# *MEDICAL CARE IN THE PACIFIC THEATRE, WWII*

The war against Japan was fought in an area that covers roughly one-third of the Earth's surface, from Burma to Hawaii and from Alaska to Australia. In 1942, outside of Australia and New Zealand, port facilities were primitive at best. Unloading was slow; storage was difficult because of the damp climate and tropical heat; and wounded and sick evacuees endured long and difficult journeys. In this island world, medical supplies, like everything else, moved only by sea or air.

Until the very last months of fighting in the Pacific Theatre in WWII, the US Medical Department faced immense obstacles – supply lines were tenuous and environmental conditions almost intolerable, malaria epidemics broke out, medical planners faced logistical difficulties, diseases took their toll, medical support often broke down, amphibious medical evacuation had to be revised.

However, new methods of preventive medicine were created, logistics were improved, and recent drug discoveries were now provided on a large scale, such as penicillin, Atabrine, and DDT. The ultimate lesson, however, lies in the flexibility of spirit and organization shown by medical personnel, who were able to save lives and improve general health conditions during those years of bitter and unrelenting struggle for peace; in those harsh times the Medical Department successfully maintained the "fighting strength of the Army."

***THE BIGGEST THREAT: DISEASE AND MALARIA***

Disease was a major threat to conserving fighting strength and enabling armies and navies to defeat the enemy in WWII. Among the commonest diseases were those spread by poor water supplies and inadequate waste disposal, especially the various forms of dysentery. The incidence of venereal disease and yaws (related to syphilis but spread by non-venereal contact, occurring mostly in rural areas) depended to a great extent upon the health of the civilian population and the opportunities for fraternization. Unwashed skin, high humidity, and contact with infected natives led to bacterial and fungal infections. Hookworm disease could result from contact with infected earth. None of these diseases were normally fatal, but all could put soldiers out of action as effectively as if they'd been wounded in combat.

Malaria is a mosquito-borne infectious disease caused by the Plasmodium parasite that attacks the red blood cells and liver of the infected person. The warm and humid climate of the Pacific islands provided ideal conditions for mosquito breeding, making malaria a common and persistent problem. When the mosquitoes feed on an infected person, they become carriers of the parasite, and then deposit the disease in the bloodstream of another person when they fed again, thus causing a chain reaction, as each new person became a carrier through which more mosquitoes could pick up the disease, and in turn, infect additional victims.

Malaria can have a long-lasting effect on the infected. American soldiers encountered two different types of disease in the Pacific Theatre of Operations: benign, which causes violent chills, fever, and weakness, and malignant, a form more likely to cause death. If left untreated or mismanaged, it could progress to more severe forms, such as cerebral malaria, which could result in coma and death.

During the early Pacific campaign to subdue the Solomon Islands, malaria caused more casualties than Japanese bullets. Following the initial landings on Guadalcanal, the number of patients hospitalized with malaria exceeded all other diseases. Some units suffered 100% casualty rates, with personnel sometimes being hospitalized more than once.

According to the U.S. Army Heritage and Education Center, about 24,000 of the 75,000 American and Filipino soldiers involved in the campaign to stop the Japanese advance in 1942 were suffering from malaria.

Starvation and disease were two of the most significant contributions to the huge mortality suffered by Japanese forces. Inadequate supplies of rice and other foodstuffs was a contributing factor to the starvation, along with the

**FIGURE 2.** Japanese military physician examining a malaria patient at a prisoner-constructed hospital on Muschu Island, Papua New Guinea, October 1945. Malaria was a major cause of illness in surrendered soldiers who had spent the last year of the war in the Sepik River basin. *Australian War Memorial (AWM) photo 098342 now in the public domain.*

fact that the New Guinea jungle had few edible plants except the sago palm, which required considerable labor to extract its protein-poor starch. Many men ate snakes, rates, and grass. Disease, particularly malaria, was also major concern for the Japanese forces, due to the lack of any suppressive medications; malaria killed more Japanese soldiers than battle injuries as the Allies took progressively larger offensive steps towards Japan. Sick

men with fevers often took their own lives rather than risk capture or a slow death alone in the jungle.

The ease with which malaria spread wasn't the only problem combat soldiers faced. Because they were more concerned with fighting, many soldiers weren't using proper mosquito repellent or weren't sticking to the strict antimalarial pill regimens. Cases were reported where individual soldiers often dumped their antimalarial pills because they thought of them only as a "useless inconvenience."

Quinine, derived from the bark of the cinchona tree, was the preferred medicine used by the U.S. Army for treating malaria; however, during WWII all sources of natural quinine were in the hands of the Axis powers. A synthetic drug called quinacrine, marketed under the brand name of Atabrine, became the main drug used to fight malaria, although it came with many unpleasant side effects.

Another measure to fight malaria was the spraying of the insecticide dichloro-diphenyl-trichloroethane, more commonly known as DDT.

It was impossible to completely stop the spread of malaria, and in the end between 60-65% of American troops in the South Pacific reported contracting the disease at some point. However, when DDT was combined with the effective use of Atabrine and other measures against the mosquitoes, it was found that malaria rates could be reduced up to 70% from what had been seen in the early stages of the war.

Other medical solutions aimed at preventing and treating malaria were implemented with varying degrees of success. Troops were educated about personal protective measures to reduce mosquito bites; these included the use of bed nets, wearing long-sleeved clothing, and taking precautions during peak mosquito activity times, such as dusk and dawn. Research and development efforts by both the Axis and Allied forces led to finding better drugs and more effective mosquito control.

While these measures helped reduce the incidence of malaria to some extent, the disease remained a persistent challenge during the war.

*Port Dispensary Tent on Biak Island, New Guinea, Aug 44.*

***CARING FOR CASUALTIES***

The military's top priority was to organize its medical services to care for battlefield casualties, make them well, and return them to duty. In all Theatres of war, but particularly in the Pacific, both the Army and Navy faced their greatest challenge dealing with the aftermath of intense, bloody warfare fought far from fixed hospitals. This put enormous pressure on medical personnel closest to the front and forced new approaches to primary care and evacuation.

Many of the combat medics went unarmed, reserving their strength for carrying medical supplies. If unable to triage the patient immediately, they might commandeer a litter team to move the casualty out of harm's way and on to an aid station, etc., for further treatment. This care would mean stabilizing the patient with plasma, serum albumin, or whole blood. In some cases, the casualty was then evacuated. Other casualties were taken to a divisional hospital, where doctors performed further stabilization including surgery, if needed.

CHAIN OF EVACUATION, 1943-1945

***Aidman/Medic***

The front line of the whole medical operation was known as the aid man or medic. The aidman, although assigned to the battalion medical section, served with the line companies and gave first aid to the injured. The medic was not a trained physician, but he had extensive Army training in first aid. During boot camp the medics were sometimes subjected to ridicule by their gun-toting fellow grunts, but things changed in combat. Then the lowly medic was universally beloved by the soldiers.

The medic was the guy who lanced and patched up the blisters. He gave aspirin for head colds and watched over the purity of his unit's drinking water. Cartoonist Bill Mauldin called him "the private soldier's family doctor." In combat he was the one expected to come to the rescue of his wounded comrades under fire. The pained cry of "Medic!" brought him on the run. It was the rapid response of the medic and his litter bearers under hazardous conditions, administering first aid, applying tourniquets, injecting pain-killing morphine, and rushing a casualty from the front to the rear hospitals that was responsible for saving many lives.

***Aid Station***

The battalion aid station, the first medical installation reached by a casualty because of its location near the front line, treated shock and provided minor surgery, dressing for wounds, and relief from pain.

The battalion surgeon, aid station personnel, and company aidmen together formed one of the three battalion sections of the regimental medical detachment. A separate battalion, however, had its own medical detachment.

***Collecting Company/Collecting Station***
In World War II the division surgeon commanded the division's medical battalion. Each of the battalion's three collecting companies was designed to support one regiment or regimental combat team. A collecting company evacuated casualties from forward aid stations, and a collecting station, which the company ran, provided additional first aid, plus oxygen and whole blood, and formed a regimental holding unit for casualties until they could be taken to the rear. Sometimes a collecting station and a portable surgical hospital worked together, with the hospital stabilizing the seriously wounded for evacuation.

***Clearing Company/Clearing Station***
Also part of the medical battalion was the clearing company. The clearing station that it operated was, in effect, a small forward hospital, providing fairly complex treatment and informed prognosis, on which further disposition of the casualty was based. In the Pacific clearing companies often functioned as small field hospitals, because most battles were small and hospital units might be absent from the task force or remote from the fighting line. Here again, a portable surgical hospital might work nearby.

***Portable Surgical Hospital (PSH)***
Unique to the Pacific Theatre of Operations, they were the operational forbearers of the larger, more robust Mobile Army Surgical Hospital (MASH units). With a capacity of 25 beds, this small unit was developed in Australia and later adapted to provide skilled surgical care in jungle fighting during the Papuan campaign. Still later, it was attached to task forces to provide early frontline surgical care in amphibious operations. In theory, hospital equipment and supplies were to be carried on the backs of the thirty-three soldiers and four officers who formed the unit. The portable might be attached to a regiment, a division, or an army, depending on circumstances.

These spartan PSH tents were set up to accommodate major surgery, sometimes so close to the front that they were under fire from the enemy. They retreated or advanced rapidly with the fortunes of war. A staff of a fully equipped PSH could disassemble and load tents, equipment, and personnel onto waiting trucks within two hours. When trucks proved unavailable or impracticable, pack mules or porters were used. PSHs were flown over the Owen-Stanley Range with the troops to participate in the battle of Buna. PSHs proved so successful that they were duplicated in every Theatre of war where Americans fought and they were an important link in the human chain that carried wounded soldiers from the battlefront back to the home front.

*Interior view of a patients' ward, 7th PSH, Soputa, New Guinea. A row of makeshift cots lines one side of a hospital tent. One serviceman stands above another who lies under a blanket on the cot.*

***Field Hospital***
Attached to a division or corps, the 380-bed (later 400-bed) field hospital was intended to be highly mobile and to concentrate on the early care of casualties. Located whenever possible within a few miles of the front line, the field hospital was a highly flexible unit that could be broken down into its component platoons, each of which, if strengthened with surgical teams, might operate as an independent small hospital.

***Medical Group***
A headquarters that organized field army medical units—separate medical battalions and field hospitals, in the main—for operational and administrative purposes, a medical group controlled evacuation to the rear of the divisions and all evacuation of non-divisional units serving under a field army.

***Evacuation Hospital (Semimobile)***
Larger and more difficult to move than the field hospital, and intended to care for 250–400 casualties (though some held up to 2,000 when fighting was heavy and/or evacuation failed), this unit primarily was utilized for the care of the seriously injured or ill designated for evacuation to large hospitals in the rear. There was also a 750-bed hospital, but it was not semimobile.

***Station Hospital***
A fixed hospital of 25–900 beds, corresponding to a post hospital in the United States, provided highly skilled care in medicine and surgery both to casualties evacuated from the combat zone and to garrison troops stationed in its vicinity. The great variation in size reflected the fact that a station hospital might serve anything from a small islet to a major base.

***General Hospital***
The last stop in the chain of evacuation, this large fixed installation of 500–1,000 beds provided the best available care and specialized treatment for all types and classes of casualties. The general hospital was authorized to evacuate patients to the United States for additional care or discharge.

***Hospital Center***
Indefinitely expandable, the hospital center was a collection of general hospitals operating under a single headquarters. Component hospitals normally specialized in the care of one or more types of disease or injury.

***Convalescent Hospital***
This unit was either a station or general hospital devoted to preparing for duty soldiers who had recovered from illness or wounds but were unready to resume full duty status. Those who reached a convalescent hospital were already on their way back to a line or support unit; normally, their next stop would be a replacement depot, outside the medical system.

***Ship and Air Evacuations***
In the Pacific, where sailors, soldiers, and marines were doing the fighting, both Navy and Army hospital ships, employed mainly as ambulances, provided first aid and some surgical care for the casualties' needs while ferrying them to base hospitals in the Pacific or back to the United States for definitive care. As the war continued, air evacuation helped carry the load. Trained army and navy nurses, medics, and corpsmen staffed the evacuation aircraft.

***Returning Home***
The final link in the chain of wounded men flowing back from the front was the arrival home. The Army Medical Department did not see its job as complete when severely wounded men arrived stateside. Men newly blind, deaf, or with loss of limb needed rehabilitation. Hospitals and vocational programs were set up and staffed for the thousands who required additional help in retraining for civilian life.

Today, the programs of the Veterans Administration are taken for granted and even expected for wounded soldiers. They were innovations of the 1940s, and thousands of men went through rehabilitation.

***THE RED CROSS***
The Pacific Theatre held many dangers for medical personnel. The famed Red Cross symbol used by all doctors and medics was not one that the Japanese regularly treated with respect. Japan had not signed the Geneva Convention before the war and did not feel obligated to abide by the international rules of conduct toward medical personnel.

The easily recognized red and white emblem of the International Red Cross was no guarantee of safety. Medics and litter bearers were killed and maimed on every front. American medical crews quickly learned to smear mud over the red and white symbol emblazoned on their tents, helmets, and trucks to prevent themselves from being more of a target than they already were. In New Guinea, American doctors attached to the PSHs were given target practice with M-1 carbines when some of their noncombatant colleagues were killed by the enemy.

In the 1940s during World War II, the American Red Cross enrolled 7.5 million volunteers along with 39,000 paid staff and more than 104,000 nurses for military service, prepared 27 million packages for prisoners of war, shipped more than 300,000 tons of supplies, and collected 13.3 million pints of blood plasma for the armed forces. By the time World War II ended in September 1945, American society contributed over $784 million in support of the American Red Cross.

***MEDICAL IMPROVEMENTS***
WWII brought about many advances in medicine. The military moved quickly to reduce the impact of malaria and other tropical diseases. Personnel were trained in preventive medicine to control malaria-spreading mosquitoes by spreading oil on breeding areas and spraying DDT. Physicians, medics, and corpsmen dispensed quinine and Atabrine as malaria suppressants.

Battlefield medicine improved throughout the course of the war. At the beginning, only plasma was available as a substitute for the loss of blood. By 1945, serum albumin had been developed, which is whole blood that is rich in the red blood cells that carry oxygen and is considerably more effective than plasma alone.

During the war, surgery techniques such as removing dead tissue resulted in fewer amputations than at any time. To treat bacterial infections, penicillin or streptomycin were administered for the first time in large-scale combat.

Also, this was the first major war in which air evacuation of the wounded became available.

Service members with combat fatigue, which later became known as post-traumatic stress disorder (PTSD), were given a safe place to stay away from battle zones with plenty of food and rest. This resulted in about 90% of patients recovering enough to return to the fight.

Service members were also inoculated with vaccinations for smallpox, typhoid, tetanus, cholera, typhus, yellow fever and bubonic plague, depending where they were sent.

Other improvements during World War II included improved crash helmets, safety belts, flak jackets and other preventive measures.

## *MEDICAL CARE (continued)*

Because of improvements like these and others, the survival rate for the wounded and ill climbed to 50% during World War II from only 4% during World War I, according to Dr. Daniel P. Murphy, who published a paper on “Battlefield Injuries and Medicine.”

If the Army Medical Department has a legacy, it is that the advancement of patient care and rapid response to injury during WWII that also led to improved peacetime medical care.

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## *FLIGHT SURGEONS*

The term "flight surgeon" originated in the early months of 1918 when the U.S. Air Medical Service of the U.S. Army collaborated with two civilian aviation organizations—the Aero Club of America and the Aerial League of America—to manage problems of medical screening and standards for U.S. military aviators.

The original intent was for the military and the Surgeon General to understand what was causing the high flight mishap rate. Shortly after the appointment of the first flight surgeons, research and experience led to a dramatic improvement in aircrew health as well as a significant raising of the entry medical standards for all aircrew. The early flight surgeons found that the Army's practice of assigning officers to flight duty who were not physically qualified for infantry or cavalry duty was improper. Because of the G-forces, risk of spatial disorientation, and risk of hypoxia encountered in the aviation environment, among other challenges, early flight surgeons found that aviation personnel must be scrupulously healthy and well trained in the basics of aerospace physiology.

During WWII, the head of the U.S. Army Air Forces, General of the Army Henry 'Hap' Arnold, directed all flight surgeons in the Army Air Forces to fly regularly with their patients in order to better understand the aviation environment. Consequently, to this day, their successor U.S. Air Force Flight Surgeons are considered "aeronautically rated" aircrew members who receive flight pay and who are required to fly a certain number of hours monthly. The same policy applies to Army Flight Surgeons and to Naval Flight Surgeons, the latter who are considered "aeronautically designated" officers like their Naval Aviator and Naval Flight Officer counterparts.

Strict racial segregation during WWII in the U.S. Army required the development of separate black flight surgeons to support the operations and training of the Tuskegee Airmen in 1941 and continued in the U.S. Army Air Forces throughout WWII. Following the establishment of an independent U.S. Air Force and the racial integration of all the U.S. armed forces following WWII, this separation was discontinued.

*Source: https://en.wikipedia.org/wiki/Flight_surgeon*

# *380TH MEDICS*

***528th MEDICAL SECTION***

Flight Surgeon: Butts, William S.
Surgical Technicians:
Bruckner, Fred J. (To GP Oct 44, From GP Aug 45)
Gill, Samuel J.
Zelkovich, Anthony J. (To GP Oct 44)
Medical Technicians:
Kalocotronis, Aristides H. (To GP Oct 44)
Murray, Walter D. (To GP Oct 44)
Medical Section Leader: Kokes, Emanuel R.
Medical NCO: Young, Eugene
Other Medical Staff:
Cookson, Walter B. (Unspecified)
Hallifield, Bert W. (Medic/Aidman) (To GP Oct 44)
Manca, Dominick A. (Medic) (From GP Aug 45)

*529th Medics at Manbulloo-- Rear: Robert Tyrell, Gordon Weimer, Capt William E. Hubbard, Chester Lindner, Waldon Robertson; Front: Floyd Imm, Albert Lally, Edward Strange, Esko Hester.*

***530th MEDICAL SECTION***

Flight Surgeons: Garron, Levon K. (also in GP)
Wilson, Nathaniel D.
Surgical Technicians: Kamley, Edward R.
Medical Technicians: Finlay, Edward R. (To GP Oct 44)
Miller, Ivan R. (To GP Oct 44)
Raby, Claude E. (To GP Oct 44, From GP Aug 45)
Medical Section Leader: Coker, Dalton K.
Medical NCO: Young, Eugene (To GP Oct 44)
Medics/Aidmen: Crobar, Floyd F.
Haught, Joseph H. (To GP Oct 44)
Hocker, David R.
Other Medical Staff:
Stephens, Hayden C. (Clerk) (To GP Oct 44)
Morrison, Elmer E., Jr. (Dental Technician)

*529th Medics-- Kneeling: Cpl Anthony J. Zelkovich, S/ Sgt Emanuel R. Kokes. Standing: Capt William S. Butts, PFC Walter B. Cookson, Sgt Bert W. Hallifield, Sgt Fred J. Bruckner, PFC Walter D. Murray.*

***529th MEDICAL SECTION***

Flight Surgeon: Hubbard, William O.
Medical Section Leader: Imm, Floyd A.
Surgical Technician: Pareut, Douglas P. (To GP Oct 44)
Medical Technician: Tyrell, Robert A. (To GP Oct 44)
Medical NCO: Manca, Dominick A. (From GP Aug 45)
Pabst, Leo M. (Supply) (From GP Aug 45)
Other Medical Staff (Nurses, Aidmen):
Hester, Esko (To GP Oct 44)
Linder, Chester E. (To GP Oct 44)
Other Medical Staff (Clerks and Unspecified):
Lally, Albert A.
Martinez, Fernando, Jr. (To GP Aug 45)
Robertson, Waldon J. (To GP Sep 45)
Strange, Edward R.
Weimer, Gordon T.

*530th Medics-- Kneeling, L-R: Capt Wilson, Sgt Young, Cpl Hocker; Standing, L-R: Cpl Kamley, Sgt Stephens, Cpl Morrison, Sgts Raby and Crobar.*

*Photo Sources: 380TH "BLUE BOOK" pp. 134, 145, 154*

## 380TH MEDICS (continued)

***531st MEDICAL SECTION***

Flight Surgeons: Glass, Irving A.
Surgical Technicians: Bothwell, James A. (To GP Oct 44)
Gribble, Jollie M. (To GP Oct 44)
Medical Technicians: Duffy, Robert W. (To GP Oct 44)
Medical NCO: Manca, Dominic A. (To GP Oct 44)
Poe, Howard A. (To GP Oct 44, From GP Sep 45)
Medics/Aidmen: LaVasseur, Edward A. (To GP Oct 44)
Plein, John P.
Quenden, William A.
Roth, Howard L. (To GP Sep 45)
Other Medical Staff:
Baker, Joseph P. (Sanitation Tech)
Bowen, John P. (Practical Nurse)

***GROUP HEADQUARTERS MEDICAL STAFF***

Group Flight Surgeons: Garron, Levon K.
Lyman, Richard W.
Still, Oscar W.
Medical Technicians: Finlay, Edward R. (From 530 Oct 44)
Kalocotronis, Aristides H. (From 528 Oct 44)
Murray, Walter D. (From 528 Oct 44)
Poe, Howard A. (From 531 Oct 44, To 531 Sep 45)
Raby, Claude E. (From 530 Oct 44, To 530 Aug 45)
Robertson, Waldon J. (From 529 Sep 45)
Tyrell, Robert A. (From 529 Oct 44)
Medical NCOs:
Manca, Dominic A. (From 531 Oct 44, To 529 Aug 45)
Pabst, Leo M. (Supply) (To 529 Aug 45)
Young, Eugene (From 530 Oct 44)
Surgical Technicians: Bothwell, James A. (From 531 Oct 44)
Bruckner, Fred J. (From 528 Oct 44, To 528 Aug 45)
Gribble, Jollie M. (From 531 Oct 44)
Pareut, Douglas P. (From 529 Oct 44)
Medics/Aidmen: Duffy, Robert W. (From 531 Oct 44)
Haught, Joseph H. (From 530 Oct 44)
Hester, Esko (From 529 Oct 44)
Hallifield, Bert W. (From 528 Oct 44)
LeVasseur, Edward A. (From 531 Oct 44)
Linder, Chester E. (From 529, Oct 44)
Miller, Ivan R. (From 530 Oct 44)
Roth, Howard D. (From 531 Sep 45)
Tyler, Clarence E.
Other Medical Staff: Jones, Robert J.
Martinez, Fernando, Jr. (From 529 Aug 45)
Stephens, Hayden C. (From 530 Oct 44)
Zelkovich, Anthony J. (From 528 Oct 44)

## MOS USED IN THE 380TH

Any military unit of the size of a World War II Heavy Bombardment Group requires a very large number of different personnel skills among its approximately 8,000 personnel. This is particularly so when the unit must serve in an isolated area far from its sources of supply and assistance from other related military units. Such was the 380th Bomb Group which served in the Northern Territory of Australia, New Guinea, and The Philippines (Mindoro) during World War II.

Fortunately, the United States Army had foreseen the need for such capability and had instituted an elaborate personnel classification and training system to supply such a need. The occupational skills and specialties needed have been recorded as MOS/SSN numbers (Military Occupational Specialties/Service Specialty Numbers) and are described in a series of Army Regulations and Technical Manuals.

For the Medical Department Division, these are their MOS listings (a * besides the entry indicates that that MOS was used in the 380th)

***OFFICERS***

3160 Aviation Medical Examiner
3161 Air Force Staff Surgeon *
3162 Flight Surgeon *

***ENLISTED***

067 Dental Laboratory Technician
072 Physical Therapy Technician
123 Nurse, Male, Practical *
196 Sanitation Tech *
250 Veterinary Technician
263 Psychiatric Social Worker
264 X-Ray Technician
303 Hospital Orderly
405 Supply Clerk Typist *
409 Medical Technician *
652 Medical Section Leader *
657 Medical Aidman *
666 First-Aid Man
673 Medical NCO
825 Medical Supply NCO *
855 Dental Technician *
858 Medical Laboratory Technician
859 Pharmacy Technician
861 Surgical Technician *

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## *380TH FLIGHT SURGEONS' STORIES*

10 June 1943
On board the *Steinmetz*, headed to the N.T., the daily routine of ship life was interrupted by a medical emergency which challenged the skills of 529th Flight Surgeon, Capt/Dr William E. Hubbard. Sgt Phillip Silverman of the 529th's S-2 Section came down with appendicitis. Hubbard performed the necessary surgery with typical aplomb and had the patient transferred off ship when they docked in Brisbane.

Dr. William Hubbard, 529th Flight Surgeon
*Howard R. Williams Collection*

22 June 1943
The voyage across the Gulf of Carpentaria was interrupted by an Australian sailor, stricken with appendicitis. His corvette pulled alongside the *Steinmetz* and transferred the man to the care of Capt/Dr Hubbard. Still basking in the fame of his most recent sea surgery, he performed this second appendectomy with equal skill. During the halt mandated by the surgery, the 380th men revved up the ship's few anti-aircraft guns and scanned the skies for possible raiders. Surgery completed, the voyage resumed as most men finished packing their gear in preparation for a fast disembarkation at Darwin.

*Source: Horton, BEST IN THE SOUTHWEST, pp. 30, 37*

*T/Sgt Tom Carter being visited by Eleanor Roosevelt while convalescing from his broken leg sustained on 3 August 1943 over Manokwari. Thomas Carter Collection.*

*Source: Horton, BEST IN THE SOUTHWEST, p. 68*

Dr. Irving Glass
*Howard R. Williams Collection*

17 January 1944
Capt/Dr Irving Glass, 531st Flight Surgeon, received a Soldier's Medal for his efforts (with other 531st members) to search for survivors of the crash landing of 42-41236 (take-off engine trouble), which hit 42-41219 (SACK TIME), and was destroyed by 42-41248 (BEBE).

21 September 1944
Thanks to the first aid class given by Capt/Dr Glass on 20 September 1944, two members of the Brasfield (86) crew (bombardier Donald Haven and navigator Stephen Resko) were able to save fellow crew members during a strike mission to Laha when a shell exploded near 42-73799 (MALE CALL) which caused injuries to the waist gunners Edward North and Clarence Newton.

*Source: Horton, BEST IN THE SOUTHWEST, pp. 152, 265*

7 August 1943
While treating wounded men, it was discovered that morphine was missing from the plane's First Aid kits. Without pain killers, the wounded men suffered through the remainder of the long flight home. The pilot, Wilbur L. Morris (530th), elected to land at RAAF-Darwin instead of Fenton. The injured were off-loaded and taken to the base hospital while the remainder of the crew refueled and returned to Fenton.

During their de-briefing, the men reported the missing morphine to Capt/Dr Levon Garron, the 530th Flight Surgeon, who told his 528th counterpart, Capt/Dr William Butts, about the problem and jointly they ordered all Fenton aircraft to be inspected. Many were found to be missing their morphine. All remaining narcotics were then removed from the aircraft with the intent of denying the addict his needed access to the drug. New orders were issued which specified the morphine would be given to flight crews as they departed for their planes. In less than a week, the flight surgeons identified their addict. A 530th co-pilot developed severe withdrawal symptoms and was relieved of his duties. The man was then transferred back to the U.S.

*Source: Horton, BEST IN THE SOUTHWEST, pp. 67-68*