



Contents



COL Akeroyd and transfusion 1-2

AMEDD DUI 3-6

The WRAIR Tropical Medicine Course 7

Women's Army Hospital 8-9

Recent AMEDD Museum Donations 10

The AMEDD and the Doolittle Raid 12-13

From the Research Collection 14

From the Museum 15, 16

The Chief's Corner

This past Saturday I attended the state of Texas Vietnam War memorial dedication in Austin. Two of our AMEDD Vietnam War veterans, Colonels (Ret) Otis Evens, MSC, and Gayle O'Rear, ANC helped unveil the memorial. When the narrator relayed their experiences in Vietnam, they truly epitomized the words of "Serving to Heal... Honored to serve!" Before the unveiling, the master of ceremonies introduced Master Sergeant (Ret) Jose Rodela, the most recent recipient of the Medal of Honor from Vietnam, and I realized I was in the company of heroes. All the veterans around me (2000 plus) performed deeds of valor, and shed tears for their lost comrades, so when you meet a Vietnam Veteran, thank them for their service, and especially Welcome them Home! To this end, the AMEDD Center of History & Heritage (ACHH) is partnering with the DOD Vietnam War Commemoration Committee to conduct over the next several years programs on the contributions of AMEDD Soldiers in Vietnam. Following our two successful medical history symposiums (WWI in February 2012, and WWII in March 2014), ACHH is planning a Vietnam War Medical History Symposium in March 2016 in San Antonio, so save the date. If you have scrap books, papers, uniforms, etc. from Vietnam, please consider making a donation to ACHH.

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Colonel Joseph H. Akeroyd: Leader in Army Blood Transfusion

Nolan A. (Andy) Watson, AMEDD Center of History and Heritage

An innovator in Army medicine and a pioneer in the field of hematology, Colonel Joseph H. Akeroyd improved the storage, collection, and distribution of blood and blood components. Col. Akeroyd's research and publications had a direct effect on saving lives.

Joseph H. Akeroyd was born in Morgantown, West Virginia in 1909. He attended the University of Pittsburg from 1928 through 1930. Later he received his Bachelor of Science degree, majoring in organic chemistry from the University of Michigan in 1932. After Michigan, Akeroyd worked as a research chemist in the Department of Medicine at Vanderbilt University from 1932 to 1935. He then proceeded to Ohio State University as a research hematologist in the Department of Medicine, and also furthered his education, obtaining a

Master of Science degree in 1937.

During World War II Akeroyd was called to active duty on May 13, 1943. He served as a clinical laboratory officer and a biochemist. One of his first assignments was with the U.S. Army's Ashburn General Hospital at McKinney, Texas in August of 1943. At that time, First Lieutenant Akeroyd served as Assistant Chief of the Laboratory Section for the hospital. Akeroyd would also serve with the 178th, 197th, and 124th General Hospitals in the European Theater. Serving in Austria with the 124th at the close of hostilities, Akeroyd studied and performed further research at the University of Vienna.



COL Akeroyd performs research within a laboratory while assigned to US Forces in Austria.

From 1947 to 1952 Col. Akeroyd served as a laboratory officer at Brooke General Hospital. During this assignment he began testing the utilization of plastic blood storage bags. His work led to improved transportation and storage as well as blood component separation. Instead of whole blood, plasma or platelets could be managed as needed for patient care.

Following his tour at Brooke General Hospital, Akeroyd became the Chief of Immunohematology at the Walter Reed Army Institute of Research. Continuing his studies and advocacy, Akeroyd reviewed transfusion records for World War II and the Korean War seeking improvement. He strived to eliminate waste, and enhanced distribution of blood components for both military and civilian organizations. Colonel Akeroyd served as the Army representative to the Task Force on Military Blood Collecting from 1957 to 1958. In 1958 Colonel Akeroyd established the Blood Bank Fellowship at the Walter Reed Army Institute of Research. In addition to his support for blood collection and research, Akeroyd discovered President Abraham Lincoln's blood type (Type A) from bloodstains preserved at the Armed Forces Institute of Pathology.

In 1961 Akeroyd returned to Brooke Army Hospital as Chief of the Blood Bank until his unfortunate passing in September of 1963. Among his accolades COL Akeroyd was recognized by the Surgeon General and was awarded the "A" prefix to his military specialty number. Akeroyd was interred at the Fort Sam Houston National Cemetery. Serving in both active and reserve capacities Akeroyd's research, instruction, and publications greatly enhanced Army and civilian medicine in the fields of blood banking and transfusions. Appropriately, the blood donor center at Fort Sam Houston was memorialized in his honor in April 1993.

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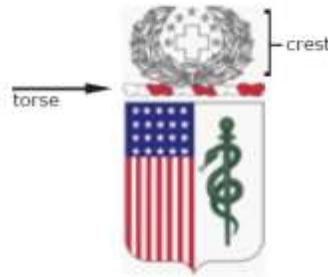
Akeroyd examines early examples of plastic "bag-type" blood storage containers, soon to replace heavier glass bottle containers. Akeroyd's research and publications studying the transportation of blood during World War II and the Korean War were instrumental in bring about the improvement.

This DUI won't send you to jail!

COL Elizabeth Vane, Army Nurse Corps Historian



Coat of Arms
1818



Regimental Coat of Arms
1986



Regimental Distinctive Insignia
1986

Distinctive Unit Insignia (DUI) are metal heraldic devices worn by soldiers to clearly indicate organizational affiliation. While the Unit Crests may change with every assignment, the Regimental Affiliation remains the same.

AMEDD personnel have one choice for Regimental Affiliation and this article will describe the history and heraldry behind the design of the AMEDD Regimental Crest. Actually, the proper term is "Regimental Distinctive Insignia" (RDI) and is covered by AR 670-1.

"Regimental affiliation is based on a soldier's branch as determined by Primary Military Occupational Specialty (PMOS) or specialty" (AR 600-82). "All Combat Service Support officers and enlisted soldiers will be automatically affiliated with their corps or special branch upon graduation from the branch or Military Occupational Specialty (MOS) producing schools, or upon award of a PMOS." (AR 600-82)

Heraldry has been defined as "picture writing with every symbol having definite significance." The most important decorations and missions are shown in the design of the devices. Prior to 1919, distinctive insignia were approved by the War Department before it could be worn as part of the uniform, and today the Institute of Heraldry is responsible for the design, development and authorization of all crests, coats of arms, flags, streamers, and other types of insignia. The Institute of Heraldry is located at Fort Belvoir and can be found online at: (<http://www.tioh.hqda.pentagon.mil>)

Coats-of-Arms were worn by ancient clans to "spur their members to greater military achievement", and to "bolster esprit de corps" and provide a unity of purpose. In the beginning, these designs were embroidered on a coat worn over the armor which gave the name "Coat-of-Arms." Later, designs were added to the knight's shield and the helmet crests. A complete Coat-of-Arms consists of a shield, a torse, a crest, and a motto.

In the Middle Ages men wearing armor needed to be able to recognize "friend" or "foe" in the chaos of battle, and the symbolism was chosen to further intimidate enemies. These symbols need to face the "honorable" position of going from left to right to show they are in a position of advancing forward.

The crest is named after the Latin word “cresta” which is the tuft on the head of many types of birds. A crest is always placed on a wreath of six skeins or twists as a “torse.” The original torse was a piece of cloth knights used to attach their crests to their helmets.

When placed on the flag, the RDI shape is known as a “shield.” The shield can be comprised of two metals and eight colors with a variety of partition lines with additional symbols placed between them. Additionally, all colors and symbols must be clear when reduced in size for other distinctive insignia (not exceeding 1 1/8 inches).

Mottoes are even older than the Coat-of-Arms, and many started out as war cries. Mottoes are chosen as sincere expressions of an idealistic nature. The motto should be shown in a scroll below the shield, but not on the shield itself.

The AMEDD

Since 1775 a Hospital Department had existed to support the Army, but the Act of April 14, 1818 created the Medical Department of the Army as a permanent and continuous Department.

According to McCullough, Ashburn and Caples, the AMEDD Coat of Arms was most likely created in 1818 and follows all of the European heraldry concerning colors and symbols. In 1986 the Army Institute of Heraldry approved a crest for the AMEDD Regiment with some changes to the 1818 design.

The rooster is associated with the ancient Greek and Roman god of healing and medicine, Aesculapius. He was the son of Apollo, and both Apollo and Aesculapius are mentioned in the Hippocratic Oath.

The Ancient Greeks also believed that the rooster’s crowing at dawn drove away the evil disease spreading demons from the temples so that it could be a place of healing. Roosters were also sacrificed so that their entrails could be examined by means of divination and medical diagnoses could be made. Roosters were also sacrificed to show gratefulness to the god Aesculapius for treatments received and many Ancient Greek healers were customarily paid for their services with poultry.

Aesculapius’s staff with a snake is a symbol traditionally associated with medicine as well. Snakes have been symbols attributed as symbols of wisdom, longevity, rejuvenation, ability to cure, and of convalescence. The ability to shed skin reinforced the rejuvenation power that snakes held. The color green was associated with the Army Medical Corps starting in 1847, and so the snake is colored green on the Coat of Arms.

The design of a shield is a historical choice, and shows twenty stars which represented the twenty states in the Union in 1818. The alternating red and white stripes represent the thirteen stripes of the American flag. There was a time where soldiers wore the states they represented on their collars, but today we wear “US” to represent that the AMEDD is part of the entire U.S. Army, and the flag represents this as well.

The torse on the Coat of Arms from 1818 shows alternating blue and silver colors which were the colors of the Army dating back to that time. The torse on the Regimental Coat of Arms approved in 1986 (seen on the Regimental Flag under the crest) shows alternating maroon and white colors as the color maroon was adopted by the AMEDD in 1901 as representing the color of blood.

The crest on the Regimental Coat of Arms (as seen on the Regimental Flag) shows a wreath made of laurel, and a cross below an arc of seven stars.

The Latin motto *Experientia et progressus*, is meant to convey the steady and unfailing progress of the Army Medical Department since 1775. It also has been translated as “Let’s do it better” or “Try and do it better.” The motto “To Conserve Fighting Strength” was first adopted by the Medical Field Service School at Carlisle Barracks, Pennsylvania in 1921, and this motto (in English) was substituted for the Latin motto on the RDI in 1986 as it reflects the medical mission of the AMEDD.

One of the oldest Distinctive Unit Insignia in the U.S. Army is the Coat of Arms of the U.S. Army Medical Department. And it helps us appreciate our ancestry when we remember that the Medical Corps was established in 1775, the Enlisted Corps came into being in 1887 (called the “Hospital Corps”), the Army Nurse Corps was established in 1901, the Dental Corps in 1911 and the Veterinary Corps in 1916. The Medical Service Corps forebears were established in 1917, the Medical Specialist Corps in 1947, and the AMEDD Civilian Corps in 1996. All military members of these corps are able to proudly wear the AMEDD Regimental Distinctive Insignia on their uniform, and the civilians can wear a mini version of the insignia on their lapels.

AMEDD Regimental Flag, with fringes



The WRAIR Tropical Medicine Course

COL Peter Weina, PhD, MD, Deputy Commander Walter Reed Army Institute of Research

The Walter Reed Army Institute of Research (WRAIR) was established in 1893 as the Army Medical School by War Department General Orders No. 51, dated 24 Jan 1893. The school began a Tropical Medicine Course in July 1941 while BG Russell Callendar was Commandant. At that time, the course ran for 30 days with didactic and laboratory sessions similar to today's Walter Reed Tropical Medicine Course (WRTMC). For most of the time WRAIR taught the course it was continuing education to approximately 30 officers.

Over the next 50 years, the original course changed names and length but remained dedicated to teaching continuing tropical medicine education to military officers. For example, in 1954, WRAIR changed the course to the 'Advanced Military Preventive Medicine Course' and in 1966 it changed once again to 'Global Medicine Course'. During the Vietnam War the Global Medicine course was offered on 8 separate occasions and carried on the tradition of teaching tropical medicine for the medical officers. This was a 12-week course that was divided into 4 weeks of Epidemiology and Applied Biostatistics, 3 weeks of Ecology and Disease, and 5 weeks of Tropical Medicine.

In February of 1972, the Global Medicine course was split into a 5 week 'Military Medical Ecology' course and a 6 week 'Tropical Medicine Course' to allow students to focus on necessary areas of study without being gone too long from their units. The first 'modern' Tropical Medicine Course was offered in July and August of 1972 with 15 students. This continued to be offered annually to between 30 and 35 military students, principally physicians and physician assistants. This yearly course endured until 1993 when it was merged with the Navy's tropical medicine course at the Uniformed Services University of the Health Sciences (USUHS) and became the 'Tropical Medicine and Traveler's Health' course leading to eligibility for the American Society of Tropical Medicine and Hygiene Certificate of Knowledge examination.

WRAIR celebrated its 50 year tradition of tropical medicine education during the summer of 1991. In memory of his significant contributions to tropical medicine education, the Institute established "The Colonel George W. Hunter III Certificate," to be presented yearly to no more than two course lecturers who embody excellence and longevity as senior lecturers. The first two recipients of the award were Dr. Jay P. Sanford (former University President and Dean of the Medical School at the USUHS) and Dr. Theodore E. Woodward (Emeritus Professor of Medicine at the University of Maryland, School of Medicine). A special presentation of this award was made to Colonel Richard N. Miller, former Course Director, for his significant contributions to this course and its organization over the previous 12 years. The 50 year celebration was particularly honored to have the commencement address given by none other than Dr. Theodore E. Woodward, who attended the very first course in 1941.

In 2010 operational needs of Special Operations Command (SOCOM) and the newly formed Africa Command (AFRICOM), caused WRAIR to revive the former six-week course. SOCOM had recognized that tropical medicine expertise had noticeably declined since the Vietnam War and wanted something that would adapt to their special needs and operational tempo. AFRICOM recognized that expertise in tropical operations were lacking as evidenced by the outbreak of malaria in Liberia in 2003. WRAIR adapted the old course to a more-frequent (quarterly) targeted short course (5 days) to provide a broader spectrum of individuals, particularly those at the leading edge of operations, what they needed to know to save lives and combat international infectious disease threats. Recently, a mobile form of the course was tried to at least familiarize a broader audience with tropical medicine.

As we find 'tropical medicine' more and more becoming 'world medicine,' this course, and all it has to offer, will remain a necessity for physicians and other medical personnel for many years to come. The future of this educational offering will undoubtedly evolve, as it has in the past, to shape itself to the needs of its audience, but will be firmly rooted in the historic underpinnings of the very first course in 1941.

The Women's Army Hospital

Sanders Marble, Senior Historian, Office of Medical History

On June 1, 1949 the Army started an experiment: how many jobs at a hospital could be filled by women? The background was a severe shortage of soldiers in the post-WWII Army; every woman who could be recruited would release men to fill other positions in the Army. It was the logical outgrowth of efforts in 1945 to train Women's Army Corps (WAC) personnel for various positions in general hospitals, roughly the equivalent of medical centers today. Over 7,000 women were trained, mainly as medical and surgical technicians and medical records clerks. These women were formed into General Hospital Companies, allowing separate administration and discipline since slightly different laws and regulations applied to the WAC.



WWII recruiting poster encouraging women to enlist specifically in WAC hospital companies.

In 1946 so many men were getting out of the Army that women were specifically targeted for recruiting. Through the late 1940s the AMEDD looked at a variety of ways to conserve personnel, including hiring more civilians and even shipping hospitals to war zones without doctors, dentists, nurses and other “professional complement,” who would be mobilized later. With a sharp personnel shortage, the AMEDD and the WAC drew up plans for a thorough test, to last well over a year, expecting that around 85% of a hospital's personnel could be females. Mainly they were testing to determine which MOS could be open to women, at least in CONUS, but they also tested whether civilian positions previously open only to men could also be filled by women. Murphy General Hospital, in Waltham, Massachusetts, was selected for the test.

Department of Defense cutbacks led to the closure of Murphy in April 1950, ahead of schedule, but the ten months had been adequate for a test. The results were encouraging for the WACs: of 301 types of jobs at the post, 247 could be filled by women. Over 400 women were part of the test, including civilian employees. The two main conclusions were: a hospital in a noncombat area could accomplish its mission when primarily staffed by women, and 84.19% of staff could be female. In the hospital itself, 92.84% could be female (the exceptions were for “discipline and treatment of males patients”), but only 60.42% of non-clinical (including garrison) positions could be filled by females. While the Army was recruiting women, it did not view them equally with men: women were considered unfit for “duty at lonely locations,” and women were considered to need more living space, more personal care equipment

(such as sewing and washing machines) and a higher standard of entertainment facilities.

Murphy General Hospital was closed in mid-1950, but with the Army expanding during the Korean War the hospital reopened. (It closed again, permanently, in 1958 and was subsequently demolished.) The Korean War also caused draft calls to increase, and with more men available the Army never had to consider the expedient of using women so widely. By the 1970s the draft was ending, but society had changed and was far more open to what women could do than in 1949. The Women’s Army Corps was ended in 1978 and MOSs that were opened to women re-written to be gender-neutral. The Murphy General Hospital experiment with WACs was interesting, and tells us about the Army at that period, but it was a dead end.



The WAC company at Murphy General Hospital, November 1949, during the test program.

Sources

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“W.A.C. Technicians Needed,” *Bulletin of the U.S. Army Medical Department*, June 1946, 644.

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Guy Denit, “Ward and Mess Attendant Training,” *Medical Bulletin of the European Command*, 6/4 (Apr 1949), 55.

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“Women’s Army Corps at Murphy General Hospital,” *Bulletin of the U.S. Army Medical Department*, 9/7 (July 1949), 577.

“State WAC Trains at Lee; Nine More to Enter Corps,” *Sunday Morning Star* (Wilmington DE), 28 August 1949.

“Army Puts Women in Hospital Jobs,” *New York Times*, 15 April 1951.

Recent AMEDD Museum Donations

Paula Ussery, Museum Specialist, AMEDD Museum

The AMEDD Museum recently received several exciting donations that increase the museum's ability to tell the story of the AMEDD in the Global War on Terrorism.

Among the donations is a group of Multi Camouflage uniforms, the first Multi Camouflage Uniforms donated to the Museum, worn in Afghanistan by LTC Claude Perkins, Medical Corps. Dr. Perkins graduated from the United States Military Academy in 1988 and graduated from Baylor College of Medicine in 1997. A reservist, he served a deployment in Afghanistan in 2012 with the 96th CSH (FWD) and the 966th FST at FOB Salerno and FOB Ghazni. The donation by Perkins also includes his boots, physical training uniform, duffle bag, and a surgical cap – all from his deployment.

Another exciting GWOT donation is an Army Combat Uniform and scrub top worn by CPT Doug Cline, who served in Afghanistan at FOB Salerno with the 349th CSH and the 4/25th ABCT. Cline was the Chief of Laboratory Services as well as the Property Book Officer, Facility Manager, Safety Officer, and Deputy XO. Cline was given the choice of wearing a lab coat or scrubs and elected to wear scrubs. As he put it "The Commander opened it to any scrubs within the confines of the hospital and what better to wear in a combat hospital than MASH 4077?" After the team saved a critically wounded Afghan officer, "The physician in charge of the ER told me it was a lucky charm and I would not be allowed into the ER again without it."



A New Generation of Army Field Hospital

In the late 1950s the AMEDD began looking at improving its deployable hospitals. For generations, canvas tents were the best option, but they did not offer the optimal patient (or staff) environment. Not only would climate control help everyone, but over-pressure would be valuable defense against chemical and biological warfare and nuclear fallout. Purpose-designed modules would also be better lit, and hard-sided shelters (the first ISOs) would provide better OR, laboratory/pharmacy, and central material sections.

Field tested at Fort Sam Houston in 1965, the first unit (the 45th Surgical Hospital) was fielded to Vietnam in 1966. Six other units followed.

MUST proved more comfortable, but the tents collapsed if punctured, and ribs had to be provided to prevent collapses if enemy fire hit, and hard floors had to be provided against wear and tear. The jet turbine engines provided ample electricity and air flow, but were noisy and required much fuel. Once tents were connected to the Utility Pack the whole hospital could inflate in 10-15 minutes.

In the early 1980s the next generation of deployable hospital equipment, Deployable Medical System (DEPMEDS) began testing. It continued using ISOs, but dropped inflatable tents and the turbine engine power packs.

For more, see this DoD film:

<http://www.youtube.com/watch?v=evcI-KcZw5E>



An Army Doctor with the Doolittle Raid on Japan, April 18, 1942

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

In addition to inflicting a severe blow crippling the United States Pacific Fleet at Pearl Harbor on December 7, 1941, the Japanese had hoped the attack would ruin American morale and discourage them from entering into a war in the far western Pacific. Had this happened, Japan would have continued, undeterred, to topple countries obtaining the oil and natural resources needed for their conquest of Southeast Asia and beyond. Fortunately, the attack turned out to have the opposite effect and virtually eradicated the non-interventionist movement within the United States and stiffened American resolve to fight on to ultimate victory.

However, the days that followed that attack added even more gloom to an already dismal situation as the Japanese successfully assaulted American interests in the Philippine Islands and elsewhere inflicting a series of shocking defeats. America badly needed a victory in these dark and uncertain days to help its wounded pride and to raise spirits. President Roosevelt sought a way to retaliate and early in 1942, Navy Captain Francis Low came up with the idea that Army bombers could likely take off from Navy aircraft carriers. Although landing on them was another story, he brought his idea to Navy Admiral Ernest King who in turn consulted with Army Air Force General Henry (Hap) Arnold. Both approved of the idea and General Arnold selected Lieutenant Colonel James H. Doolittle to plan the attack.

The B-25 bomber was selected for the mission and was subjected to heavy modifications to cut weight to allow more fuel and bomb payload. The initial plan called for the planes to bomb Japan and fly on to Vladivostok in the Soviet Union where the aircraft could be given to the Russians. The Russians refused on the grounds they were not at war with Japan and had signed a neutrality pact. Doolittle's subsequent idea was to bomb Japan and continue on to China for refueling. The Navy, for its part, dispatched the carrier *Hornet* to the Pacific but kept its mission a secret, even from its captain, until they were underway with 16 bombers loaded on the flight deck.



B-25s on the *Hornet*'s flight deck en route to Japan.

While keeping the mission a secret, Doolittle solicited volunteers to embark on a highly dangerous mission. Among those chosen for the mission was Army doctor, 1LT Thomas R. White, who volunteered as a gunner so he could be included as there were no positions for medical personnel. During gunnery training 1LT White had the second highest score. Because of weight restrictions, he was only able to bring a small surgical set and very limited medical supplies. During training 1LT White inoculated the crews against many tropical ailments and on the trip across the Pacific gave training on first aid and other medical issues.



1LT White in his flight jacket on the deck of the *Hornet*.

The plan called for the *Hornet* to come within 400 miles of Japan before launching the bombers. This would allow sufficient fuel for the bombing mission and subsequent flight to airfields in China. On 18 April the plan encountered a snag when a small Japanese vessel discovered the force. The ship was sunk by the Americans but not before it had radioed a warning. Doolittle made the decision to launch the aircraft while still 600 miles from Japan. Reaching the Chinese airfields became unlikely.

All sixteen bombers launched successfully and reached their destinations around noon on the 18th. Despite the early warning, the crews encountered very little resistance in reaching and engaging their targets. After dropping their munitions all but one of the bombers turned and headed for China. The remaining bomber, running severely low on fuel, detoured to the closer Russian area of Vladivostok where it landed. The five crew members were detained by the neutral Russians and although

they were well treated, they were not repatriated for over a year.

The remaining 15 planes ran out of fuel before reaching their destinations with four landing in the water and eleven crews parachuting from their aircraft. During these actions, three of the seventy-five men died. The aircraft piloted by LT Ted W. Lawson, ditched in the water off the coast of China. All but one of the crew members were injured with LT Lawson the most serious. Chinese civilians and soldiers harbored the remaining crews, helping them to avoid capture and assisted them with their escape. Recognizing the severity of Lawson's injuries, they moved him and the other injured members of his crew to a medical facility. 1LT White's plane also crash landed at sea. 1LT White assisted others to escape the plane and then returned to retrieve his medical gear, but could only retrieve the surgical kit. When later informed of the injured members of Lawson's crew, he immediately made his way to the medical facility to tend to the injured.

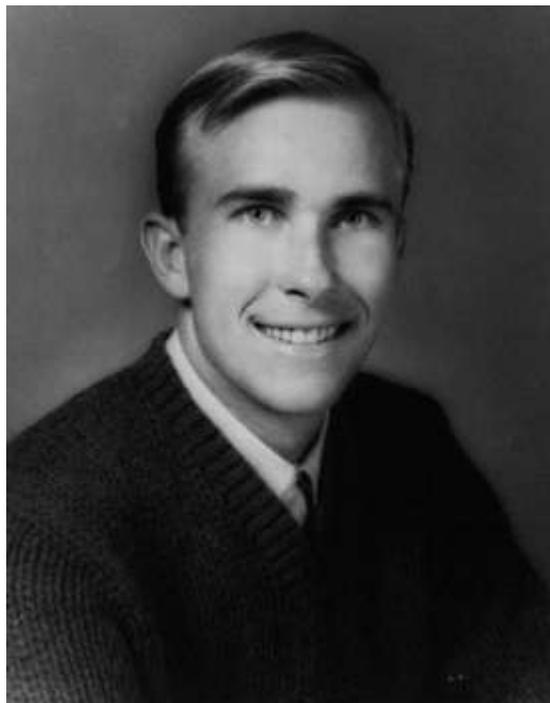
1LT White tried in vain to save LT Lawson's injured leg, but he eventually had to amputate the limb in order to save Lawson's life. 1LT White also provided dental care and eye exams to the Chinese villagers they came across during their movements. He stayed with his patient, moving constantly to stay ahead of the fast-approaching Japanese who were brutally interrogating villagers while searching for the Americans. The Japanese managed to capture 8 crewmen from two aircraft, charged them with war crimes and sentenced them all to death. Of these eight, 3 were executed, one died of illness while imprisoned, and 4 would survive the war in confinement. They were finally freed in August 1945. Meanwhile, on June 3, 1942 White and Lawson would finally be rescued.

Although the raid was not a major military victory, it did restore American morale and dispel the mistaken image of Japanese invincibility. As a result of the raid, LTC Doolittle was promoted to brigadier general and received the Medal of Honor. All of the raiders received the Distinguished Flying Cross for their roles in the raid. LT Ted Lawson would go on to write a best-selling book "Thirty Seconds Over Tokyo" which would be made into a movie. For his part, 1LT Thomas R. White would be awarded a Silver Star for the treatment and subsequent evacuation of LT Lawson and others while being pursued by the Japanese. He would go on to serve in England, North Africa, Sicily and Italy. 1LT White passed away November 1992. A synopsis of his Silver Star can be viewed on the AMEDD Regiment web site http://ameddregiment.amedd.army.mil/silverstar/wwii/wwii_wxyz.html.

From the Historical Research Collection: Medal of Honor Recipient Donald Evans

Carlos Alvarado, Assistant Archivist

As a medical aidman attached to A Co., 2d Bn, 12th Infantry Regiment, Donald Evans trained alongside the men in his unit. They negotiated the terrain of Fort Lewis, WA together, walked, dug foxholes, and walked some more—all in preparation for a tour in Vietnam. He had only been with A Co. for two months when he wrote home to his parents on July 17, 1966 and announced “I have a new name now and I’m finally getting used to it.” Like U.S. Army medics before and after him, Evans lived among the grunts of third platoon, shared their experiences, heard their complaints, treated their injuries, and thus earned both their admiration and respect. “All [infantrymen],” he proudly continued, “call a medic ‘Doc.’”



This is just one rarely seen aspect of Donald Evans’ life that is presented in a series of letters he wrote home between January 1966, while in-processing at Fort Bliss, TX, and January 1967, just a few days prior to his death in Vietnam. The Research Collection of the AMEDD Center of History and Heritage has recently processed this small but unique collection of 12 handwritten letters sent by the Medal of Honor recipient. The letters provide a brief insight into the thoughts and experiences of a young company line medic preparing for and participating in the Vietnam War. If you are interested in researching or would like more information about this collection, please contact the archives staff at usarmy.jbsa.medcom.mbx.hq-medcom-office-of-medical-history@mail.mil or 210-808-3297, DSN 471-3297.

Read Donald Evans’ Medal of Honor citation: <http://ameddregiment.amedd.army.mil/moh/bios/evans.html>

The Chief’s Corner (continued)

This issue of the *AMEDD Historian* is another good one. Our staff of historians and curators has put together interesting articles, but we would like to hear from you. You don’t need to be an historian to write, simply have a passion for our history. If you want to read about more Army Medicine history, follow us on Facebook at: www.facebook.com/medhistory

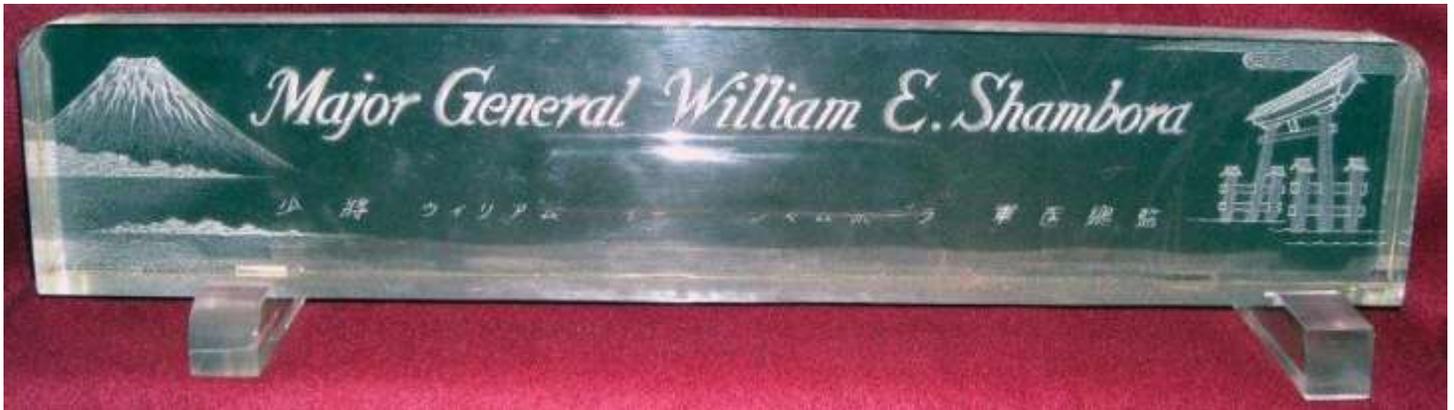
Please keep the comments coming (robert.s.driscoll.civ@mail.mil) on how you like your *AMEDD Historian*, and what we can do to make it better!

Bob Driscoll
Chief, ACHH

More than a Desk Plaque

Paula Ussery, Museum Specialist, AMEDD Museum

One of the more interesting and unusual Korean War artifacts in AMEDD Museum is a desk plaque from Major General William E. Shambora. Made of Lucite with Mount Fuji engraved on the left side and a floating Japanese Torii (gate) on the right, this plaque is from his service as Chief Surgeon, Far East Command. Shambora was assigned to Tokyo on November 1, 1951 and was promoted to major general two months later. As Chief Surgeon, FECOM, Shambora directed the U.S. Army and United Nations medical activities during the Korean War.



Shambora had a significant “command presence.” As Dr. Otto Apel recalled in his memoir MASH: An Army Surgeon in Korea, “Maj. Gen. William E. Shambora, the Far East Command surgeon, arrived from Tokyo unexpectedly. . . . General Shambora was about as high as you could get in the Medical Corps. He was an imposing man physically, short and square like a bulldog, with a bulldog’s scowl on his face. By reputation he was very aggressive, very brusque, very hot-tempered. We were frankly somewhat intimidated.”

Shambora had entered the Army in 1925, after receiving his M.D. from Georgetown University. After completing an internship at Fitzsimons General Hospital, he attended the Army Medical School in Washington D.C. graduating in January 1927. After completing the officers’ course at Medical Field Service School at Carlisle Barracks, he was assigned to Fitzsimons again and then to the Philippines. Returning to Medical Field Service School in 1930 he served as Company Commander and Executive Officer of the First Medical Regiment there. He also served as a Medical Field Service School instructor. Shambora also served at Fort Sam Houston with the Second Medical Regiment during the inter-war years as well as completing Command and General Staff School and the Army War College.

Shambora was assigned as Assistant Surgeon, Army Ground Forces beginning in April 1942. He became Chief Surgeon, Army Ground Forces in December 1942, serving in that capacity until May 1944. With the activation of the Ninth Army, Shambora served as Surgeon as it fought its way across Northwest Europe in 1944 through the German surrender in May 1945.

Shambora continued to use the desk plaque after Korea, during his last assignment as Commander of Brooke Army Medical Center from 1953-1960. He retired on 30 September 1960 and was awarded the Legion of Merit by Surgeon General Leonard D. Heaton. The plaque is currently on display in the Korean War section of the AMEDD Museum.

The security gate at the intersection of Harry Wurzbach and Stanley Road on Fort Sam Houston was designated the Shambora Gate in October 2002.

Plasma and Blood

Chuck Franson, Registrar, AMEDD Museum

The use of blood plasma as a substitute for whole blood and for transfusion purposes was proposed in March 1918. Research led to the first successful plasma mass production techniques. A large project began in August 1940 to collect blood in New York City hospitals for the export of plasma to Britain. Liquid plasma had a rather short shelf life, however, and the glass bottles were too fragile to send to forward areas.

Many wounded soldiers, however, were succumbing to shock, and plasma was vital for the treatment or prevention of this life-threatening condition. The answer came in the form of “dried plasmas” in powder or strip form, which were developed and first used in World War II. Due to the long distances to foreign battlefields, the decision was made to develop a dried plasma package for the armed forces, as it would reduce breakage and make the transportation, packaging, and storage much simpler. The resulting dried plasma was packed in a box with two tin cans each containing 400 cc bottles. One bottle contained enough sterile water to reconstitute the dried plasma contained within the other bottle. An IV administration set was included, so that in about three minutes, the plasma would be ready to use and would stay fresh for around four hours. This enabled forward medics to carry one or two units for immediate administration and for a portable, easily stored supply to be kept at forward aid stations and mobile hospitals.

By the end of the war the American Red Cross had provided enough blood for over six million plasma packages. Most of the surplus plasma was returned to the United States for civilian use. Serum albumin replaced dried plasma for combat use during the Korean War.

The AMEDD Museum has a container of the type the plasma was packaged in on exhibit in our current temporary exhibit “Under the Red Cross”, which presents an overview of medical care in WWII.



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 (initially we will try 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.

Scans should be in Adobe Acrobat (.pdf) format.

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