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Next month we say good-bye to a supporter of the AMEDD Center of History & Heritage (ACHH), LTG Patricia D. Horoho. General Horoho sent me an email in November 2012 asking for ways to leverage history for use in the AMEDD. She said “the AMEDD is charting a new course that will change how health and healthcare is being delivered in the future. I want to ensure that we are capturing this journey.” To that end, we added a historian to the OTSG staff, and deployed two teams of historians to Afghanistan to capture AMEDD operations in war. LTG Horoho recognized our responsibility to capture this history and to ensure our legacy is preserved. We wish her well, and thank her for her support!

In this issue of the *AMEDD Historian* the authors have given you some interesting readings on the AMEDD’s past. LTC (Ret) Bill Emerson, a nationally renowned expert on U.S. Army chevrons, has written a very informative article on medical chevrons that included pictures of some specialty medical chevrons for AMEDD cooks, saddlers, and farriers. October 2 is the birthday of MEDCOM, but how did the medical department get started? We have a review of the latest book by (continued on page 20)...

Medical Chevrons in the Twentieth Century
 LTC (Ret) William K. Emerson



In 1902 the US Army adopted point up chevrons that were approximately three inches wide. This is the same general design used today on non-combat clothing. At the same time medical chevrons changed from green with white trim to maroon with white. The color change came from Captain Fredrick P. Reynolds. Reynolds wrote the Uniform Board, “Green seems to have no place in Medicine and has been the traditional color of Archers and riflemen. The maroon on the other hand is associated, not only with the Medical Corps of our Navy but, is in use by the English, French, and Italian services and several others. It is more effective in combination with blue and I think would make a much handsomer uniform.” Acting Surgeon General William H. Forwood liked Reynolds’ idea and approved it. Less than two weeks, after the Surgeon General indorsed the idea, the Uniform Board approved the color change.

It took many years for the Quartermaster General’s Department to make and stock the new uniforms and insignia; most men did not receive them until 1905. Priority went to units returning from the Philippines. Typical was medical private Richard Johnson who joined the army in

This Hospital Corps sergeant has chevrons used into 1918 when the Army officially omitted most branch devices.

1899 and served over 20 years, who noted it was 1905 before he received his new uniform. Initially the 1902 regulations called for chevrons to be made on material that matched the uniform coats. These were: blue for winter dress uniforms, white for summer dress, olive drab for winter service, and khaki for summer service. Chevrons were also made in the colors for each branch---maroon with white trim for medical soldiers.

Making this large number of chevrons on four different backgrounds and in colors for each branch proved expensive and time consuming so at the end of 1904 the army kept only branch colored chevrons for the dress blue uniform. For all other clothing, chevron designs were made in olive drab. As an economy measure for a few years the army issued some of the 1902-1904 colored chevrons made on OD wool and cotton khaki simply to use up the stocks on hand.

Through World War I, on the white ward uniform men wore chevrons bearing an olive drab embroidered caduceus. Existing stocks allowed medical personnel to wear chevrons on a white background into the early 1920s.

Before World War I, enlisted ranks were very complex and designs constantly changed into World War I. Between the end of 1902 and the end of 1919 the army had eight different medical rank chevron designs as shown here.



Hospital Sergeant,
1916-1918.



Hospital Sergeant,
1918-1920.



Master Hospital Sergeant,
1916-1920



Hospital Steward, 1902-
1903. Sergeant First Class,
Hospital Corps/Medical
Dept., 1903-1920.



Acting Hospital Steward,
1902-03. Sergeant, Hospi-
tal Corps/Medical Dept.,
1903-1920.



Corporal Hospital
Corps/Medical Dept.,
1903-1920.



Lance Acting Hospital
Steward, 1902-03.
Lance Corporal Hospital
Corps/Medical Dept.,
1903-1916.



Private Hospital Corps,
1902-1903. Private First
Class Hospital Corps/
Medical Dept., 1903-1920.



This medical sergeant is wearing a chevron of olive drab on white duck. The army made such chevrons until 1918 but allowed them to be worn into the 1920s. Courtesy National Archives.

Most medical chevrons displayed a caduceus. In June 1916 Congress authorized additional ranks for the Medical Department, some of which other branches had used for many years, such as farrier and saddler. Chevrons worn on service uniforms had chevrons of OD designs and medical men simply used these existing insignia. For the dress blue uniform used before World War I, medical enlisted men had their chevrons in the maroon and white medical colors. Three differed designs are shown below. As the dress blue uniform was on its way out, these examples survive today in the Quartermaster Museum collection at Fort Lee, Virginia.

As in all wars, during WWI unauthorized insignia appeared. One that saw wide use was that for a hospital supply sergeant. Supply sergeants usually wore a horizontal bar below their sergeant chevrons, but many men wore chevrons that included a caduceus.

In 1920 Congress overhauled the enlisted grade structure and created seven different pay grades. In response the army simplified chevrons and designed seven chevrons, a system very similar to that used today. (In 1958 Congress added two additional pay grades to make the current nine.) The Army did not authorize chevrons that would show to which branch a soldier belonged. Eager to make money, various manufacturers made post-1920 chevrons with branch insignia and in some units soldiers wore them. Shown below are two such unauthorized medical chevrons. On the left is one for a staff sergeant while on the right is for a PFC who also was a specialist 6th class.



Medical chevrons for the dress blue uniform, 1916. Left to right cook, saddler, and farrier. The chevrons are approximately 2.75 inches in diameter. Author's collection.



Left: An unofficial but widely worn chevron used by hospital supply sergeants during and immediately after World War I.

Right: Examples of typical unauthorized chevrons worn by medical personnel in the late 1920s and the 1930s. A staff sergeant chevrons is on the left while the right example was for a PFC who also drew extra pay as a specialist 6th class.



The 1920 enlisted grade restructuring provided extra pay for those privates and PFCs who were rated as specialists. These ratings came in six classes, ranging from the lowest, a specialist sixth class, up to a specialist first class. Corporals and above were not able to receive this extra specialist pay. Specialist positions were budget driven and for the combat

arms frequently varied by year. For the technical branches there were seldom changes in the number of specialists authorized. In 1928, for example, the entire Medical Department was authorized only 34 specialists first class, 378 specialists 4th class, and 1,529 specialists 6th class soldiers. This number remained unchanged for medical personnel into early 1939.

The army continually fought a losing battle against the unauthorized specialist chevrons. Soldiers liked them and local commanders often let men wear them to maintain high morale. Insignia makers, on their own, devised a simple but effective and popular set of PFC chevrons. Specialists added one through six arcs below a standard PFC chevron, often with a specialty mark in the center open area. At right is a chevron that one of the few medical specialists first class might have worn in the 1930s. The specialist system, and its unofficial chevrons, was replaced in 1942 by technicians and chevrons that carried a T. This continued through World War II.

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Richard Johnson papers, Military History Research Collection

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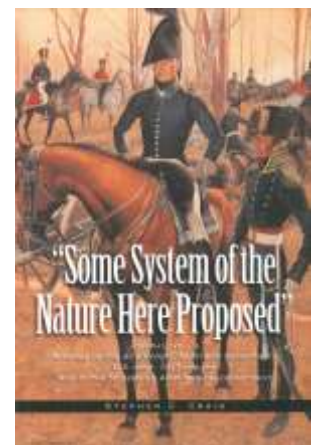


A PFC specialist chevron for a specialist 1st class.

Stephen C. Craig, "Some System of the Nature Here Proposed": Joseph Lovell's Remarks on the Sick Report, Northern Department, U.S. Army, 1817, and the Rise of the Modern US Army Medical Department. Fort Sam Houston, Texas: Borden Institute, US Army Medical Department Center and School, 2015.

How did the Army Medical Department get started? is the question of Stephen Craig's short (139 page) book. Certainly the Continental Congress authorized "an hospital" on 27 July 1775, but there was no permanency or detail, and problems sprang up. Regimental surgeons were separate from hospitals and the Apothecary General was separate again. The Continental Congress tried adding Medical Directors for various geographic areas, but much effort was spent trying to determine who had authority over whom. Individual doctors did what they could but patients – and the Army as a whole – suffered.

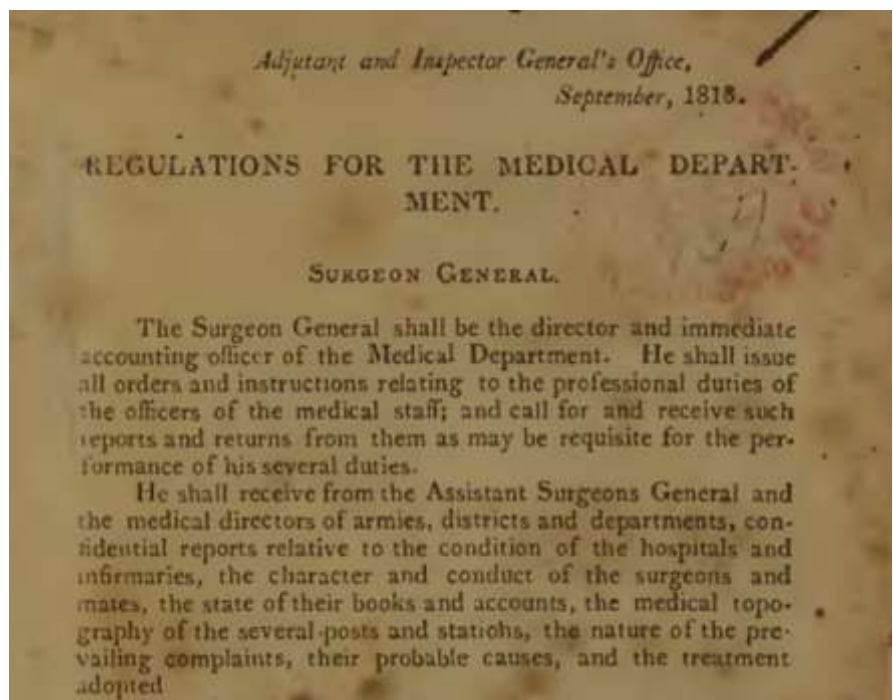
After the Revolution, the problems persisted but in smaller form as the Army shrank. There were certainly indicators on what an army needed from its doctors – military surgery was a known specialty since bullet wounds were rare in civilian life,



while sanitation was a known help to the military even if reasons behind it were unknown. (Baron von Steuben had a section on ‘necessary regulations for preserving order and cleanliness in the camp’ in his *Regulations for the Order and Discipline of the Troops of the United States*.) Yet the Army had no organized medical support. Young Joseph Lovell joined the Army in 1812 and had regimental service, then commanded a hospital (including leaving it to go on campaign), of course interacting with the medical supply system. His hospital was the main one supporting the Army on the Lake Champlain sector, which made him well known to the most influential officer in the Army, MG Joseph Brown, who commanded the theater. Lovell stayed in the Army after the War of 1812 and in 1817 wrote a close-out report on medical affairs that described how doctors should support line commanders at the tactical, operational, and strategic levels.

In 1818 Secretary of War John C. Calhoun overhauled Army administration and created, among other things, a Surgeon General. MG Brown now had the title “senior officer of the United States Army” and readily brought the thoughtful medical adviser to Washington City (as it was called at the time) as Surgeon General. Lovell immediately took charge; he wrote regulations and policies, with the backing of Commanding General Brown (his new title from 1821) and the Secretary of War against both doctors and line officers who had become accustomed to operating as they saw fit. Lovell assigned doctors where they were most needed, kept soldiers as healthy as could be, supported research, directed his doctors to gather data that might be useful, raised the quality of doctors in the AMEDD, and even saved money. Lovell’s doctors went beyond treating patients, advising commanders on keeping them healthy. Lovell provided the Army a responsive medical system; his ideal was medical officers rather than doctors in uniform, an interesting theme of military and medical professionalism that Craig runs throughout the book. He also wanted them respected as medical officers, with full military rank rather than courtesy rank as auxiliaries, something that would not happen in his lifetime but his successor would achieve in 1847. Craig rounds out the story with Lovell’s years as Surgeon General (1818-1836) and brief summaries of major periods of AMEDD evolution until 1902, when scientific medicine had replaced the empirical version that had lasted since the Greeks.

Looking at the earliest period of the AMEDD allows us to think about why a permanent AMEDD was established. This clearly-written book penetrates the writing style and different terminology of the early 19th Century to show how it is relevant to the AMEDD of today and tomorrow.



The opening of Lovell’s Regulations for the Medical Department. The entire regulation, including blank forms for reproduction, was only 31 pages long.

The Hospital Steward of the American Civil War: Pharmacist, Hospital Administrator, or Nurse?

William T. Campbell, Ed.D., RN, Salisbury University

Part II

In an attempt to gain insight into the roles and responsibilities of the Hospital Steward this researcher has been able to locate seven first person or primary sources by and about Hospital Stewards in addition to Woodward's official manual. These sources, which are all available in print today, give us a glimpse into the lives of these individuals during the Civil War years. These books were all written by the Hospital Steward himself post-war or were edited by others using journals, diaries, and/or letters written by the Hospital Steward during the war years. Primary sources often allow us to see what the individuals are actually doing especially if their performance differs from the official manual. All seven men were obviously doing what was expected for their title and position, but there are many personal notations throughout that suggest they were engaged in much more than the routine.



Left: Stewards at a field hospital, outside Petersburg VA, 1864.

Courtesy Library of Congress.

Right: Surgeons and stewards at Harewood General Hospital, Washington DC.

Courtesy National Archives.



John Samuel Apperson was a steward in the 1st Virginia Brigade, Confederate States of America, the famous "Stonewall Brigade." Apperson described compounding and administering medications, organizing and inventory of supplies, dressing wounds, and administering anesthesia. He also talked about seeing patients independently, diagnosing and treating, vaccinating for smallpox, collecting tissue samples, extracting teeth, performing autopsies and triage, attending the wounded, practicing percussion and auscultation, and being an apprentice to a surgeon. At one time he went into the community to do minor surgery on a child's neck and open an abscess. On other occasions he was doing surgery on gunshot wounds, amputating fingers, amputating a leg below the knee, and removing a ball from a foot - more advanced excision rather than amputation. He stayed "up to see that the nurses gave every attention necessary." After the war Apperson would continue in health care to become a physician and open Virginia's first mental asylum.

C. Marion Dodson served as a Navy hospital steward aboard the USS Pocahontas, Arkansas, and Hollyhock. His duties ranged from being a clerk to compounding prescriptions, and he was involved in diagnosis, treatment, minor surgery, administering chloroform, dentistry and prescribing medications. He volunteered to serve on board a ship quarantined for yellow fever where the surgeon was ill and he was the sole provider. He served on a second ship where he was also the sole provider; for an extended period there was no surgeon on board, and then with an ill surgeon who was unable to perform his duties. He also mentions nurses and states he had a male nurse detailed to assist him. Originally from St. Michaels MD, he became a physician after the war with a practice in Baltimore and later retired back to St. Michaels.

Spencer Bonsall was steward of the 81st Pennsylvania Infantry. Bonsall comments in his journal on compounding many prescriptions daily, opening boxes and examining stock "enough for a small drug store," and dressing wounds. He also listed autopsies as one of his responsibilities. In reference to supervisory duties

with nurses he stated that he took five nurses up to the Lacy House (Fredericksburg, VA) with orders to open a hospital. His military career ended a few months later at Gettysburg, PA, when his horse was shot from under him. He was seriously injured and hospitalized for an extended period of time. Official records state that he walked away from the hospital and returned to Philadelphia.



Hospital Steward Perry W. Bahl, 16th Ohio Infantry.
Author's collection.

His book is interesting in that as it was written 45 years post-war. He contrasts the Civil War era care he saw and delivered to what should have been done based on his current (1917) knowledge of medicine. He describes and discusses medical care, medicines, surgery, and nurses. One practice he describes is assigning numbers to frequently used prescriptions. The surgeon ordered them by number and he compounded and administered them by number. He had no experience as a druggist or chemist, but was an educated man and apprenticed under the previous hospital steward. His book is a very descriptive narrative of the medical care that he saw the surgeons deliver, but contains little detail of what he personally was doing as a hospital steward other than assisting at sick call. He briefly mentions nurses and matrons and at one point states that he personally "nursed" and cared for a patient with typhoid.

John N. Henry served first as a nurse and later became hospital steward of the 49th NY Volunteers. He stated that he was ordering and obtaining supplies and assisting the surgeon with sick call. He also set up a hospital and a smallpox hospital, was called out to see sick patients independently, and was called out to see a patient in an emergency. As for supervisory duties he said "...the charge of the inside of the hospital...over 50 men in my Supervision." In relation to the importance of his position he stated "...any other person could leave (on furlough) better than I could..."

Daniel McKinley Martin was hospital steward with the 2nd Regiment Virginia Infantry and 5th Regiment West Virginia Cavalry. Both regiments were Union with the 2nd Virginia being formed early in the war of men from western Virginia (pre-West Virginia) and including many Ohio and Pittsburgh PA men. Mar-

Solon Hyde wrote a book about his experiences as hospital steward with the 17th Regiment Ohio Infantry during the early war years and more interestingly about his later war years serving as a hospital steward while being a POW. He was a prisoner in three different Confederate POW camps. At a POW camp (located in the Pemberton warehouse building across from the famous Libby Prison) in Richmond VA, he took care of sick POWs and was in charge of a hospital ward. At the Danville VA POW camp, he worked as a hospital steward. At Andersonville GA, he was in the hospital outside the gates where he was in charge of the dispensary, was dispensing to civilians and families, was allowed to go out into the countryside to collect herbs, and on one occasion left to visit some lady friends! He not only survived Andersonville, but stated that he returned after the war with Clara Barton to help identify the thousands of unknown graves. He dedicated his book to Clara Barton.

Charles Beneulyn Johnson wrote a book about his experiences as a hospital steward with the 77th and 130th Illinois Infantry. He was one of the relatively few hospital stewards that left healthcare and returned to active duty, only to retire his musket and return again to field hospital du-



Unidentified Hospital Steward,
DOB (written on back) is
10/12/1834. Author's collec-
tion.

tin discussed examining soldiers with the surgeon, making up pills and dispensing to the sick, setting up and maintaining a dispensary, cleaning compounding equipment and surgical instruments, and attending the wants of the wounded. He also referred to himself as the “tooth puller.” One day he “vaccinated (for smallpox) perhaps 100 of our regiment” and on another occasion mentioned “...how many operations I assisted with the doctor in performing I can’t tell...” For a period of time the surgeon went to Baltimore and Martin was “the only surgeon [sic] left with the regiment...I have to prescribe and dispense the medicines...” During his time on the march and in the field he was constantly prescribing, advising, and instructing his wife and daughter on health issues long-distance via the mail.

After reviewing the seven primary sources, compiling and comparing the self-identified roles and responsibilities, it is obvious that the roles and responsibilities of the hospital steward far exceeded those that J. J. Woodward penned in his official manual. It could be that an individual overstepped his role, but yet some of the same themes appear from different stewards. The reader sees mention of diagnosis, treatments, prescribing medications, administering vaccinations, performing minor surgery and suturing, and administering anesthesia. The most important repeated theme is autonomy or practicing independently. This theme of autonomy is repeated throughout the primary sources in military environments, settings that were normally anything but autonomous. If one were to compare the hospital steward’s roles, responsibilities, duties, and skills along with his level of autonomy to modern day health care, similar individuals can be identified. Those individuals are Advanced Practice Nurses (APN) – either nurse practitioners (NP) or Certified Registered Nurse Anesthetists (CRNA) – and Physician’s Assistants (PA). These modern healthcare providers diagnose, treat, prescribe, order/administer immunizations, perform minor surgery, suture, and administer anesthesia with varying levels of autonomy, and in some cases independently, depending on site and military or civilian state regulations. While Woodward identified the hospital steward as a combination of pharmacist and hospital administrator and nursing supervisor, based on these primary sources one could add to the list the first APN/NP/CRNA/PA in healthcare, and answer “yes” to all three questionable titles – pharmacist, administrator, and nurse.

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Acknowledgement:

The author and this publication wish to thank The National Museum of Civil War Medicine, Frederick, MD. This article is excerpted from a presentation at their 20th annual National Conference on Civil War Medicine and articles published in *Surgeon’s Call, Journal of the National Museum of Civil War Medicine, The Hospital Steward: His Role & Responsibilities Including His Relationship to Nursing, Part I, Volume 18, No. 2, 2013, and Part II, Volume 19, No. 1, 2014.*

Combat Lifesavers in 1901? 1895? 1889? 1886?

Sanders Marble, Office of Medical History

In issue #9, Robert Ampula looked at the immediate background of the Combat Lifesaver, and how it was adopted in the 1980s. Some of the factors he identified – shortage of qualified medics, and medics becoming casualties themselves – had been identified even before the Army had medics. However, it would take generations for a systematic solution to be implemented and practiced.

On 20 November, 1886, General Orders No.86 called for Army doctors to train officers and men on “early aid to the injured, the most expeditious and proper manner of treating temporarily gun-shot-wounds, poisoned wounds, frost-bite, bruises, dislocations, hemorrhages, and fractures of bones; application of the tourniquet; the most approved method for resuscitation from drowning; and other kindred subjects.” The training could not be systematic since it was by voluntary lecture, but it recognized that just relying on the doctor (and the handful of hospital stewards who might or might not go to the field) was not enough.

On 1 March 1887 the Army created the Hospital Corps, which mainly worked in hospitals but was identified to deploy should a large force be mobilized. When deployed, they would help the surgeons at the aid station, they would operate the ambulances, and they would serve at any field hospitals that were organized. Yet there was also recognition that the wounded could need some care forward of the aid station. There were no medics assigned that far forward, and the voluntary lectures had not had time to take effect.

In 1889 the Army recognized there would not be enough Hospital Corps men and directed “There shall be in each company four privates designated for instruction as litter bearers. . . . Company bearers, together with all available men of the hospital corps, shall be instructed under the supervision of the senior medical officer for at least four hours in each month . . . in the duties of litter-bearers and the methods of rendering first aid to the sick and wounded.” (First aid was itself a novel term.) The intent was “to insure the constant presence in each company of a number of men who can, in emergencies, render temporary aid to the sick or wounded. . . .” On campaign they were to wear red brassards on the left arm. So by the Spanish-American War there were supposed to be medically-trained infantry and cavalry soldiers available, but it is not clear that many (or indeed any) company bearers worked in that capacity. Some line troops certainly helped at the improvised field hospitals in Cuba.



A medical officer demonstrating tourniquet and bandaging on an enthusiastic volunteer.
Courtesy National Museum of Health and Medicine.



Just four trained first aid litter bearers per company proved inadequate, and in 1901 the Army declared “Special instruction in the duties of litter bearers and the methods of rendering first aid to the sick and wounded will be given to all enlisted men of the line . . . by their company officers for at least four hours in each month.” (Coast Artillery men were allowed only one hour per month.) Note that the line commander was responsible for the training, which would be according to a manual provided by the Medical Department,

and the line officers would be supervised in this by the medical officer. On paper it was impressive: every soldier in the Army would spend a half-day every month on first aid and patient evacuation, it was a responsibility of line officers, and the Medical Department got to set the training standards. The only problem was it does not seem to have been enforced.

By WWI tables of organization had a much larger Medical Detachment attached to each infantry regiment, with the presumption that the men would be further attached to battalions, and that each infantry company would have two aid men – the term medic was not yet common. This was the first time medical personnel

routinely accompanied companies into action. Yet two per company, especially when considering the carnage of WWI, was obviously not enough. Various units addressed this in different ways. The 2d, 3d, 4th, 5th, 26th, 32d, 36th, 42d, and 82d Divisions trained line troops as litter bearers. (Some litter bearers were Medical Department personnel, assigned to ambulance companies or infantry regiments, but additional litter bearers were line personnel.) In April 1918 the 42d Division ordered eight men from each company trained in first aid, litter-carrying, and splints. This was later increased to twelve infantrymen per company, while 3d Division trained up to 16 men per company. At the end of July 1918, after the first substantial American battles of WWI, I Corps ordered twelve men from each infantry company and two from each artillery battery trained as medical auxiliaries; this was around 4% of the strength of an infantry company, a significant amount of resources. They were even given extra insignia, a blue brassard with L.B. in white. (Since many divisions rotated through I Corps, presumably more than the nine divisions mentioned trained line soldiers as medical auxiliaries.) Showing this was not universal, V Corps refused to allow infantrymen to get first aid training or to be diverted into carrying litters, and in the early stages of the bloody Meuse-Argonne campaign in 1918 III Corps had a shortage of litterbearers.

So, about a century before the combat lifesaver the Army identified a need for more medical training. Getting it implemented was the hard part: soldiers need training on many things but time is finite. (Some medical training would be recognized as a common soldier skill and included in the Basic Field Manual in 1936; that information moved through a series of other manuals and is now in FM 4-25.11, First Aid.) In some ways these medically trained men were the forerunners of combat lifesavers: they were line troops, not medical troops, but had extra medical training. But in other ways they are not combat lifesavers because they are detailed from their normal duties and put under the unit surgeon. Regardless of how they are interpreted, they show the Army recognizing how important prompt first aid is, and that there are never enough Hospital Corpsmen, aid men, or medics.

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Happy Birthday MEDCOM!

On 2 October 1994, U.S. Army Medical Command replaced Health Services Command, which dated from April 1973. The intent was to establish a broader scope than HSC, clearer lines of authority, more manageable spans of control, and more efficient use of Army medical resources. It also provided The Surgeon General control of all Army medical resources and matched their responsibility as senior medical officer on the Army staff. Previously, TSG often had to answer for HSC activities while not having direct control. LTG LaNoue, Surgeon General at the time, commented, "This reorganization streamlined and flattened the command and control structure of Army Medicine. These changes were not undertaken for the sake of change, nor were they designed simply to create a smaller organization."



What is Heritage?

By Nolan A. (Andy) Watson

Our organization is named the AMEDD Center of History and Heritage (ACHH), and we incorporate the AMEDD Museum, the AMEDD Regimental History Office, and the Office of Medical History. This article is part two in our series of organizational missions. In issue #11 of the newsletter we examined “What is an artifact?” Both history and heritage draw from the events of the past, but with different intent for different audiences. History is generally understood as the study and interpretation of past events; it is a consideration of both what happened and why it happened.

Heritage can be similar, but is a more nebulous word to define for most people. Heritage can be visible signs of our past that we maintain through traditions, or what is remembered as a cultural or organizational legacy. In an example with regards to the military, there are historical records of uniforms and regulations from the past, but it is a heritage function to maintain contemporary memory of military courtesy concerning headgear use and saluting etiquette.

For ACHH, the AMEDD Regimental History Office maintains most of the tasks of promoting the heritage function. There is also a blending of some tasks with the Office of Medical History. Examples of services we provide in connection with promoting the heritage of the AMEDD include the historic uniform loan program, answering heraldry questions, maintaining affiliation for the AMEDD Regiment, and maintaining records of AMEDD Soldiers that have exemplified excellence for the Army Medical Department. It does not have to be all good news to be part of our heritage. Medical Soldiers persevering in difficult situations or fixing problems are also part of the story.

The presentation and preservation of heritage and the collection and analysis of history are different, but they do not have to contradict each other. Despite the distinction there is a great opportunity for cooperation from our sections to offer more historical knowledge and insight. Each section has an appropriate function. The Office of Medical History generally provides the more in-depth historical interpretation, the AMEDD Museum exhibits and interprets historic objects, and the AMEDD Regimental History Office combines these tasks. Although it has less historic depth, it maintains an ease of access with historical information and more public interaction.

Visit the AMEDD Regimental History Website!

<http://ameddregiment.amedd.army.mil/>



In early World War II the Japanese seized the Dutch East Indies (now Indonesia) the world's main source of quinine for malaria prophylaxis. Since the US would be fighting in several malaria-endemic areas it was fortunate that atabrine had recently been developed as a synthetic anti-malaria drug. The Army had various ways to encourage troops to take their atabrine...

Courtesy National Museum of Health and Medicine.

The 135th Medical Detachment – from special diets to life-saving surgery

LTC Kaitnarine Harilal, OIC 135th Medical Detachment

The 135th Forward Surgical Team was constituted on 7 October 1944 in the United States Army as the 135th Medical Service Detachment. The unit was activated 22 November 1944 in Belgium during World War II, the following year on 10 April 1945 the unit (still in Belgium) was reorganized and re-designated as the 135th Medical Mess Detachment. (Medical Mess Detachments were 3-10 cooks to augment hospitals that had substantial numbers of patients on special diets.) On 31 January 1946 in Belgium the 135th Medical Mess Detachment was inactivated. The Medical Mess Detachment was re-designated on 27 September 1951 as the 135th Medical Detachment and allotted to the organized Reserve Corps. During the Korean War the 135th Medical Detachment was activated on 12 November 1951 where they took part in four campaigns: the UN Summer-Fall Offensive, Second Korean Winter, Korea Summer-Fall 1952, Third Korean Winter, and Korea, summer 1953. The 135th Medical Detachment was once again activated at Fort Meade, Maryland 31 October 1962 and then inactivated on 13 May 1968 at Fort Meade. The unit was again activated on 21 June 1976 at Fort Meade for active service and then was later inactivated on 15 June 1993 at Fort Bragg, North Carolina. In this iteration it was an eight-man blood distribution detachment. On 11 June 1997 the 135th Medical Detachment was reactivated, reorganized, and designated as the 135th Forward Surgical Team (FST) at its present location in Seoul. Its mission is to provide a rapidly deployable urgent initial surgical service forward in a division Area of Operations, provide forward surgical capability and Health Service Support as a Role II to the 210th Field Artillery Brigade.

The 135th FST is attached to the 121st Combat Support Hospital (CSH), Brian Allgood Army Community Hospital, and the 65th Medical Brigade located in Yongsan Garrison, Seoul, Republic of Korea. The team consists of 4 surgeons, 2 anesthetists, 1 detachment NCOIC, 1 executive officer, 3 nurses, 3 operating room technicians (68D), 3 medics (68W), 3 licensed practical nurses (68C), and one Korean Augmentee to the U.S. Army (KATUSA). This team of highly trained experts has a dual mission: provide armistice health care at the Brian Allgood Army Community Hospital and to be ready to save lives on the battlefield at a moment's notice.

Today's continuing threat from North Korea demands a state of constant readiness for all military units located in South Korea. The FST's readiness in conjunction with the 65th Medical Brigade, the 121st CSH, and the Republic of Korea, stands poised and ready to save lives on the battlefield. This resolve is a reflection of our continued commitment to the ROK-US Alliance, Katchi Kapsida (We go together).

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Left: 135th FST fully established with Battalion Aid Station at Camp Stanley, Korea



Above right: Simulated patient in the ER/ATLS section



Below right: Simulated patient undergoing surgery

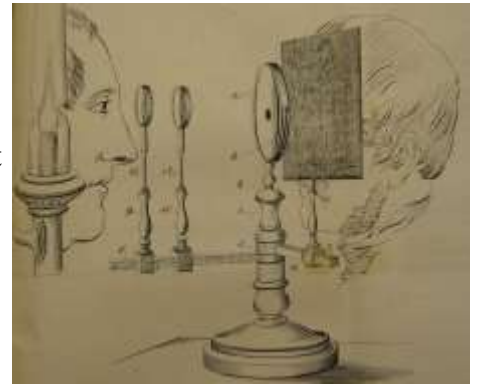
Ruete's Augenspiegel and the U.S. Army

James L. Vendeland M.D.

The ophthalmoscope (augenspiegel in German) is an instrument used to examine the interior of the eye in order to determine disease. Hermann Helmholtz invented it in 1850. His ophthalmoscope is the most famous in the world. Following his invention, numerous ophthalmoscopes based upon his original design were developed.

In my opinion, the second most famous ophthalmoscope in the world is that of Theodore Ruete. He invented it in 1852 and shortly thereafter published a textbook in which he included a very precise drawing and the dimensions of his instrument. This drawing is very famous and can be found in most textbooks and articles dealing with the invention of the ophthalmoscope. (right) The Ruete ophthalmoscope has a different design from that of the Helmholtz instrument.

To my knowledge there are only two surviving Ruete ophthalmoscopes in the world. One was donated to the U.S. Army and Navy Museum in 1901 following an eye meeting and exhibit commemorating the 50th anniversary of the invention of the ophthalmoscope. This instrument disappeared for 115 years! I located it at the National Museum of Health and Medicine (NMHM). The only other Ruete ophthalmoscope in existence resides in my private collection. (below) This instrument and the one at the NMHM are most likely replicas or refurbished originals. In



almost every detail, they look exactly like the original 1852 drawing.

Now, you may well wonder what my instrument has to do with the U.S. Army. On the back of the magnifying mirror of the ophthalmoscope a metal plate is attached. Engraved on this plate is: U.S.M.D. I believe these initials stand for U.S. Medical Department. Unfortunately the seller and his agent for this artifact had no information to offer me about this instrument or how it came into the possession of the U.S. Army.

At this point, I want to tell you about another of my instruments. This instrument is also associated with the U.S. Army and is called a vision tester. It comes with multiple pieces including a miniature Ruete ophthalmoscope



mounted on the top lid of the instrument's case. Its design is exactly the same as the Ruete ophthalmoscope which I have just described.

On the upper lid of the vision tester is a metal plate, below:



Hospital Department
3rd Div 9th Corps

U.S. ARMY

My collection now contains two instruments (the Ruete ophthalmoscope and a vision tester) associated with the U.S. Army. There is also an accompanying card stating that the U.S. Army vision tester was used in 1854-1855. From all the experts and historians to whom I have spoken, this seems highly unlikely.

For almost one year I have been conducting an investigation as to where these instruments originated and how the U.S. Army got involved. Regarding the Ruete ophthalmoscope, I began by contacting two dozen medical museums world-wide and asked two questions: Do you have a Ruete ophthalmoscope in your collection, and with regard to my instrument (I had enclosed some images of it) did you have any thoughts as to whether it is a replica or an original?

With the exception of the Ruete ophthalmoscope at the NMHM, the response to my first question was a resounding “no.” Most of the museums contacted had not even heard of Ruete let alone his ophthalmoscope. Ruete was a brilliant German scientist credited for being the first to recommend and prove the superiority of using a concave mirror in the design of the ophthalmoscope in place of a convex or plano mirror. Almost all ophthalmoscope designers (and there were many) readily adapted the concave mirror to their instrument. Ruete is also known for being the first in the European literature to describe what the aura (visual appearance) of a migraine headache looks like. Apparently he suffered from migraines and was a good observer.

Regarding the question about my own ophthalmoscope, the responses were many and varied. Essentially no one would commit to saying that the instrument was a refurbished original or replica or when it was probably made. As far as the association with the U.S. Army, no one knew anything. It is extremely difficult to determine when the ophthalmoscope was first used in the United States, let alone by the U.S. Army. We do know that American physicians studied in Germany during the early and mid 1850s and thus were exposed to the newly invented ophthalmoscope. A few returned who did try to encourage their colleagues to adopt this marvelous instrument in their routine exams. But it was slow to catch on and probably did not become popular with American physicians until after the Civil War.

I should mention the limited availability of information regarding use of the ophthalmoscope by the U.S. Army. In 1860 a drawing of a modified Ruete ophthalmoscope appeared in the U.S. Army Manual. There was no description and only a reference that this photograph was obtained from a civilian medical journal, “The Medical and Surgical Reporter.” The U.S. Army manual referred to the word “ophthalmoscope” a few times as a device used to screen enlistees for functional blindness and malingering. Aside from these findings, I found no other references.

Let us now return to the other part of my investigation, that regarding the U.S. Army vision tester. No one to whom I spoke had any idea when the U.S. Army first used this instrument. But a 3rd Division, 9th Corps of the U.S. Army really did exist during the Civil War. Formed in 1862, it saw action during the siege of Petersburg, Virginia in 1864-1865. There is even a photograph of unidentified surgeons of the division in a textbook of photographs of Civil War hospitals and prisons. Unfortunately no details about this picture are available. Had an ophthalmologist been one of the medical officers in the picture, it might have solved some of the mystery behind these instruments. Also, I have found no references to a military vision screener in use by the U.S. Army during the Civil War. If this instrument existed, it would have been employed for screening enlistees rather than at a field hospital.

My research now took a different direction. I reasoned that I could establish that the military might have used a vision screener if I could determine when thorough physical exams started. This would include having the recruits strip naked for a complete exam. I was surprised to find that the U.S. Army manual of 1840 was the first to mention this type of detailed physical exam! However, I could not find any mention of a vision tester in U.S. Army manuals during the Civil War period.

One surprising finding which I did come across in my research was that a significant number of women (estimated from 250 to over 400) disguised themselves as men and successfully passed the recruit physical! And many of them were not discovered for many decades following the Civil War. One can only guess how this was possible, but one must remember that the primary physical requirements for enlistment were presence of a trigger finger, good teeth to tear open gun-powder cartridges, and absence of severe mental illness.

So I have learned:

That I have two instruments in my collection (an ophthalmoscope and a vision tester which includes a miniature version of this ophthalmoscope), and during the Civil War both may have been used by the U.S. Army. Perhaps my artifacts are originals, or refurbished originals, or replicas, or just plain forgeries. I doubt the latter since it just would not be worth the counterfeiter's effort to design these instruments in such detail as to match the original 1852 drawing.

During the Civil War the military discouraged use of diagnostic instruments such as the ophthalmoscope and stethoscope. The main medical concerns were amputating limbs, treating post-operative complications, and managing diseases which brought devastation to many military camps. Also the U.S. Army was interested in curtailing costs, and the purchase of new diagnostic instruments and textbooks would not have been of primary concern.

In conclusion, my search continues to learn about these two instruments: Ruete's ophthalmoscope and the U.S. Army vision tester. I am hoping that some of you may have suggestions or insights as to how I can proceed in my quest. And if you do, please feel free to contact me. My email address is: jl6@att.net.

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Patient Transport Bag

During the Korean War, H-13 helicopters were used for casualty evacuation. Litter patients were placed on racks attached to the skids. To minimize the danger of cold injuries, LTC Burt Nelson Coers developed a special down-filled transport bag with zippers to access the patient without undoing the bag. (Coers died in a North Korean POW camp in 1951.)

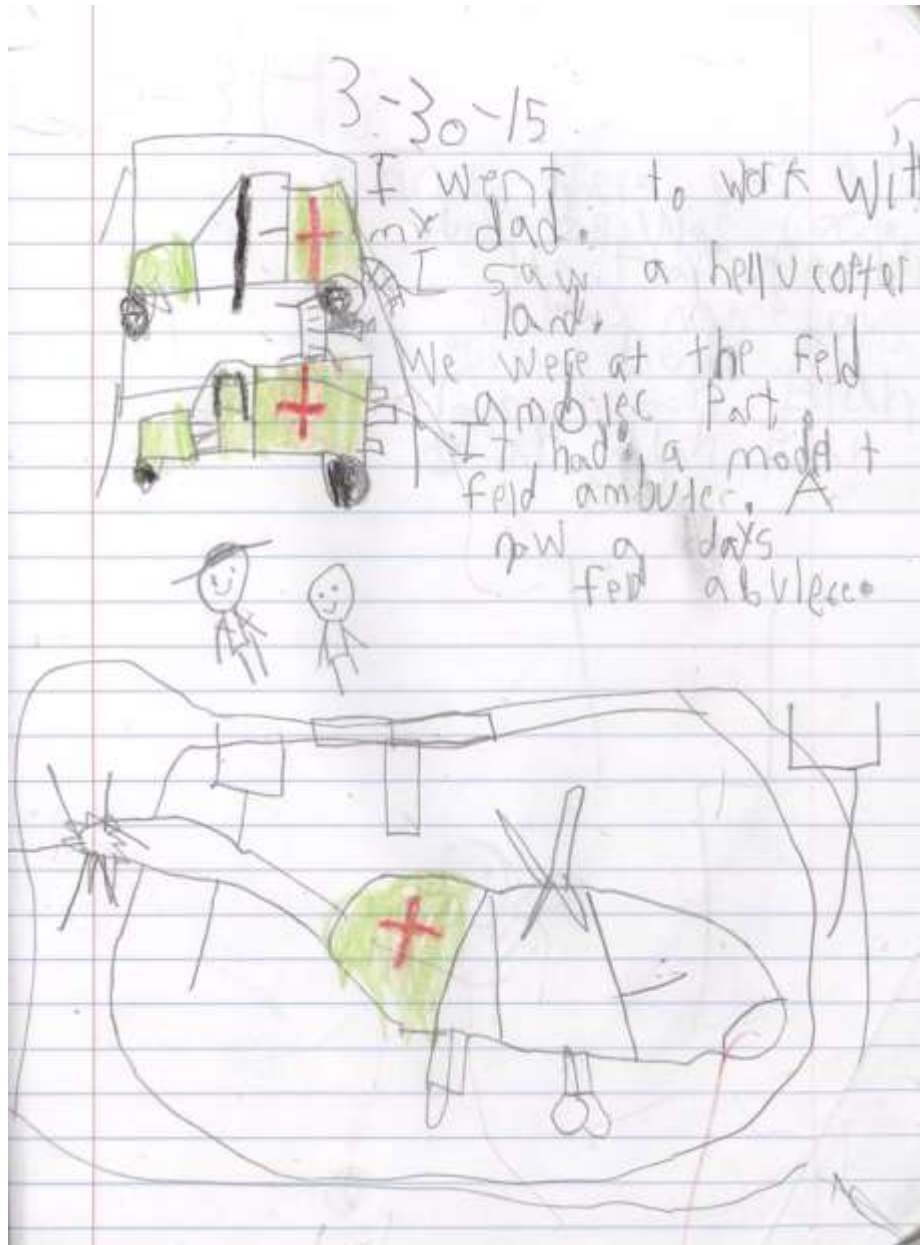
This bag was found in a depot in Europe in 1972 and used for decades by LTC Harold Christopher MSC. To quote Christopher, "I was assigned to the 557th Medical Co (AMB). This organization

had recently moved from Hanau to Darmstadt. While returning to Hanau to clean up the old location, my supply sergeant discovered a number of these in an old warehouse. I kept it for my entire career, using it as my sleeping bag any time we went to the field in cooler or cold weather. It has kept me warm many a night in Army training areas around the world."



Developing Historical Mindedness?

Army leaders must convey our history or the past will be lost. This conveyance can be in many forms. Andy Watson, an AMEDD Center of History & Heritage (ACHH) historian, along with Scott Woodard, Historian, and COL Betsy Vane, Army Nurse Corps Historian, recently participated in History Day Activities at Tejada Middle School, San Antonio, as part of the ACHH Ambassador/Outreach program, to tell the AMEDD story. The intent of Tejada History Day was to inspire youngsters to become interested in history. Andy used this opportunity and brought his son Jack with him for the day, and while at the history fair, Jack enhanced his historical mindedness through a journal. It's amazing how Jack captured the events of the day.



Jack's Journal



Jack's dad, Andy Watson, sharing a piece of history with some Tejada students. (Notice the WWI helmet worn by Mr. Watson, and see how Jack's drew it in his journal.)

Staff rides, living history displays, and museums such as the AMEDD Museum at Fort Sam Houston all help develop the historical mindedness for the uniformed and civilian communities alike.

Knowledge of history is important in furthering the professional development of uniformed service members. It enhances awareness of the past, and thereby instills pride and esprit de corps in the profession. So, the next time a military history event is happening in your area, encourage your staff to attend. Who knows, it might even have the same impact as it did for little Jack! Contact ACHH for more information, it is always our pleasure to assist!



MEDEVAC helicopter from TXARNG

Harold Hughes - Truck Driver, Alcoholic, U.S. Senator: The fight to establish a Military Substance Abuse Program

CW5 Roger A. Wheatley, Human Resources Command

This September marked 44 years since the signing of Public Law 92-129 by President Richard Nixon, cited in Army Regulation 600-85 as the authority for the Army Substance Abuse Program. The law is a direct result of the efforts of a “trucker turned politician” as his New York Times obituary described Senator Harold Hughes. Those who were treated in the last half century for alcoholism in uniform instead of punished may wish to thank Senator Harold Hughes for the opportunity for recovery and continue their military career.



Sen. Harold Hughes.
Courtesy U.S. Senate Historical Office.

Harold Hughes was born on a farm in Ida Grove, Iowa. He dropped out of college, served in World War II as an infantryman in North Africa and Europe where most of his unit was destroyed, and returned home to become a truck driver. He later developed alcoholism and at one point attempted suicide using his brother’s shotgun; his wife once began the legal process to have him committed to the state hospital. From the pits of hell a friend reached out to him and convinced him to seek help. This opportunity changed the course of his life and the lives of many men and women in uniform.

In recovery he found faith and family. He considered the ministry, but ultimately others encouraged him to use his persuasive speaking skills to help others through public office. Harold Hughes’ story is of a man who went from hopeless alcoholic to serve three terms as Governor of Iowa and six years as a United States Senator.

As a truck driver, Harold Hughes was outspoken and persuasive. He became a successful spokesperson for independent truckers and a union organizer. His success led to a political appointment as Chairman of the Iowa Commerce Commission in 1958 and four years later he won the election for governor of Iowa.

After six years as governor he won election to the U.S. Senate in 1969. His legislative emphasis was alcohol and drug abuse reform. His personal experience in recovery aided in bringing compassion and understanding of the problem to the American conscience. As a freshman senator he was appointed chairman of the first congressional subcommittee on alcoholism and narcotics. Within the first year he achieved remarkable results winning funding for alcoholism programs. The first comprehensive legislation, The Federal Alcoholism Treatment and Prevention Act, is commonly known to this day as the Hughes Act. President Nixon signed the bill into law just before midnight on December 31, 1970.

Senator Hughes earned the trust and confidence of his fellow Senators and expressed an interest in expanding treatment efforts to men and women in uniform. Congressional reports claimed 10-15% of American troops in Vietnam were on hard drugs. If these reports were accurate, it meant that there were 30,000 to 40,000 abusers in uniform. Regardless of the accuracy, public opinion and concern demanded that we deal with the problem before American streets were ‘overrun’ with heroin addicted veterans.

Senator John Stennis of Missouri, Chairman of the Armed Services Committee (SASC), invited Hughes to a Senate Prayer Breakfast. Harold Hughes wrote in his biography, “I had heard of this prayer breakfast, but suspected that most of those attending were southern conservatives like Stennis, rabid hawks on the Vietnam War who stood at the far end of the pole from me politically...as I looked around the table, my misgivings seemed to be confirmed. Except for Mark Hatfield from Oregon, most of my prayer breakfast companions, Republican and Democrats alike, were arch conservatives.”

Hughes developed several key relationships during his efforts to help alcoholic and drug addicted service members. His guarded attitude about Senator Stennis softened. Once when they met in the halls of the Capital, the two men embraced each other warmly. After departing, his staff member Nancy Olson said, “I should think you would hate that man.” Hughes smiled and replied, “Nancy, you don’t have to agree with a man to love him.”

In April 1970, Stennis authorized Hughes to investigate the drug problem in the military. It is very un-

usual for a Senator to allow another Senator's subcommittee to investigate something in their jurisdiction, and this reflects Stennis' regard for Hughes. Once the investigation began, Hughes' staff got to work researching military drug use and alcoholism. Hughes' report was printed in the Congressional Record of April 20, 1971.

Hearings included testimony of various experts from the services. Army testimony came from Dr. Carl Segal and Captain Jim Adelman, the officers responsible for the first Army substance abuse treatment program: Benning House, a halfway-house program at Fort Benning. That program's success would grow to the beginnings of the modern Army Substance Abuse Program. At the time, however, it was only a pilot project that had treated 36 soldiers in a renovated World War II barracks building. Thanks to Senator Hughes hearings the programs would gain attention at the highest levels of the Defense Department.

A short time later Senator Stennis created a subcommittee on Drug Abuse in the Military and invited Senator Hughes to join the SASC and chair the new subcommittee. Despite his opposition to the war in Vietnam, Hughes accepted, becoming what he called the only dove on a committee of hawks.

The subcommittee determined that the Defense Department had no alcoholism rehabilitation program nor any guidelines or procedures for treating alcoholics. Hughes directed a Government Accounting Office study which found there was also no reliable data showing the extent of alcoholism in the Armed Forces. The GAO reported that negative attitudes and punitive statutes and regulations hid the problem; the military alcoholic had little incentive to seek help. The report read in part, "Military regulations and certain statutes deal punitively with those intemperate in the use of alcohol....The official stated policy of DOD and the military services on alcoholic consumption by military personnel is 'to encourage abstinence, enforce moderation, and punish overindulgence.'"



Hughes campaign button.
Author's collection.

In 1971, Nixon was setting the conditions for the all-volunteer force. To achieve this goal required amendment of the Military Selective Service Act of 1967 to increase military pay and extend the draft one last time. Senator Harold Hughes, the Vietnam "dove" (who as Governor of Iowa bravely faced up to President Johnson in opposition to the war) was bold enough to propose an amendment to the Act when it came to the floor of the Senate for renewal – and he succeeded.

The Hughes Amendment became Title V of Public Law 92-129, signed into law on September 28, 1971. It required the Secretary of Defense to prescribe and implement procedures and provide necessary facilities to identify, treat, and rehabilitate members of the Armed Forces who are dependent on drugs or alcohol. It is the authority for today's the Army Substance Abuse Program though few know about the history of the effort or the man that made it possible. Those facing the challenges of alcoholism and drug abuse in uniform today can receive help and turn their lives around because of his efforts. Countless service members in recovery serve with distinction today contributing to our readiness after being treated for this illness. Because Harold Hughes understood from personal experience that addiction is a treatable illness and those in uniform can, like him, embrace and walk the road to recovery to greater purpose. The law he championed was intended to pave that road.

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COL (Dr) Stephen C. Craig (Ret) with some insights. William T. Campbell, Ed.D has contributed Part II on Hospital Stewards in the Civil War. Sanders Marble wrote a follow-on article to Bob Ampula's article on Combat Lifesavers, questioning whether combat lifesavers go back to 1901. Army units experience many organizational changes and LTC Kaitnarine Harilal sent us an article on the 135th Medical Mess Detachment, which today is the 135th Forward Surgical Team.

Included in each issue is a piece on the AMEDD cultural history, Doctor James Vendeland sent us an article on the "Augenspiegel" (ophthalmoscope in German). CW5 Roger A. Wheatley, from HRC, sent an interesting article about the life experiences of Senator Harold Hughes that eventually led him to investigate the drug problem in the military.

So as I close, I remind you that we are always looking for amateur AMEDD historians to submit articles to the *Historian*, and the next time you're at Fort Sam Houston, don't forget to visit the AMEDD Museum and archive!

Bob Driscoll

Chief, AMEDD Center of History & Heritage

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.

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

AMEDD Center of History and Heritage

Director, Mr. Robert Driscoll

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Office of Medical History history.amedd.army.mil 210-295-0977

Office of the AMEDD Regiment ameddregiment.amedd.army.mil/ 210-221-8160

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