Medics in 'the Nam'

By James S. Nanney

In the 1960s, Air Force medics dedicated themselves to halting the spread of communism in Southeast Asia.

Twenty years after the fall of Saigon—May 1975—it is appropriate to assess the effect of the Vietnam War on the Air Force Medical Service.

The increased tempo of flying during the war years (officially dated 1961-1973) caused a growth in the number of Air Force flight surgeons, from 550 in 1963 to more than 700 in 1971 (almost 20 percent of Air Force physicians on duty). In Vietnam itself, about 110 Air Force physicians were on duty in the 7th Air Force medical service at the peak of the fighting in 1968.

Specially trained flight surgeons, graduates of the Residency in Aerospace Medicine (known as "RAMs"), were generally the first to deploy and take leadership positions. Besides flight surgeons and other physicians, a full complement of other medics—dentists, nurses, and medical technicians—helped establish a substantial medical presence in Vietnam and Thailand. The strength of the Air Force medical staff in Vietnam averaged 1,350—310 officers, 940 enlisted medics, and 95 civilians.[3 11]

Although an accurate count today is difficult, it appears likely that about 350 Air Force medics were deployed to Thailand, since about 25 percent of Air Force beds in Southeast Asia were in Thailand. In addition, the wartime buildup of Air Force facilities in the Philippines, Guam, Okinawa, and Japan accounted for several hundred medics.

The roughly 1,900 medics supporting Southeast Asia in the summer of 1968 represented about 5 percent of the 41,000 military personnel assigned to the Medical Service worldwide.[3 4 9 13]

Although small in numbers, the Vietnam medics were spirited. Early in the war, most flight surgeons in the Vietnam war volunteered for flying duties, including combat sorties. No restriction was placed on their flying.

Later in the war, although the volunteer policy remained in effect, some commanders limited flying hours for doctors. While this was understandable, several key flight surgeons concluded line commanders should have shared more classified knowledge with their chief flight surgeons, who needed to know about even highly classified missions to provide optimal support of flying operations.

Although many flight surgeons volunteered enthusiastically for civic action programs that treated nearby villagers, only a few of them conducted research or recorded their professional experiences.[2 11]

Poor working conditions may have hindered professional work. In the first deployments, Air Force medics lacked adequate fixed facilities. The Vietnamese and Thai hosts were unable to provide suitable buildings, and the Air Force itself had nothing to deploy.

By mid-1966, however, the Medical Service procured modular steel boxes, 10 by 40 feet, and shipped them over water to Southeast Asia, where they were connected and equipped as medical units. By 1968, the 12th USAF Hospital at Cam Ranh Bay AB was the largest in-country Air Force facility, and the second largest hospital in the Air Force, with 475 operating beds and a 100-bed casualty staging facility. The Cam Ranh Bay airfield was also the main aeromedical evacuation hub for Southeast Asia.[2 3 12 14]

Advances in aeromedical evacuation improved medical care during the Vietnam War.

Rapid evacuation from Vietnam's battlefield by a helicopter and jet transport saved many lives. Helicopters picked up most battle casualties shortly after they were wounded. PACAF operated a scheduled in-country aeromedical service and also a transoceanic jet service to the hospitals at Clark AB, P.I., and Yokota AB and Tachikawa AB, Japan. MAC helped evacuate many casualties out of Vietnam, and handled all patient movement to the States.

Although the Air Force acquired its first specially designed aeromedical jet, the C-9A *Nightingale* in August 1968, C-9s began to fly missions in Southeast Asia only in March 1972. Ordinary transport planes, equipped with

litters, flew most of the war's aeromedical missions.[1 5 6 7 11]

Most aeromedical evacuees were battle casualties from the Army and Navy. As the war progressed, the most common medical problems among Air Force pilots and air crews were standard wartime ailments: upper respiratory and digestive diseases and accidental injuries. Southeast Asia, however, was a more threatening environment than CONUS, Europe, or even Korea.

Vietnam, for instance, contained several hazardous diseases: cholera, malaria, dengue, typhoid, and scrub typhus. Appropriate preventive measures kept these under control. For example, aerial and ground spraying prevented a serious malaria problem on USAF bases, even when it was causing problems for the other Service. In 1967, however, high Air Force incidence rates for infectious hepatitis and venereal disease became items of concern.[2 9 11]

Some pilots, navigators and bombardiers experienced the psychological problems that American fliers had encountered in World War II and Korea—depression or debilitating fear. But most crew members learned to cope.

Starting in 1968, a limited Southeast Asia tour (one year) reduced some of the strain (prior to this it was 100 missions). Many fliers and airmen arranged visits by their families. Such visits were usually "unauthorized" but possible through foreign embassies in the United States. Most "visitors" could live reasonably well in Vietnam or Thailand. Air Force medics felt an obligation to take care of U.S. family members once they were in country.

Although sometimes driven to exhaustion, crew members got

Bien Hoa, Vietnam, 1966: Air Force Capt. (Dr.) Calvin C. Chapman examines a Vietnamese boy during one of his many visits to villages near Bien Hoa AB. While serving as commander of the 34th Tactical Dispensary at Bien Hoa, Chapman treated more than 20,000 Vietnamese men, women, and children in his off-duty hours.

December 1967, Danang, Vietnam: An HH-43 Huskie rescue helicopter from Detachment 7, 38th Aerospace Rescue and Recovery Squadron, stands by with rotors churning as the 500th litter patient of the year is loaded aboard for air evacuation to the Naval Support Agency Hospital at nearby Marble Mountain.

adequate rest and recreational leave, pleasant quarters, and plenty of good food. Unit sports and parties also helped. [11]

Some of the partying, however, was rough and resulted in serious injuries. According to a 1988 after-action medical conference, "Contests in eating egg shells, squeezing drinking glasses until they broke, and squirting people in the face with high pressure hoses or fire extinguishers were favorite pastimes." Flight surgeons understandably kept apart from such events. [11]

Living conditions were generally bearable. The ground fighting in Vietnam was not always guerrilla in nature, but it was unconventional; the lack of a firm defensive line forced most Allied troops to concentrate their living quarters on small, secure bases where the privacy and quiet needed for sleep often were rare.

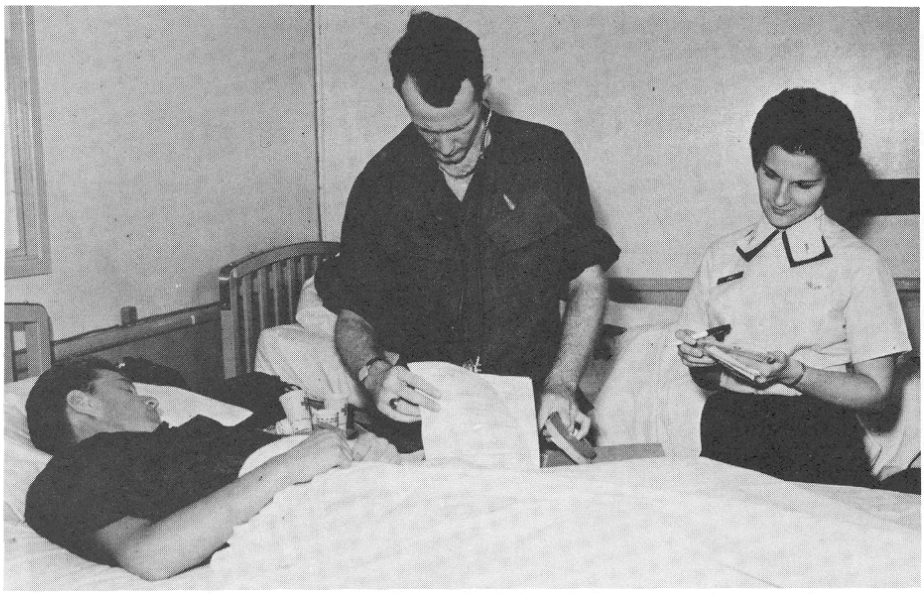
Crews who flew at night and slept during the day usually needed special quarters. All fliers needed air conditioning, and the climate varied enough to make rain gear and warm clothing also a requirement. [11]

Partly because of such preparations, the Air Force weathered the Vietnam War well. From 1961 to 1973, there were about 4,585 Air Force battle casualties, but only 1,125 of these resulted in death.

By contrast, the total American battle death toll in the war was 46,170. Compared with the Korean War experience, Air Force wounds in Southeast Asia were much less likely to result in death. Only 25 percent of the non-fatal Air Force wounds in Vietnam required hospital care.

Health problems did not materially reduce the effectiveness of Air Force troops in Southeast Asia. Although "non-effective" and admission rates for Pacific Air Forces fliers rose during the war, the rates were still below those generated by commands less involved in combat.

The PACAF rate of temporary removal from flying duty, while high for the Air Force, was still below that of several other com-



February 1968, Tan Son Nhut AB, Saigon: First Lt. Francis P. Jones (right) and an unidentified flight surgeon screen patients for suitable evacuees.

mands. PACAF's morbidity rates, however, started to climb as the war dragged on.[8 9 10]

The nature of the Vietnam air war was a main cause of the low Air Force casualty rates.

Except for strong opposition from anti-aircraft missile batteries in North Vietnam, the Air Force enjoyed total air superiority throughout the war. But the high quality of Air Force medicine in Southeast Asia also can be credited with sustaining Air Force effectiveness in America's longest war.

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In Country

The height of the Vietnam War came just after the Tet Offensive in early 1968. The numbers of Air Force medical personnel most certainly rose slightly after Tet, as America responded to the offensive with greater firepower and more troops.

By 1969, however, troop levels had begun to drop and the peak of Air Force Medical Service involvement in Vietnam also began its descent.

Available records, from 7th Air Force archives, provide a monthly "head-count" of medical personnel "in country," from June 1967-May 1968.

A good measure of average AFMS presence in Vietnam can be determined by looking at those figures for February 1968, at the peak of the Tet Offensive:

Corps	Authorized	Assigned
MC	115	112
DC	45	48
VC	10	10
MSC	25	27
NC	141	129
BSC	18	17
Enlisted	977	960
Civilian	100	96
Percentage Manned		97