prompt response: although the unit commander was concerned with the welfare of each of his soldiers, the animal was not in the best interest of safety for her son or the hospital's patients.

DIVERSIONS

While off duty, staff sought diversions to pass the time and help them feel more normal and closer to home. Not everyone had much time off: nurse anesthetist Rosemary Sue Smith commented that her working hours were long enough that she mainly slept when off duty, or talked with her friends.

Sports were an outlet for handling frustration and stress. A volleyball team was organized that eventually played "away" games at other bases; when the players left the 12th, they received a "varsity letter." Betting was allowed, and nurse anesthetist Ken Hickman recalled winners getting a case of beer each. Hickman also used athletic competitiveness to distract people from the late arrival of steaks for a special dinner: he used a sledgehammer as a faux Scottish hammer, the challenge being the longest toss. The unit also had flag football and softball teams.

There were also evening classes and movies. The USO brought various performers through on tours. Bob Hope, Neil Armstrong, Billy Graham, and a range



Figure 3-20. Spectators watching sports.
Photograph courtesy of Howard Hirsch.

of sports stars visited Cu Chi and the 12th. The retired burlesque performer Gypsy Rose Lee visited patients on a recovery ward.

Clubs were major social centers. The enlisted men's club was run by a sergeant and, despite low prices, did enough business to make a good profit. The money was spent on upgrading club facilities, entertainment, and extra food. The officers' club, the "Crash and Burn," hired off-duty enlisted men to serve drinks, paying them from the profits. There, events such as the procurement of pickled eggs were a novelty and an excuse for a party. Parties meant alcohol, and the Army took a different view about alcohol in the 1960s than it did in later years. As long as individuals were fit for duty, the Army did not try to restrain them from drinking, and personnel knew when they were on call and when they could relax. Drugs were also readily available, especially later in the war, and some members of the 12th used them; Lieutenant Colonel Aultman recalled at least one soldier who overdosed on stolen narcotics and died; deaths were fairly rare even while drug use became more common and many soldiers were treated for use and abuse. Although they used alcohol and drugs, most troops of the 12th obeyed the unwritten rule and stayed fit for duty. Dr Jeriel Beard never saw anyone drunk in the OR, but recalled a radiologist who "had a pretty good



Figure 3-21. Bob Hope and Playboy “bunnies” at Cu Chi, December 25, 1966. *“The USO did a bang-up job in bringing into country some of the biggest named people in sports and show business. On Christmas Day 1966, 40,000 soldiers met in the “Lightning Bowl” to see the Bob Hope show. Since many of the wounded couldn’t stand or sit, they were placed on the ground or in wheelchairs in front of the crowd right in front of the stage. Fortunately, a lot of our medical personnel had to escort them and we never wanted for an excellent seat.”* —Captain Garth Holmes
Photograph courtesy of Howard Hirsch.

alcohol level most of the time,” although he perceived that it did not affect his work. Beard also noticed the smell of marijuana outside officers’ “hootches,” but never saw anyone incapacitated by drugs.

Nurse Susan O’Neill commented on both alcohol and drugs:

Booze was extremely cheap, I mean, ridiculously cheap. You might not be able to find the kind of stitches you want in the operating room, but you could certainly find whatever variation on the theme you wanted for a drink. We drank quite a bit in general. When I was at Phu Bai, I’d come back from a full day and I’d have four doubles of Chivas. I’m a small person and I don’t have a lot of body weight, but it wasn’t really affecting me. That’s what really drew me up; here I am pounding it down, and it’s not making any difference in how I feel. So I started kind of cutting back on that, thinking that this is a very unhealthy thing; I’m turning into an alcoholic over here. I pulled back and I got to the point where I drank at parties. I’d smoke pot if it was available and being passed around, but that stuff was dynamite. You’d be sitting there and smoking and your brain would start to crawl out your ear. It was not good. So I really didn’t do much of that because it made me very depressed. It was not my drug of

choice, booze was. It was just done and I know for a fact that we actually had people operating on folks, doctors who had had a few before they went in. I never saw a competent doctor operate incompetently.

Rest and relaxation (R&R) trips were allowed after individuals had been in Vietnam for a few months. Staff took short R&R trips in Asia and longer trips as far away as Australia or Hawaii. The commander of the 12th was able to send a few personnel at a time on 3-day passes to an R&R center in Vietnam, as long as it did not interfere with patient care. Although units were allowed only a limited number of trips, the 12th was able to take unused slots from other units to send its staff on trips. R&R trips were generally inexpensive; a nice room in a Hong Kong hotel cost only \$8.

Contact with home was another distraction from Cu Chi. Getting news was easier than before; jet aircraft could transport mail far faster than during World War II. There were also radio broadcasts by the military (including Adrian Cronauer, famous for his “Good morning, Vietnam” catch-phrase, on Armed Forces Radio, Saigon) that some dismissed as “what the military wants to tell us.” With smooth-flowing mail service from the States, service members in Vietnam could get current newspapers and magazines, and were aware of public opinion back



Figure 3-22. The pool at an aviation unit at Cu Chi was another place to relax. Photograph courtesy of Howard Hirsch.

home about the Vietnam War, as well as sports and other interests. Nurse Susan O'Neill subscribed to *Time* magazine and the overseas edition of the *New York Times*, which might arrive only 3 days after printing. Unlike in World War II, the media was not censored, and *Stars and Stripes* carried news about the My Lai massacre.

There was another difference between the two wars in how soldiers learned about the war: instead of units mobilizing for the duration, as in World War II, individuals were rotated through units, so someone drafted in 1969 had been exposed to 4 years of news about Vietnam, and might have a very different opinion before entering the Army than someone drafted in 1965. The changes in technology also made more contact between the war zone and the States possible. Audio tapes were mailed back and forth, letting soldiers hear their children talking and bringing the sounds of the war to the home front. Trans-Pacific telephone calls were also possible, although rare; more common was using the Military Affiliate Radio System (MARS). MARS used shortwave radio to broadcast calls from Vietnam to the United States, where a ham radio operator would relay messages via telephone to the family. These calls had to be arranged in advance. The MARS network used proper radio protocols, including "over" and "out." Once Rosie Weston was connected to her mother, who got emotional and cried, never saying "over," which meant there never was a conversation. Rosie Weston also found the uneven news frustrating. Sometimes family in the States heard nothing about a substantial artillery bombardment, and sometimes a reporter made a big story out of a single shell.

LIVING CONDITIONS

Officers and enlisted personnel had different living quarters at Cu Chi. Officers first used quarters left by the 7th Surgical Hospital. Enlisted soldiers lived in tents at first, but the quarters were soon upgraded. Floors made of scrap lumber and pallets were added to the tents, which were then replaced by wooden buildings, first with tent canvas as roofing until corrugated iron became available. Inside the quarters, officers had more private space than enlisted personnel, if not necessarily rooms with doors. Everyone could personalize their quarters a bit, even if just by making shelves for more storage. Lieutenant Beth Parks recalled the nurses subdividing their quarters with bamboo screens and adding some decoration. Buildings had electricity for lights and fans but not air conditioning, and pipes were finally laid late in 1970, just before the 12th left Vietnam. Showers were available thanks to a 500-gallon tank, but water was heated by the sun, so late-night showers were cold. The Army also had a landscaping program, including plantings. A chief nurse had a white picket fence built, which some liked and some thought a nuisance, especially those who tripped over it at night.

Hospital laundry was done by the laundry detachment, but many soldiers hired Vietnamese maids to do their personal laundry. At one point an extra washer/



Figure 3-23. Male officer's quarters, roughly January 1969. *"Our hooch consisted of 6-8 small rooms with bamboo covering on the door and basically thin, grass-lined walls that transmitted all the sound. We had a small bed, a fan, a tiny table, and a small place to hang your clothes, and we put in a light bulb in the closet all year round to keep the humidity down and your uniform dry. We slept there with a flak jacket under the bed, a .45 caliber pistol with a clip in and with nothing in the chamber, and a helmet, because we were frequently attacked at night with rockets and mortars and sometimes small arms fire."* —Thomas J McDonald, MD
Photograph courtesy of Howard Hirsch.

dryer set was ruined by nurses who—in the words of their chief nurse—had lived at home or at nursing school and never had to do their own laundry. When new machines arrived, the chief nurse made them off limits to the nurses and allowed only the maids to use them. The regular laundry initially had problems with waste water, which did not soak into the clay soil but puddled, creating breeding grounds for malaria-carrying mosquitoes. The solution was underground: the water was piped into the Vietcong tunnels under Cu Chi.

As the 12th stayed longer at Cu Chi, more Vietnamese civilians were hired to do various types of work, employed both by the unit (and paid from official funds) and by individuals, who paid from their own pockets. Landscaping help, interpreters, and laundry work fell into the first category, but kitchen workers and cleaners were hired as servants by Americans. Some previously military jobs were civilianized, with hired Vietnamese replacing US enlisted men, although skilled labor was scarce in the largely agrarian country. Some Vietnam-



Figure 3-24. Officers' "hootches" with Vietnamese maid.
Photograph courtesy of Howard Hirsch.

ese worked on the hospital wards, transporting supplies and cleaning. Some short training programs were set up for ARVN personnel and local women; the ARVN were taught sanitation and first aid, and the women learned nursing basics. Civilian contractors, frequently third-country nationals (neither Americans nor Vietnamese) hired by US companies, also worked at the 12th, mainly on maintenance work, but they often lacked the skills to fix machinery such as air conditioners or refrigerators.

THE VIETNAM DRAWDOWN

US strength in Vietnam peaked in 1969 at 543,000, but public support had already begun to wane, and President Richard Nixon began looking for ways to reduce US involvement. Nixon focused on building up the ARVN and tried various measures to buy time for it to increase both its numbers and effectiveness. He increased the bombing of North Vietnam and, in 1970, sent US troops to raid communist supply dumps in Cambodia, gradually withdrawing US troops from Vietnam at the same time. By mid-1970, only about 375,000 US troops remained in Vietnam, with further reductions planned.

As US troop levels fell, the need for American hospitals also declined. On Oc-



Figure 3-25. Vietnamese workers lined up at the security checkpoint to enter Cu Chi base camp. Photograph courtesy of Howard Hirsch.

tober 9, 1970, the 12th learned it was scheduled to close down; the 25th Infantry Division at Cu Chi was leaving, and it made sense to pull the 12th out as well. To inform the troops and reduce the number of rumors circulating, the command held meetings with officers and enlisted men the next day. After some date juggling, a timeline for departure was established. Lieutenant Colonel Richard Harder took command when the physician previously in command broke his wrist and was evacuated. Ordinarily, Army physicians commanded Army hospitals, but as Harder acknowledged, the situation as the unit prepared to depart was largely administrative.

The timeline showed when wards would be closed, when outpatient services would end, and when the entire 12th would close. Processing began immediately: supplies and equipment had to be handed in, with some going to other units. Personnel were heading to different places, but assignments could change. Help from other units was needed but could be delayed for all sorts of reasons. Gradually, the problems were sorted out; other American hospitals got first pick of medical equipment, then the Vietnamese took what they needed. An odd piece of equipment was the piano from the Crash and Burn, which was transported by helicopter to the new unit of an orthopedic surgeon (and pianist) who was staying in Vietnam.

The last patient was admitted on November 8, and all remaining patients were evacuated to other hospitals 2 days later. A formation was held the evening of

November 9 to mark the closing, and personnel left on December 4. Most individuals were transferred to other units in Vietnam and others (with little time remaining in Vietnam) were sent home.

THE 12TH'S VIETNAM LEGACY

Through the years of the Vietnam War, US forces sustained 313,616 wounded in action; at peak strength, there were 26 American hospitals. The 12th Evacuation Hospital was at Cu Chi for 4 years and treated just over 37,000 patients. Records for the 12th are incomplete, but the average died-of-wounds rate in Vietnam was about 2.8% of patients who reached a hospital alive. Applied to the 12th, that rate amounted to about 1,036 patients, including prisoners and Vietnamese as well as Americans. But over 36,000 people survived and could return



Figure 3-26. Original emblem of the 12th Evac. Reproduced with permission from: 1481museum1497, Garth Holmes Collection, The Vietnam Center and Archive, Texas Tech University.

home because of the treatment they received at the 12th Evac. For this dedicated work the 12th was awarded three Meritorious Unit Commendations, the Army's highest commendation for noncombat units. The Vietnamese government also recognized the 12th with three awards, the Cross of Gallantry with Palm (twice) and the Civil Action Honor Medal (while the Cross of Gallantry was awarded to all US units in Vietnam, the Civil Action Honor Medal represented special recognition of the 12th's MEDCAP).

On December 15, 1970, a six-man honor guard brought the 12th Evac's flag



Figure 3-27. Official distinctive unit insignia, approved in April 1969.
Graphic courtesy of the Institute of Heraldry, Department of the Army, Washington, DC.

back to Fort Lewis, Washington. With due ceremony, the 12th Evacuation Hospital (Semi-mobile) was inactivated for the third time as the United States again reduced its military.

Sources

Unit reports are incomplete (covering only 1966 and 1969–1970), but valuable where they exist. A range of oral histories, including that by Laura Calkins of the Texas Technical University (Lubbock, TX) Vietnam Archive, interviewing Susan O’Neill, provides information and quotations, as do written anecdotes from unit veterans. For a list of these, see the appendix. Copies of the *12th Evacuee* (the unit newspaper) and the *25 Lightning* (the 25th Division’s newspaper) have some information. Stories from Lily Adams and Saralee McGoran are in Kathryn Marshall’s *In The Combat Zone: An Oral History of American Women in Vietnam, 1966–1975* (Boston, MA: Little Brown; 1987). Dr Howard Hirsch was generous with his photographs, and the Texas Technical University Vietnam Archive kindly granted permission to use others. A general overview of Army medicine in Vietnam is Spurgeon Neel’s *Medical Support of the U.S. Army in Vietnam, 1965–1970* (Washington, DC: Department of the Army; 1991). Robert Hardaway’s *Care of the Wounded in Vietnam* (Manhattan, KS: Sunflower University Press; 1988) has clinical information. Richard W Stewart, ed, *American Military History, Vol. II: The United States Army in a Global Era, 1917–2003* (Washington, DC: Center of Military History; 2005) provided a general overview of the Vietnam War.

Copies of this material are on file in the historical research collection of the Army Medical Department Center of History and Heritage, Fort Sam Houston, Texas.