Sgt. 1st Class Ray Garrin, Company B (Medical), 173rd Airborne Brigade, treats Vietnamese citizens 13 June 1966 as part of a Medical Civic Action Program during Operation Hollandia in Long Hải, Vietnam, in what was then the South Vietnamese province of Phước Tuy. (Photo courtesy of U.S. Army Medical Department Center of History and Heritage)

Praise the Host and Pass the Fish Sauce

Medical Advisers in the Vietnam War

Maj. Scott C. Woodard, U.S. Army, Retired

I was not sure what to expect when I was first assigned as the officer in charge of an embedded training team in support of the Afghan National Security Forces in 2006. I had once read David Donovan's *Once a Warrior King: Memories of an Officer in Vietnam*, the autobiographical story of an adviser in Vietnam, but he was a combat arms officer, and I was a Medical Service Corps officer.[1] Recognizing that the role of advising was not a new military mission, I wondered what the experience of medical advisers had been in our last sustained war, Vietnam.

As one reads through memoirs, reports, and analyses written before the January–February 1968 Tet Offensive, the goal of enabling a fledgling country to become self-sustaining was emerging and doing well. The medical field, in particular, benefited from dedicated advisers and other medical personnel providing education and assistance to their military medical counterparts. In addition, civilian and military patients reaped the harvest sown by the various medical assistance programs.

The roles of advisers in Vietnam, specifically those in the Army Medical Department, are presented here as a reminder of the valuable work those individuals accomplished and as potential historical lessons for similar future counterinsurgency missions.

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The Command

The U.S. advisory effort in Vietnam began in 1950 with Military Advisory and Assistance Group–Indochina support to the French. In 1955, it then became the Military Advisory Assistance Group–Vietnam (MAAG-V) and was augmented with the Temporary Equipment Recovery Mission the following year. It initially focused outward on fighting an invasion from North Vietnam, while other nonmilitary agencies worked internally with the Vietnamese Civil Guard and the Self-Defense Corps.

Beginning in 1959, MAAG–V turned toward the emerging insurgency, refocusing on counterinsurgency operations. As the situation deteriorated in South Vietnam from 1961 to 1964, adviser and combat support to the Army of the Republic of Vietnam (ARVN, also known as the South Vietnamese Army) increased. Advisers, however, were forbidden to participate in direct combat alongside Republic of Vietnam Armed Forces (RVNAF) and to operate near international borders. Consequently, the advisers organized into mobile training teams that rotated throughout conventional units, ranger units, and the Montagnards in the Civilian Irregular Defense Group program. To oversee this increased adviser population and mission, the U.S. Military Assistance Command, Vietnam (MACV) was established in 1962.

With the chaos following the death of South Vietnam's President Ngo Dinh Diem in late 1963 and an increase of successful Viet Cong attacks in the south, Gen. William C. Westmoreland took command of U.S. forces during a tumultuous period in June 1964. American cadre assigned to ARVN units were deemed at an acceptable level, and beginning in 1965, U.S. command interest turned toward the buildup of U.S. combat forces in South Vietnam. Consequently, MACV became an operational headquarters for these forces and focused less on the advisory and counterinsurgency roles from previous years. Now, the main U.S. effort was command and control of combat units instead of embedded advisers. Because RVNAF units did not serve under U.S. commanders, unity of effort replaced unity of command and resulted in advisers having a U.S. chain of command and their advisees having a separate chain of command. South Vietnamese units answered to South Vietnamese commanders while American advisers answered to other Americans in charge of combat forces. This disjointed union created a physical battle space where U.S. and RVNAF units occupied positions near each other, but not necessarily in synchronization. American advisers would now have an even more difficult situation.[2]

To mitigate the risks involved in focusing primarily on the command and control of U.S. forces, the Civil Operations and Revolutionary Development Support

Sgt. 1st Class Fred A. Edwards, a medical sergeant assigned to Special Forces Operational Detachment-A, Ha Tien, examines a patient's teeth circa 1967 in Ha Tien, approximately 150 kilometers southwest of Saigon (now Ho Chi Minh City). Edwards operated a twelve-bed hospital in Ha Tien while training and mentoring his counterpart, Sgt. Nguyen Tong, a Vietnamese Special Forces medic. (Photo courtesy of U.S. Army Medical Department Center of History and Heritage)

Members of D Company, 7th Cavalry, 1st Cavalry Division (Airmobile) gather villagers for questioning 11 December 1967 while American and Vietnamese medics treat villagers during a "sweeper" mission near Chu Lai, Republic of Vietnam. (Photo courtesy of U.S. Army Medical Department Center of History and Heritage)

(CORDS) program was established under a civilian deputy to the commander of MACV in April 1967.[3] The program focused on the counterinsurgency effort and combined advisers from the Office of Civil Operations (working revolutionary development and pacification) with district and provincial advisers. As a consequence, the contentious contest for civilian control among nonmilitary pacification organizations, at times operating in the same area as military units charged with pacification, was settled. All pacification programs became unified under Westmoreland, and subsequently, civilians were fully integrated into CORDS.[4]

CORDS enabled a major focus on transforming the Civil Guard and the Self-Defense Corps into regional and popular forces supported by mobile advisory teams and mobile advisory logistics teams. After Gen. Creighton Abrams took command of MACV in mid-1968, he shifted focus to improving RVNAF combat effectiveness while supporting the pacification efforts of CORDS. The result of this effort was an advisory force of officers and senior noncommissioned officers numbering 11,596 in 1968.[5] This force of senior leaders could have filled the required officer and senior noncommissioned billets for seven U.S. Army divisions. This increased manpower was in addition to the core leadership already filling eleven U.S. Army division equivalents in combat on the ground. In still another change, as newly elected President Richard Nixon changed to a Vietnamization policy in 1969 that shifted the burden of combat operations and control to the Vietnamese military and government, the adviser

mission morphed into combat assistance teams providing combat support coordination.[6]

The Advisers

In South Vietnamese divisions, U.S. advisers were assigned down to the battalion level beginning in December 1961. Since the process of conducting counterinsurgency dictated a requirement for civil-military interaction, provincial coordination was led by a province senior adviser (PSA) who was paired with the South Vietnamese district chief. When the PSA was military, his deputy was a civilian and vice versa. Medical noncommissioned officers were also a critical part of the adviser teams.[7]

However, the reality of this effort was that many first lieutenants with two years in the U.S. Army and no combat experience "advised" commanders twice their age with twenty-five years of combat experience. As is seen in the early advising roles, most American military advisers were unfamiliar with the society, culture, and language of South Vietnam. In fact, they were unfamiliar with the advisory role itself. According to a senior adviser in 1960, the advisory role was "entirely new and challenging to most American soldiers … [who] spent most of their lives giving and executing orders. As advisers to South Vietnamese counterparts, they neither give nor take orders; they have a much less positive role—that of giving advice, providing guidance, and exerting influence."[8]

Advisers often found themselves performing three roles: a U.S. Army officer in charge of soldiers, a fellow combatant with the South Vietnamese, and a mediator between the two forces. By March of 1965, advising became a position of tactical combat support, changing from the earlier mission of training and advising of the early 1960s. Still, these difficult duties appeared simple compared to those of the PSA advisers, who were required to juggle the former in addition to the U.S. Agency for International Development (USAID) and various other nongovernmental organizations within a given province and district.[9]

The Role

In the beginning, advisory duty was sought after by soldiers desiring to perform a combat duty. As the U.S. effort in Vietnam became more involved in direct action in 1965, the enthusiasm shifted to leading the buildup of U.S. forces in combat. Additionally, the role of a provincial adviser placed a soldier into areas outside the normal realm of his previous warfighting training.[10] Westmoreland addressed the role of the adviser in 1967:

> You are still the 'heart and soul' of our total commitment to South Vietnam … . Your job is a most difficult and sometimes frustrating task. Under any circumstances, the relationship of adviser-to-advised is a testy and tenuous one. Here, that relationship is compounded by daily decisions with life or death consequences, and by communications problems complicated by language difficulties and different national origins. The training of the U.S. military officer is characterized by conditioned traits of decisiveness and aggressiveness. The essence of your relationship with your counterpart is constituted by patience and restraint. As a threshold to development of a meaningful affiliation with your counterpart you must succeed in the reconciliation of these contrasting qualities.[11]

By November of 1967, assignment to the various adviser programs was backed up by preferential treatment in the form of promotion consideration, next assignment choices, family location, and advanced schooling. These improvements, however, became a moot point as U.S. forces decreased their presence in South Vietnam around 1970. Cultural and language training was incorporated into the preparations given to advisers at Fort Bragg, North Carolina, while civil affairs training was given at Fort Gordon, Georgia. Additionally, advisers might get specialized training at the State Department's Foreign Service Institute in Washington, D.C., and instructor training in South Vietnam.[12]

Dai Dien and Counterpart Relationships

Former RVNAF officers remarked that the advisory movement was a synthesis of "Vietnamese experience with U.S. Army professionalism," and the American adviser was the "representative," or *dai dien*, of the U.S. government.[13] A key element of any advisory relationship is the rapport both parties have with one another. However, entrenched French influence, personal loyalties, and corruption often generated vast differences between the RVNAF officer corps and their U.S. advisers.

Among the many challenges were those that arose from the language barrier. To function optimally, those advisers assigned to regional forces and provincial forces

required some fluency in Vietnamese, but according to South Vietnamese officers, advisers "rarely achieved a desirable fluency for effective professional communication."[14] Cao Van Vien, the former RVNAF chairman of the Joint General Staff, observed, "I know of no single instance in which a U.S. adviser effectively discussed professional matters with his counterpart in Vietnamese."[15]

Interpreters helped to overcome some of the language barriers, but that resolution was fraught with problems due to reliance upon a third party to properly convey precise and often nuanced information in Vietnamese, negotiate meaning across cultures, and then receive and properly convey information back in equally nuanced English. Additionally, the preference for indirectness was perceived by the Americans as dishonest.[16] William Shelton, an adviser to the South Vietnamese from 1961 to 1962, explained how the Vietnamese would say they were going to do what they believed the Americans expected and then do something else.[17] The problem may have been the different style of communication or a different notion of how to express politeness, even as a lack of candor, which greatly frustrated the U.S. advisers.[18]

As relayed by Stuart Herrington, a former district intelligence adviser from 1971 to 1972, disdain was a two-way street, where many Americans looked down upon the seemingly uneducated "little people," and their Vietnamese counterparts frowned upon Americans' arrogance, waste, and lack of respect for cultural traditions.[19] A Vietnamese officer might display contempt for an adviser who was not of the proper rank or experience compared to his Vietnamese colleague. One U.S. Marine Corps adviser in Vietnam, John Miller, reported that within Vietnamese culture, the "cult of the commander" was alive and well.[20] A subtle approach was key in facilitating the environment for the Vietnamese counterpart to incorporate any recommendation. However, seemingly obvious problems and solutions faced daily screamed immediacy for the American working at full speed for one year, while the Vietnamese could never meet this expectation when working at a problem for twenty years.[21]

Balancing the intimacy of the relationship also created challenges. Partnering too close raised fears that familiarity would breed contempt and that the counterpart would not take advice seriously. In contrast, partnering in an aloof manner risked not developing a working relationship at all. On the one hand, maintaining a professional, detached distance left maneuverability for the adviser to bring pressure in shaping the decision making, as might be needed.[22] On the other, an adviser might inadvertently diminish the commander's authority when the Vietnamese soldiers began to see that it was the American who was able create a victory from potential defeat with his ability to call upon helicopter and artillery assets. An effective adviser allowed the counterpart to develop his own plan based upon tactful suggestions and quiet, low-key coordination of support.[23]

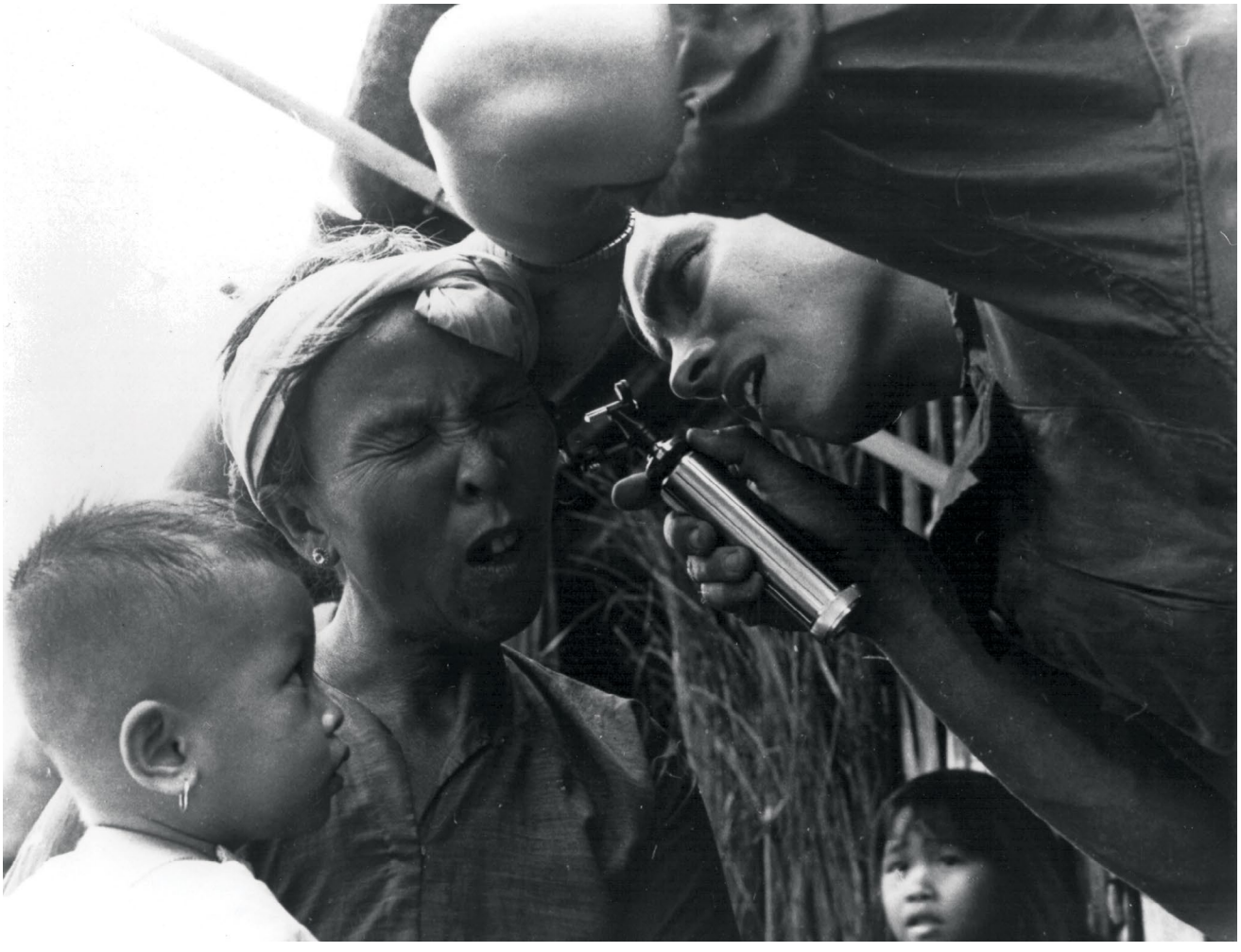
Another challenge the adviser faced was lack of time. In a culture that relies heavily upon the formation of personal relationships as a prerequisite for doing business, advisers were expected to develop effective relationships that ordinarily would have taken years to foster. For example, as a former ARVN division and corps commander describes at the tactical level, a one-year tour of duty usually became a de facto six-month tour because of the rotation policies in theater. In contrast, at the district level, advisers served for eighteen months and usually had much greater influence on locals. Success reflected the relationship built between an adviser and his counterpart. A commitment of time spent was interpreted as a sign of mutual respect, positive attitude, and genuine desire to help, which was the recipe for good relations and, therefore, better outcomes.[24]

Medical Advisers in Counterinsurgency

Just as in previous wars, medical soldiers deployed into medical or nonmedical organizations. As a supporting specialty in a nonmedical unit, Army Medical Department soldiers were often one or two deep and filled critical roles. Life support for American advisers was the responsibility of the RVNAF. The MACV command surgeon was responsible for any U.S. support provided to the medical adviser under the director of the Logistics Advisory Directorate (J-46), who also served as adviser to the assistant chief of staff (J-4) on matters concerning RVNAF logistics.[25]

When serving in a medical unit, while primarily focused on support for U.S. troops, advising was often a collateral duty performed in support of counterinsurgency operations. Medical personnel assigned specifically to advising teams were focused solely on advising the Vietnamese in their particular medical specialty.

Maj. Robert J. Lander, of the Medical Service Corps, was assigned to MACV, Advisory Team 10 to the



Capt. Edmond P. Zimsky treats a Vietnamese woman in 1968 during a Medical Civic Action Program in a hamlet of Dat Loi, Vietnam. (Photo courtesy of U.S. Army Medical Department Center of History and Heritage)

RVNAF 4th Area Logistical Command in the Mekong Delta in December 1967. In this role, Lander supervised fellow U.S. medical advisers (a medical supply officer and a medical maintenance repairman) and advised three station hospitals, one field hospital, twelve sector hospitals, sixteen subsector dispensaries, a field medical depot, a veterinary detachment, and a preventive medicine unit. His RVNAF counterpart, a very competent physician and a graduate of a French medical school, was the newly appointed 4th Area Logistical Command surgeon and former 4th Corps surgeon.[26]

Lander recognized that a close relationship was critical in achieving good results. As a result, he described his method of advising his counterpart on implementing suggestions as "low key"; he was not demanding. A proposed suggestion might be discussed over beer or dinner two to three weeks after a specific inspection. For example, during the time period, Lander lamented the lack of funding to fully equip the subsector hospitals in his area of operations and the lack of evacuation platforms. The majority of wounded ARVN soldiers had to wait at least eight hours before getting to a hospital. In an attempt to advise his Vietnamese counterpart's subordinates on how to rectify this problem, his approach was to not overwhelm them with too many advisers. Instead, he pressed to make the already existing Vietnamese system work for them and did not try to impose a foreign system on them. In elaborating on this approach, he observed, "We have a system—the Vietnamese have a system and if it is made to work it will work."[27]

Medical Assistance Programs

Medical units in Vietnam contributed to the various programs aimed at countering the Viet Cong threat to

the civilian population in the various hamlets and villages across the country. This support was obtained through the Provincial Health Assistance Program (PHAP), the Military Provincial Health Assistance Program (MILPHAP), the Medical Civic Action Program (MEDCAP), and the Civilian War Casualty Program.[28]

Provincial Health Assistance Program and Military Provincial Health Assistance Program. Initially begun in the early 1960s by USAID, the PHAP was intended to improve health services by training doctors, nurses, and medics. The intent of this training was to better Vietnamese hospitals and help control malaria. Although civilian surgical teams were stationed at different provincial hospitals, this task proved overwhelming, and the teams could not substantially improve the civilian health-care system due to the fighting. As U.S. forces increased, MACV directed U.S. Army medical units to begin serving in these same civilian institutions. Partnering with USAID, MACV instituted MILPHAP in 1965 with the intent to develop a sustained national health-care system for Vietnamese citizens. As teams augmented the provincial hospitals and dispensaries, they improved continuity in medical care and evacuation even though they were augmenting a Vietnamese civilian system with U.S. military assets.[29] At least through 1967, the teams were directed to not take over the facilities but to instead help and teach Vietnamese medical personnel.[30] Some U.S. teams, however, did replace the Vietnamese staff by 1970.[31] This augmentation of U.S. military medical assets did provide the above mentioned access and care. However, the program's intent was to institute a national health-care system. By filling Vietnamese medical gaps with U.S. medical teams, they did not fulfill the mandate of "Vietnamization" of the health-care system.

Capt. Larry P. Kammholz, Medical Corps, served as the medical officer in a MILPHAP in the Moc Hoa area of the Mekong Delta between 1966 and 1967. His unit consisted of three physicians and twelve enlisted men. Throughout his memoirs, Kammholz discusses the importance of interaction with civil authorities in coordinating medical care for so many underserved people. It was a continual process in working out who the "good guys" were and who was providing more business for the doctors. Partnering with USAID officials and local leaders became essential. Often, making do with less medicine, supplies, and translators was a part of the job. However, successes culminated in trusting friendships with fellow providers and doing well for those who were hurting.[32]

Medical Civic Action Program. In 1963, the U.S. Army assumed control of MEDCAP, a joint program developed by the U.S. Embassy and MACV that became the most well-known medical venture during the Vietnam War. The purpose of MEDCAP was to meet civilian medical needs in the Vietnamese countryside, foster mutual respect and cooperation through partnered U.S. Army and ARVN medical teams, and build credibility for the government of South Vietnam. This partnership facilitated training in medical procedures for the Vietnamese.[33]

Initially, U.S. military advisory teams and Special Forces had primary responsibility for conducting MEDCAPs.[34] Medical stability operations through MEDCAP I (as the original mission became known) focused on Special Forces and MACV medical advisers partnering with the ARVN, with the U.S. personnel attempting to take a back seat. All pharmaceuticals were requisitioned from ARVN supply depots.[35]

In describing the programs following his tour as the MACV surgeon, then Col. Spurgeon Neel detailed the importance of creating self-sufficiency in the RVNAF as part of the counterinsurgency effort. Of its potential to transcend the distrust in the central government, he wrote that "medicine is a universal language, and provides immediate high-impact communication within any culture, anywhere in the world."[36]

Capt. James Erwin Anderson Jr., Medical Corps, was a physician assigned to Medical Civic Action Team 20, a component of MAAG-V in 1963, and served in the Da Nang area of operations. He recorded that his six-man team (one to three were American advisers, and the rest were Vietnamese soldiers) would visit different villages throughout the area conducting sick call and provide follow up during return visits. As stated earlier, apart from providing medical relief, the additional intent of this program was to foster credibility for the government of South Vietnam. Consequently, highly visible participation by Vietnamese counterparts was critical to its success. Thus, it was standard procedure that two medics conducted screening and examination, two performed dispensing and treatment, and two maintained the medical records, with the Vietnamese medical personnel prominent. However, there was rarely an ARVN

physician available, so training and scope of practice focused at the senior noncommissioned officer level.[37]

Treatment of the most common diseases was not hampered by this lack of a physician, since two-thirds of all patients presented with arthritis, bronchitis, pyoderma (skin disease characterized by pus), helminthiasis (worm infection), and headache. Most surgical requirements involved draining skin infections. In accomplishing those missions, the language barrier was again an impediment. Any interaction using an interpreter doubled the time required to accomplish a conversation; consequently, sick call procedures took twice as long with interpreters.[38]

In deploying to outlying villages, a field ambulance or helicopter would carry all the equipment for the team. The supplies came from an official list of medicines that could be requisitioned through the ARVN medical supply system and funded by USAID. Additionally, the team distributed training booklets produced in English and Vietnamese that laid out common procedures, diagnosis, and treatments, and maintenance of supplies.[39]

In evaluating his experience as a lesson for future medical advisers, Anderson observed the dilemma of seemingly short-term solutions for chronic illnesses and the inability for patients to even increase their standing by allowing them to pay something for the services if they chose.[40]

As U.S. Army forces were built up in 1965, conventional forces began participating in the program. Though the original MEDCAP I program continued, the MEDCAP II program allowed for rotating teams from large medical units to service remote hamlets where permanent care was not available. This filled the gap created from MILPHAP services at permanent sites. By working through members of the RVNAF, the way was intended to have medical care continued by the Vietnamese themselves.[41]

By 1967, supplies were soon obtained through normal U.S. supply channels. Building upon the success demonstrated in medical programs, dental and veterinarian services were incorporated.[42]

Civilian War Casualty Program. As the Vietnam conflict became more violent and expansive, the Department of Defense was tasked to provide care for civilian casualties of the war. As a result, the Civilian War Casualty Program (CWCP) was established, and it began operating in earnest in late 1967. The original concept was to build two separate systems: one for civilian Vietnamese patients and one for U.S. military patients. However, this eventually merged into a "joint occupancy" system rather than entirely separate CWCP hospital systems.[43]

Consolidation of the programs streamlined construction and evacuation coordination, and allowed civilians to have treatment closer to their homes. Eventually, all Vietnamese military hospitals and civilian hospitals merged into a common system, thus providing a better system of care for all of Vietnam.[44]

End State

As discussed in the introduction, advisory efforts and the medical portion of the strategic counterinsurgency were working well before the Tet Offensive in 1968. Reports touting the amount of vaccinations given, the numbers of patients seen, or other metrics all measured input into an evaluation of a medical system. While a measure of disease reduction is an outcome, in American reports it was often measuring the results of U.S. efforts. Any truly effective counterinsurgency stability operations program must measure the outcomes derived from the host nation. The student must show the teacher that he has mastered the subject. Instead of reporting the number of classes taught to ARVN medics, the real measure is how many patients were treated and evacuated by those ARVN medics. The bureaucracy of MACV and the U.S. Army seemed to only measure effectiveness by the quantity of "inputs" during a six- to twelve-month officer evaluation report. The lag time from an academic theory of effectiveness to real-world application may be longer than a twelve-month tour.

What happened? In 1975, the Republic of Vietnam fell despite having received years of advice and material aid. In hindsight, the previous 1st Division, IV Corps, and the last I Corps commander, Lt. Gen. Ngo Quong Troung remarked, "The advisory effort should have endeavored first to bring about an effective command, control, and leadership system for the ARVN before trying to improve the combat effectiveness of small units."[45]

As revealed in a critique of the adviser role of U.S. personnel in Vietnam, part of the Indochina Monographs series, former senior RVNAF officers wrote that U.S. advisers did remarkable work. However, the inability to instill motivation and leadership into the officer ranks ended up reflecting the political regime plaguing the struggling country and ultimately led to its end.[46] Those

former senior leaders in the RVNAF (chairman of the Joint General Staff; commander of the 1st Infantry Division, IV Corps, I Corps; chief of intelligence; commander of the Central Logistics Command; and Joint General Staff Chief of Staff, to name a few) praised the tough mission accomplished by U.S. advisers:

> The success of giving advice or receiving it is an art that depends a great deal on personal virtues and the individual's approach to human relationships. Professional competence and experience did not always make a good adviser if he was not at the same time a man of tact and good manners. Irascibility and haughtiness would not solve problems, but only make them worse. The key to success depended on flexibility, restraint, and understanding. A good adviser was neither too passive nor too aggressive. He would accomplish little if he waited for his counterpart to come to him for advice and only provided it when asked. On the other hand, if by overzealousness, he flooded his counterpart with a cascade of problems, real or imagined, and aggressively told him to do this and that or tried to do everything by himself, his good intentions would be defeated. For unmeasured aggressiveness sometimes gave a counterpart the impression that he was being spied on or under scrutiny or surveillance. His self-preservation instincts would prevent him from cooperating wholeheartedly or worse, push him into rebellion and he would refuse to cooperate and let the adviser do it all.[47] ■

The views expressed in this article are those of the author and do not reflect the official policy or position of the U.S. Army Medical Department, the Department of the Army, the Department of Defense, or the U.S. government.

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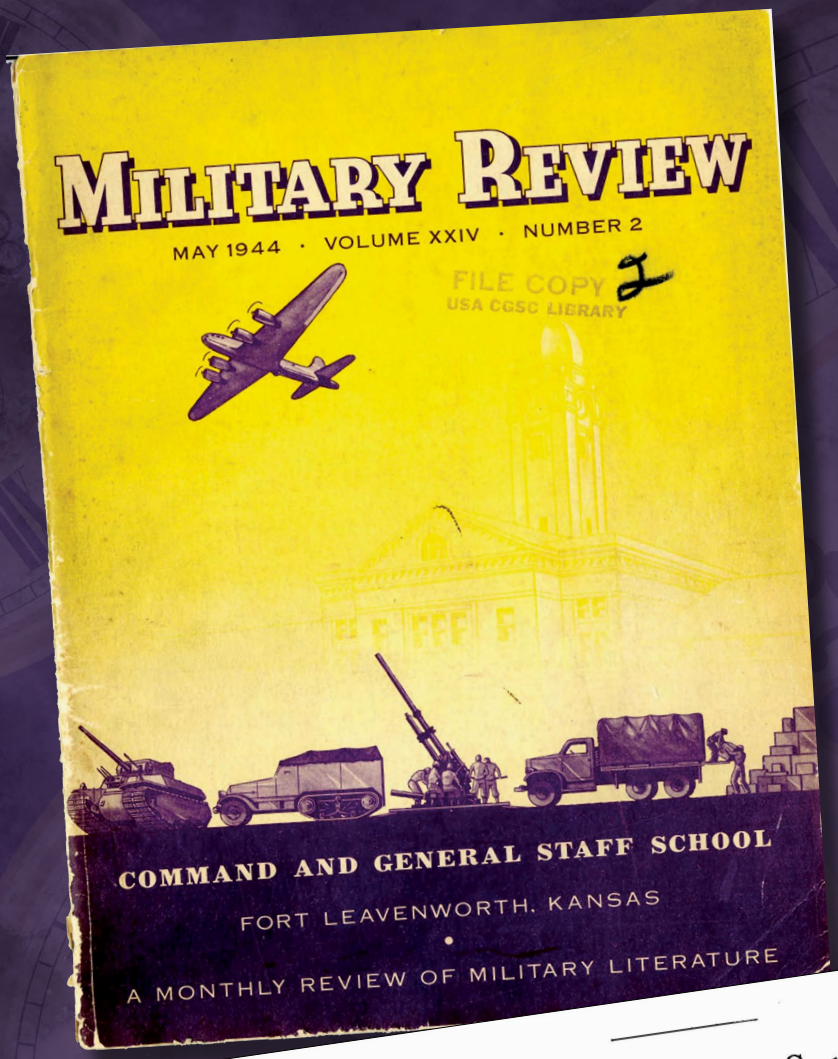

A Look Back in Time

During periods of conflict, *Military Review* has often been used as a venue to pass along lessons learned from the field, especially through the medium of short entries. The featured short extract below provides insights and recommendations to field surgeons deploying to the war in Europe during World War II. To view the entire May 1944 edition of *Military Review*, Volume XXIV, Number 2, visit http://cgsc.contentdm.oclc.org/cdm/singleitem/collection/p124201coll1/id/1138/rec/9.

Hints for Battalion Surgeons

A MEDICAL officer, battalion surgeon for an artillery battalion in Italy, writes:

SUPPLIES

"Bring from the States an ample supply of practical, everyday drugs, especially cough syrups, gargles, adrenalin, and coramine in 1-cc ampules. If you can manage it, keep them in a chest with a large flat top and doors opening outward, which will be handy not only to store them in but to facilitate their transportation and immediate access to them. An electric otoscope and hot water bottles are worth bringing.

"Get plasma as soon as possible. It is invaluable, as are the morphine Syrettes.

TRAINING

"Training at home should emphasize that the functions of an aid station in the field are identical with those of a dispensary in garrison. Train personnel to give immunizations; it will save valuable time. Practice moving around at night in blackout so that strangeness and fear of dark are eliminated.

LOCATION OF AID STATION

"Battalion Surgeons will find that a personal reconnaissance of forward positions is essential.

"The aid station must be located as close to all batteries as possible. This eliminates long litter carries and the waste of valuable time. A house should be used as a station if possible but don't pick one the enemy will think is a CP or OP. Tents are impractical in a forward position. Setting up a station in a vehicle is unsatisfactory because of vulnerability to shell fire and lack of space. Proximity to a road we find is the most valuable adjunct to an aid station.

THE AID STATION IN ACTION

"We feel our treatment here in the forward area should anticipate definitive treatment later and should prepare the patient as much as possible along those lines.

"X-ray all patients injured by flying bodies. Apparently slight wounds have revealed the presence of foreign bodies at a distance from the point of penetration.

"Be ultraconservative in the initial treatment of all battle casualties when in a position where an evacuation hospital or surgical group can be reached within one to two hours.

MISCELLANEOUS

"Telephone communications to the gun batteries and CP are essential.

"Excellent lighting can be obtained from a 'Sealbeam' headlight and a vehicle battery. Coleman lanterns are unatisfactory because of lack of 'white' gasoline. Kerosene lanterns can be used as night lights, but kerosene is relatively scarce."