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AUTHORITY

AGO ltr 29 Apr 1980

HEADQUARTERS
3D SURGICAL HOSPITAL (MOBILE ARMY)
APO US FORCES 96227

22 April 1966

SUBJECT: Operational Report on Lessons Learned for Quarterly Period Ending 30 April 1966, Reports Control Symbol CSGPO-28 (R1)

TO: Assistant Chief of Staff for Force Development
Department of the Army
Washington, D.C. 20310 (ACSFORDA)

1. Significant Organizational Activities.

a. The 3d Surgical Hospital (Mobile Army) is composed of 86 enlisted men and 33 officers. The mission of the hospital is to perform basic resuscitative surgery and emergency life-saving measures in preparing patients for further evacuation to the rear. In order for the hospital to carry out its mission, it is divided into major sections, namely: Pre-Operative, Surgery, Post-Operative, Holding, Pharmacy, Laboratory & X-Ray, Admission & Disposition, Central Material Supply, plus its administrative sections and supply.

b. During this reporting period, the 3d Surgical Hospital (Mobile Army) played a major role in support of war operations of three of the major combat elements in the Republic of Vietnam. These were various search & destroy operations conducted by the 173rd Airborne Brigade (SEP), the 1st Infantry Division and the 25th Infantry Division. Also during this reporting period, the 3d Surgical Hospital (Mobile Army) operated in two areas of Vietnam, namely Bien Hoa and Ban Me Thuot, Republic of Vietnam, some 200 miles north of Saigon. Latter sections of this report will cover this breakdown in detail.

(1) The weather itself continues to be a problem daily facing the troops. Adjustment to the climate of Vietnam continues to be a major task, especially now that the hospital personnel are beginning to rotate, and the new replacements arrive. During this period, the monsoons were replaced by the hot dry, dusty days. Small flying particles of dust and dirt have continued to plague the sanitary operations of the hospital. Few effective ways, other than constant watering or oiling, have been found to solve or lessen this problem.

(2) The unit personnel continue to be in a training status. All personnel of the unit are involved in an on-the-job training program. Since there has been an approximate 25% of turnover in the unit strength (due to ETSs) this continues to be a most important aspect of the hospital operations. Also during this period, the unit's nursing personnel experienced a changeover. As of (27 February 1966) the unit's nursing slots were all filled by male nurses. This made the 3d Surgical Hospital (Mobile Army) an all-male unit and was necessitated by the unit's deployment which will be covered in another section.

c. During this quarterly reporting period, the unit's activities can be most effectively described and dealt with according to three definite and distinct time periods. The three periods are as follows: 1 January 1966 through 28 February 1966, 28 February 1966 through 3 April 1966, and 3 April 1966 to the present.

(1) In the first period of time, the 3d Surgical Hospital (Mobile Army) continued to be deployed in the Bien Hoa Area. Construction on the semi-permanent jungle structures continues at a slow pace but some progress has been made. Currently the hospital sections are all housed in the semi-permanent jungle structures, with the exception of the Pharmacy, Laboratory and X-Ray section. This section building is nearing completion, and movement of the section into the new building should be accomplished within a few weeks. Construction is currently being delayed due to lack of sufficient material to construct the required X-ray facilities.

(2) From the previous reporting period until 22 February 1966, the 3d Surgical Hospital (Mobile Army) was engaged in direct support of units in the Bien Hoa Area. Major support roles were performed for the 173rd Airborne, the 1st Infantry Division, and the 25th Infantry Division. During this period, a constant daily flow of patients passed through the hospital. Wounds ranged from minor fragment wounds to traumatic amputations of both legs. During this period, the hospital personnel received valuable on-the-job training in all aspects of patient care.

(3) The housing situation has also improved. Tent dwellings are being replaced by cement-floored semi-permanent jungle structures. Currently, six such structures are completed and occupied and six others are in the process of being completed. Moving into these semi-permanent structures has greatly enhanced the overall morale and performance of the unit. It is expected that by mid-May the entire unit will be billeted in these structures.

d. On 20 February 1966, the 3d Surgical Hospital (Mobile Army) Headquarters received orders from VOCG, MACV to cease all in-patient operations as of 1200 hours 20 February 1966. By 1200 hours, 22 February 1966, all patients had been evacuated through channels and the hospital was temporarily inactivated per VOCG Headquarters, MACV. The purpose of this action was to enable the unit to enter a readiness state for an air-load movement to a destination then unknown. During the week of 21 February 1966, the unit engaged in an intensive preparation period for movement. Some twenty trucks (2½ Ton) with trailers were completely loaded with hospital TOE equipment and prepared for movement. The hospital personnel packed only the minimum necessary personal equipment, loaded it onto one 2½ ton truck and stored all other personal effects.

(1) On 27 February 1966, the go ahead was received from 68th Medical Group. The next morning, 28 February 1966, the unit moved out via road convoy and arrived at Bien Hoa Airbase at 0600 hours to await further transportation. Shortly thereafter, the unit was shuttled via six U.S. Air Force C-130s, to its new operational site.

(2) After twenty shuttle flights via the C-130s, the complete unit arrived at its new site at Ban Me Thuot, Republic of Vietnam, some 200 miles north of Saigon. The entire unit worked diligently and within twelve hours from the first C-130s takeoff at Bien Hoa, the unit was completely set up and operational under canvas at Ban Me Thuot.

e. This was the beginning of the period 28 February 1966 to 3 April 1966 in which the unit was to be operational at Ban Me Thuot, Republic of Vietnam. It was during this operation that the mobility phase of the MASH hospital was tested completely. The unit quickly and effectively grasped the situation and fully proved it was not only mobile, but air mobile as well.

(1) During this period, the 3d Surgical Hospital (Mobile Army) was in direct support of Operation Garfield, a clearing operation conducted in the Ban Me Thuot Area by the 3rd Brigade of the 25th Infantry Division.

(2) From 28 February through 7 March 1966, the unit was located at Ban Me Thuot East Air Strip. On 7 March 1966, the 25th Infantry Division's 3rd Brigade moved further north, and thus necessitated a move by the 3d Surgical Hospital (Mobile Army) to nearby Ban Me Thuot City, a more secure area.

f. It was here at Ban Me Thuot that the unit was to receive the bulk of its work. In addition to supporting the 25th Infantry Division, a large scale Civic Action Program was set up. While here, in addition to

U.S. Troops, the unit treated a variety of foreign nationals including Viet Cong Prisoners, Army Republic of Viet Nam Troops and Montagnard Tribesman. The unit was kept busy administering to the numbers of patients that were brought in through this program by the Special Forces personnel. The professional staff was faced with many challenging problems under this program. All in all, the unit gained many hours of valuable experience and Operation Garfield was an overall success for the unit.

g. On 3 April 1966, orders were received per VOCO 43rd Medical Group, our immediate higher Headquarters at Nha Trang, that the unit was to cease operation and prepare once again for movement. Two days later, 5 April 1966, the unit pulled out and convoyed via road to Ban Me Thuot East where once again the U.S. Air Force C-130's went into action. At approximately 1000 hours, the first aircraft left. Due to an aircraft shortage, the remainder of the unit did not close into our home base at Bien Hoa until 8 April 1966. However, as of 1800 hours 7 April 1966, the 3d Surgical Hospital (Mobile Army) was again fully operational at Bien Hoa.

h. Since this date, the 3d Surgical Hospital (Mobile Army) is once again housed at its original home station, Bien Hoa. Once again it is in direct support of the 173rd Airborne Brigade (Separate) and the Big Red One 1st Infantry Division. During this quarterly period, the 3d Surgical Hospital (Mobile Army) has truly been faced with a test of its mobility. In its direct support of Operation Garfield, it has proved that it can quickly and efficiently tear down, set up and be fully operational within a minimum of time. Its personnel were faced with a large challenge and through their drive and dedication met and won this challenge. It can be stated that this unit is truly 100% mobile and able to proceed into full operation quickly and efficiently.

2. Lessons Learned.

a. Discussion: Although the 3d Surgical Hospital (Mobile Army) is rated as 100% mobile this is not so in terms of the TOE. Modest augmentation of the TOE in vehicles, tentage and cots effectively made this unit 100% mobile. The TOE does not provide for transportation or billets (other than shelter halves) for the personnel.

b. Observation: Augmentation of the TOE by three (3) 2½ Ton trucks and three (3) 1½ Ton trailers, nine (9) GP large tents and 120 cots effects 100% mobility to a MASH Hospital.

SUBJECT: Operational Report on Lessons Learned for Quarterly Period Ending 30 April 1966, Reports Control Symbol CSGPO-28 (R1) 22 April 1966

3. Commanders Recommendations.

a. Supporting air operation in a relatively remote area (Ban Me Thuot) has brought to light several problems. Aeromedical evacuation of patients from the combat zone to a forward hospital is enormously efficient and successful. Evacuation of patients from the forward hospital to the rear was in general unsatisfactory.

b. Neurosurgical and eye wound patients require immediate evacuation to either Qui Nhon or Saigon (at the present time). From many areas in Vietnam this constitutes a prohibitive turn around time for medical evacuation helicopters. These patients probably tolerate helicopter travel poorly. Attempting to divert fixed wing aircraft was rarely successful within the time frame of an immediate priority. Evacuation of priority post operative patients was rarely accomplished within the specified time frame due to aircraft commitments.

c. Personnel from the hospital accompanying patients on evacuation flights were delayed as much as four (4) days in returning to the unit for lack of available air transportation. Whole blood shipment to the hospital was on occasion responsive to aircraft availability and not to need.

d. Personnel travel for personnel actions, R & R, leaves and passes was impractical due to relative isolation. Mail delivery was sporadic. These latter situations had a deciding undermining effect on morale. Communications with our higher headquarters was poor and in some forseeable future operations could be nil.

e. In spite of (and because of) the burgeoning requirements for fixed wing aircraft in unconventional warfare I submit that it is time to consider fixed wing capabilities within the medical evacuation and support framework. One fixed wing aircraft (an Otter or larger) under operational control of medical brigade or group would have alleviated 95% of the problems encountered. In future larger scale operations I anticipate these problems to persist and be even more acute.

FOR THE COMMANDER:

JAMES C. WARD, JR.
1st Lt, MSC
Registrar

3

(22 Apr 66) 1st Ind
SUBJECT: Operational Report on Lessons Learned for Quarterly Period Ending 30 April 1966, Reports control Symbol CSGPO-28 (R1)

HEADQUARTERS, 68TH MEDICAL GROUP, APO U. S. Forces 96227, 9 May 1966

TO: Commanding Officer, 44th Medical Brigade, APO U. S. Forces 96307

1. Forwarded in compliance with 1st Logistical Command Regulation 870-2, 1965.

2. The following are considered significant lessons learned by Medical Group observations of the operation of a Surgical Hospital, Mobile Army, in support of counterinsurgency warfare in tropical South East Asia.

a. Generator capacity provided by current TO & E 8-571E, (Total 45 KW) is insufficient to provide power for operation in semi-permanent buildings in a tropical climate. Refrigeration, fans, air-conditioning, ice-making equipment all represent power drains which are essential for high quality medical care. If these resources are provided, as they are now being provided in Viet Nam, the total power consumption will approach 100 KW. For sustained operation two generators of 100 KW capacity are recommended.

b. Air conditioning can be medically fully justified for surgery and intensive care wards by reducing perspiration contamination of sterile fields, by permitting effective exclusion of dust and insects; by permitting effective building black out; by reducing physiological heat load problems of the surgically draped patient; by easing the heat load problems of malaria and other febrile patients; and by quickly healing skin rash conditions due to heat. Air conditioning is not required for non-critical, non-febrile and heat acclimatized military patients, who are maintained in comfort even in plaster casts if electric fans are provided. Prolonged stay in air conditioned wards is undesirable for the soldier who will return to duty in country, because his heat acclimatization may be diminished dangerously. Air conditioning and the generators to power it should constitute a tropical augmentation to the TO & E for the Surgical Hospital, Mobile Army.

c. The comments regarding vehicles required to render the TO & E equipment fully mobile should be expanded upon. In addition to canvas and cots for housing assigned personnel, this unit deployed with 15 days of expendable supplies as determined by their experience to date in Viet Nam. This expendable load constituted some of the bulk which required a total of 17 trucks (2½ ton) as compared to the TO & E authorization of 14 trucks. The expendable load contains large amounts of plaster of paris, bandage, and intravenous fluids which are both heavy and bulky. 15 day level of expendable supplies for a Surgical Hospital supporting active combat is shown in inclosure 1, based on experience obtained during period of this report.

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SUBJECT: Operational Report on Lessons Learned for Quarterly Period Ending 30 April 1966, Reports Control Symbol CSGPO-28 (R1)

d. Medical Tactical Considerations: When sited at Bien Hoa this hospital was frequently no farther than 10 minutes flying time from the point of wounding, and it was only another five minutes to an evacuation hospital (93rd Evac Hosp Long Binh), and 15 minutes to a Field Hospital (3rd Field Hospital, Saigon, vicinity Tan Son Nhut). This compressed casualty evacuation chain, when expressed as helicopter flying time, has meant that the contribution of the 3rd Surgical Hospital as a site for forward immediate life saving surgery of the non-transportable patient has been somewhat blunted. It is too close to other facilities with equal surgical capabilities. This was not the case when it shifted to Ban Me Thout. Here it had a clear field without competition. It now appears that for the coming months military operations will consist of brief helicopter borne and ground movement of brigade sized forces for relatively brief sweep and destroy operations lasting from a few days to a few weeks. In the later portion of this reporting period operations such as Abilene, Austin I, Garfield, and Birmingham have included the temporary establishment of a logistical base, usually an air head, which has been the location of division clearing station(s). It has been concluded that whenever such a logistical base or point of wounding is more than 15 minutes flying time from a hospital then a forward surgical capability should be established at the division clearing element. This capability has been provided to date by:

(1) Reinforcing the division medical company by temporary attachment of surgeons and/or anesthetists as required to enable surgery to be done. (Less than one full team) Airlift-one or two seats.

(2) Attaching a Surgical Team (team KA) to division clearing platoon. (one table capability) Airlift-one caribou ~~with~~ (CV-2) load.

(3) Attaching a composite team from the 3rd Surgical Hospital and other units which contains two teams (able to run two tables) and which can be packed in three 3/4 ton trucks with trailer. Airlift-three loads C-123.

(4) Attaching the entire Surgical Hospital, as in Operation Garfield. Airlift-20 C-130 loads. Of these four levels of re-inforcement of division level medical service, #1 & #2 are appropriate when the supported force consists of one to three combat battalions; #3 seems appropriate for one or two brigades; #4 seems too heavy and unwieldy for anything less than a full division in a prolonged operation. Alternative #3 is expected to prove of high utility in the next 6 - 12 months in Viet Nam, if there is no quantum jump in the rate of wounding.

SUBJECT: Operational Report on Lessons Learned for Quarterly Period Ending 30 April 1966, Reports Control Symbol CSGPO-28 (R1)

3. The following specific comments are keyed to paragraphs of the basic report:

a. Para 1d:

(1) "Inactivated" is incorrect. The hospital was relieved of its patient care mission in order to pack for movement.

(2) Prior to moving it was necessary to reconstitute the unit's basic TO & E equipment. Vehicles and tentage had been loaned to other units. The necessary equipment was quickly found in parallel units and laterally transferred. It is hoped that in the future the hospital will be so equipped that one set of necessary apparatus will be ready to load, while duplicates are in daily use. Then the hospital should be ready to move in the time required to dispose of its patients--six to eight hours should be a feasible time for an experienced unit to pack.

(3) The hospital loaded the following vehicles for its air transported move from Bien Hoa to Ban Me Thout.

2½ ton trucks	17	
1½ ton trailers	10	
Water Truck 1000 gals.	1	
Water Trailer 250 gals.	1	
3/4 ton Ambulances	2	(attached)
3/4 ton truck	1	
3/4 ton trailer	1	
*¼ ton truck	1	
*¼ ton trailer	1	
15 KW Generators on trailer	3	

*Advance party also took one ¼ ton truck with ¼ ton trailer.

b. Para 3: This Headquarters strongly supports the recommendation for assignment of fixed wing aircraft to Headquarters, Medical Group or Headquarters Medical Brigade to move casualties, supplies, and medical personnel over distances more than 45 minutes helicopter flying time. The greatest contribution of the medical gas turbine helicopter is its quick extraction capability so emphatically demonstrated to date in Viet Nam. Many successful helicopter evacuations have been made under enemy fire. These aircraft have totally usurped the task formerly done by litter bearers and front line ambulances in former combat. They have seldom been unable to perform their task because of darkness or weather. Jungle terrain difficulties will be overcome to large degree when a suitable winch for hoisting a litter through the jungle canopy is available on Army medical helicopters.

3.

SUBJECT: Operational Report on Lessons Learned for Quarterly Period Ending 30 April 1966, Reports Control Symbol CSGPO-28 (R1)

To exploit these capabilities the helicopter must remain forward, moving casualties from point of wounding or battalion aid station to division clearing companies. To also require medical helicopters to move patients more than 30 minutes flying time to supporting hospitals is probably uneconomical. Since clearing stations are normally sited at air-heads movement to Army level hospitals by small fixed wing aircraft would be frequently feasible. The Otter is probably of suitable size and economy for Army level aero-medical tasks. An allocation of one aircraft per Medical Group is considered appropriate to tasks now being experienced in Viet Nam.

Richard F Barquist

RICHARD F. BARQUIST
Lt Col, Medical Corps
Commanding

1 Incl Added
as

Cy Fowarded :
ACofSFD, DA, Wash, D. C.

Fifteen day consumption of expendable supplies for a Surgical Hospital in support of active counter-insurgency actions in Vietnam, 1966.

Stock No.	Item Description	15 Day Level
4720-141-9080	Tubing	6
6505-023-6481	Isoproterenol	12
6505-055-5716	Lidocaine	48
6505-074-4702	Diphenoxylate	18
6505-074-4582	Quinine Dihydrochlorde	45
6505-147-1820	Tetracaine	36
6505-153-8809	Lubricant	11
6505-153-8818	Tetracaine	20
6505-153-8225	Ether	96
6505-153-8515	Soda Lime	60
6505-116-1890	Dextran	72
6505-153-8651	Sodium Chloride Inj.	50
6505-299-8615	Ringers Inj.	50
6505-113-9310	Chloroquine Phosphate	6
6505-201-1261	Diphenhydramine	3
6505-299-8014	Chloroquine	125
6505-263-3362	Phenylephrine	10
6505-261-7251	Propylhexedrine	18
6505-116-4600	Dextrose Injection 5%	50
6505-116-5000	Dextrose Sodium Chloride Inj.	50
6505-237-8468	Undecylenic	12
6505-299-8123	Benzalkonium	5
6505-299-8740	Bacitracin	19
6505-299-9496	Levarterenol	5
6505-299-8608	Oxytetracycline	6
6505-299-9475	Tubocararine	3

Inch #1

Stock No.	Item Description	15 Day Level
6505-299-9505	Potassium-Chloride	144
6505-116-1740	Detergent	48
6505-559-8456	Sodium Chloride	24
6505-687-7901	Ethoheptazine	2
6505-582-4209	Sodium Diatrizoate	1
6505-721-8899	Hydroxyzine	6
6505-660-1798	Benzonatate	12
6505-656-1612	Pot. Phenoxymeth Pen.	24
6505-579-8432	Heparin	24
6505-720-9680	Succinylcholine	30
6505-543-4048	Water Injection	144
6505-680-2433	Tetanustoxoid	36
6505-680-2787	Antivenin Kit	6
6505-550-8464	Meprobamate Tablets	9
6505-598-6116	Lidocaine 1%	28
6505-660-1601	Metho Carbamol	18
6505-597-5843	Chlorpromazine	94
6505-584-3280	Promethazine	33
6505-890-1575	Tetracycline	3
6505-753-9601	Metaraminol	6
6505-890-1496	Prednisolone	5
6505-890-1420	Chlorpheniramine	6
6505-854-2499	Phytonadione	30
6505-687-4482	Terpin Hydrate	12
6505-958-1719	Calcium Chloride	144
6505-999-0562	Mannitol	12

Incl #12

Stock No.	Item Description	15 Day Level
6505-753-4956	Streptomycin	48
6505-890-2172	Pot. Pen. G.	600
6505-890-1574	Tetracycline	36
6505-753-9609	Hydrocortisone Sodium	33
6505-753-5043	Chloroquin-Primaquine	6
6505-967-8735	Propoxyphene	6
6505-889-9033	Bisacodyl Supposiyories	22
6505-890-1574	Tetracycline Hydrochloride	108
6505-754-0280	Chloramphenicol Sodium Succinate	66
6505-890-1658	Calcium Carbonate	2
6505-782-2662	Quinine	12
6510-063-1896	Strip Fat, USP	36
6510-063-1897	Cellulose	3
6510-200-2400	Bandage Cotton 4"	45
6510-200-2500	Bandage Cotton Elastic	48
6510-200-6000	Bandage Gauze Roller	12
6510-074-4579	Gause Cellulone	3
6510-200-3035	Bandage Felt Ortho 4 in.	30
6510-200-3040	Bandage Felt Ortho 6 in.	30
6510-200-5000	Bandage Gauze Roller 3 in.	12
6510-201-2009	Plaster of Paris 6 in.	16
6510-203-8480	Pad Gauze Surg 4X8 in.	100
6510-210-2001	Plaster of Paris 3in.	22
6510-245-0078	Plaster of Paris	66
6510-372-5100	Splints Leg Half	25
6510-200-2185	Bandage	4
6510-200-5000	Gauze	2

Incl #3

12

Stock No.	Item Description	15 Day Level
6510-200-6000	Gauze	2
6510-582-7943	Bandage	24
6510-634-7079	Ball Gauze	12
6510-559-3221	Gauze	.160
6510-582-7993	Gauze	2
6510-203-8448	Pad Gauze Surgical 4" X 4"	60
6510-597-2361	Plaster of Paris 4 in.	60
6510-890-1371	Plaster	7
6515-378-7100	Suture	4
6515-333-3100	Forceps	12
6515-387-4180	Tube	60
6515-371-3100	Sphygmomanometer	3
6515-342-6850	Intravenous	75
6515-299-8356	Catheter Urethral Rubber	12
6515-307-4220	Catheter	1
6515-299-8679	Catheter	13
6515-664-2334	Blood Collection	24
6515-663-1561	Cannula	24
6515-616-9450	Suture	24
6515-616-9454	Suture	24
6515-890-1621	Catheterization Set	48
6515-999-0035	Syringe Bag	1
6515-754-2660	Foot Rest	20
6515-817-1203	Tube Duodenal	6
6515-817-2547	Tube Drainage	3
6515-616-9447	Suture Absor Surg	27
6515-754-0426	Blade Safety Razor	100

Incl #1

Stock No.	Item Description	15 Day Level
6515-982-5077	Foley Catheter Sterile	20
6515-616-9455	Suture Absor Surg.	8
6515-890-1628	Catheterization Pack	4
6515-754-0412	Syringe 10cc	16
6515-890-1540	Syringe 2cc	26
6515-954-0406	Syringe 5cc	10
6515-754-2836	20 Ga. Needle 1½in. 100's	150
6515-754-2834	18 Ga. Needle 1½in. 100's	90
6515-575-2839	23 Ga. Needle 3/4 in. 100's	60
6530-065-9598	Pad, Bed	4
6530-663-1556	Pin, Safety	34
6530-299-9812	Tubing Sterilization Plastic	2
6530-299-9821	Tape Pressure	90
6532-790-1020	Slippers	96

Tool # 16

AVLC-MB-PO (22 Apr 66) 2nd Ind
SUBJECT: Operational Report on Lessons Learned for Quarterly Period Ending 30 April 1966, Reports Control Symbol CSGPO-28 (R1)

HEADQUARTERS, 44TH MEDICAL BRIGADE, APO US Forces 96307 25 May 1966

TO: Commanding General, 1st Logistical Command, APO US Forces 96307

1. Concur with observations and recommendations as set forth in basic letter and 1st indorsement, with the following exceptions:

a. Reference: para 3, 1st indorsement. It is recognized that fixed wing aircraft have a definite place in the chain of medical evacuation on an on-call basis and have been utilized on several tactical operations in Vietnam. The present policy for requesting in-country fixed wing evacuation from division/brigade clearing to the supporting hospital is through the USARV Surgeons Office. Two (2) types of aircraft are available, the Army Caribou and the Air Force C-123, to date all requests have been honored.

b. It is the opinion of this headquarters that the solution to overcoming the distance problem, as well as full utilization of meager resources in the aviation field, is the establishment of a medical air ambulance detachment of Chinook helicopters. These helicopters can accomodate 24 litters and/or a large quantity of cargo. They can be used from both fixed air fields or LZs that cannot take fixed wing aircraft. The speed and radius of action is superior to the UH-1 aircraft (helicopter) and almost equals that of the Army Caribou fixed wing. This is in keeping with the current Army policy of converting almost exclusively to helicopter type aircraft.

2. To date the air ambulance units have received 13 hoists. Litter hoisting devices are presently arriving in-country for field evaluation for the two (2) air ambulance companies.

FOR THE COMMANDER:

Byron L. Evans

BYRON L. EVANS
1st Lt, MSC
Adjutant

AVLC GO-H (22 Apr 66) 3rd Ind
SUBJECT: Operational Report on Lessons Learned for Quarterly Period Ending 30 April 1966. RCS CSGPO-28 (RI)

HEADQUARTERS, 1ST LOGISTICAL COMMAND, APO US Forces 96307 17 JUN 1966

TO: Commanding General, United States Army, Vietnam, ATTN: AVC (HIST) APO US Forces 96307

1. Forwarded in accordance with AR 525-24 and USARV Circular 870-1.

2. Concur with the comments as set forth in basic letter and 2nd indorsement.

FOR THE COMMANDER:

GLENN A. DOYLE
Col, AGC
Asst. AG

16

17

AVC-DH (22 Apr 66) 4th Ind
SUBJECT: Operational Report on Lessons Learned for Quarterly Period Ending 30 April 1966, Reports Control Symbol CSGPO-28 (R1)

HEADQUARTERS, UNITED STATES ARMY, VIETNAM, APO San Francisco 96307

THRU: Commander in Chief, United States Army, Pacific, ATTN: GPOP-MH APO 96558

TO: Assistant Chief of Staff for Force Development, Department of the Army, Washington, D.C. 20310

1. This headquarters concurs with the 3d Surgical Hospital (Mobile Army) Operational Report on Lessons Learned as indorsed, with the following remarks.

2. Reference paragraph 3b: With proper coordination through medical command and control, both Army and Air Force fixed wing patient evacuations have been timely and efficient. Prior coordination must be effected to have a workable system.

3. Reference paragraph 3c: Both medical attendants and whole blood have been moved with dispatch and have received the highest priority, to include the use of COMUSMACV's personal aircraft when other aircraft were not available.

4. Reference paragraph 3e: The Army Medical Service has in the past and will in the future, have priority for use of fixed wing aircraft. Doctrinally, these are under operational control of the appropriate command surgeon while performing air evacuation. Continuing shortage of logistical aircraft in Vietnam precludes permanent standby or attachment of fixed wing aircraft to medical units.

5. Reference 1st Indorsement, paragraph 3b: The assignment or attachment of long haul aircraft to the medical service is desirable and would be of benefit both for patient movement and emergency medical resupply. The capability for both frontline pickup by tactical helicopter and long haul by either fixed or rotary wing aircraft, would enhance the responsiveness of the medical service to patient needs. This will depend on availability of Army aircraft and require reorganization of the AMEDS air ambulance service.

FOR THE COMMANDER:

[illegible]
1LT AGC

1 Incl
nc

GPOP-MH (22 Apr 66) 5th Ind
SUBJECT: Operational Report on Lessons Learned for Quarterly Period Ending 30 April 1966, Reports Control Symbol CSGPO-28 (R1)

HQ, US ARMY, PACIFIC, APO San Francisco 96558 2 AUG 1966

TO: Assistant Chief of Staff for Force Development, Department of the Army, Washington D.C. 20310

1. The Operational Report on Lessons Learned of the 3d MASH for the period 1 January - 30 April 1966 is forwarded herewith.

2. The ORLL is basically a good report, while the 68th Medical Group's 1st Indorsement provides an outstanding additional contribution that reflects both thought and effort.

3. This headquarters concurs in the basic ORLL as modified by the preceding indorsements.

FOR THE COMMANDER IN CHIEF:

D. A. HARRISON
Capt, AGC
Asst AG

1 Incl
nc

UNCLASSIFIED
Security Classification

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