Army Health System Support in the Forgotten Theater: China-Burma-India, 1942-1944

A Monograph

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This study is a critical examination of Army Health System support in the China-Burma-India (CBI) theater from 1942-1944. In CBI, the Theater Surgeon was tasked with two primary missions: to train and equip the Chinese Army's exhausted and ill-equipped medical units and to enable the Northern Combat Area Command's (NCAC) combat operations in northern Burma. Presenting each mission as a case study, this paper seeks to answer the question of how effectively the Army Medical Department supported the attainment of the United States' political and military objectives in CBI. The study concludes that the Medical Department successfully generated a sustainment structure within the Chinese army that, however incomplete, was resilient enough to withstand the rigors of large scale combat. In contrast, while the NCAC's mission to seize Myitkyina was an operational success, the Medical Department's failure to plan adequately for its conduct contributed significantly to an avoidable medical calamity.

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Abstract

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This study is a critical examination of Army Health System support in the China-Burma-India (CBI) theater from 1942-1944. In CBI, the Theater Surgeon was tasked with two primary missions: to train and equip the Chinese Army's exhausted and ill-equipped medical units and to enable the Northern Combat Area Command's (NCAC) combat operations in northern Burma. Presenting each mission as a case study, this paper seeks to answer the question of how effectively the Army Medical Department supported the attainment of the United States' political and military objectives in CBI. The study concludes that the Medical Department successfully generated a sustainment structure within the Chinese army that, however incomplete, was resilient enough to withstand the rigors of large scale combat. In contrast, while the NCAC's mission to seize Myitkyina was an operational success, the Medical Department's failure to plan adequately for its conduct contributed significantly to an avoidable medical calamity.

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Acronyms

ADP	Army Doctrine Publication
AHS	Army Health System
CAI	Chinese Army in India
CAT	Combat Advisor Teams
CBI	China-Burma-India (Theater of Operations)
DNBI	Disease and Non-Battle Injury
LSCO	Large Scale Combat Operations
MAES	Medical Air Evacuation Squadron
NCAC	Northern Combat Area Command
PSH	Portable Surgical Hospital
SEAC	South East Asia Command
SFA	Security Force Assistance
SFAB	Security Force Assistance Brigade
SOS	Services of Supply

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Introduction

> What reached Myitkyina…was not the 5307th [Composite Unit] but a rapidly decomposing corpse. The painful controversies that arose late in May were quarrels about what should be done with the body and whether someone should be tried for murder.
>
> —James Stone, *Crisis Fleeting*

In early 1944, Allied forces launched the first of several campaigns to wrest the country of Burma from Japanese control. Their objective was the city of Myitkyina, a critical communications and logistics hub for Japanese forces in Burma. The 5307th Composite Unit, a specially-trained infantry regiment, spearheaded the advance of two Chinese divisions into the rugged countryside. In the next four months, "Merrill's Marauders" – as the 5307th would become known – advanced over 500 miles on foot, claiming victory in five major engagements against the numerically superior forces of the Japanese 18th Division.[1]

As Allied forces advanced on Myitkyina, the formation began to fracture under the strain of three months of uninterrupted combat. Mounting combat casualties, rampant disease, and exhaustion forced the medical evacuation of nearly 100 Soldiers each day. Of nearly 3,000 Soldiers who began the campaign, only 1,300 Marauders remained for the decisive operation. Following the capture of the Myitkyina airfield on May 17th, the Marauders counted less than 200 Soldiers in their ranks.[2] On May 30th, Lieutenant General Joseph Stilwell, operational commander of American forces, dejectedly noted, "[Only] 12 men left in 2nd Battalion of Galahad. Galahad is just shot."[3] In pursuit of victory, the Marauders had effectively ceased to exist.

The history of the ill-fated Marauders provides a glimpse into the crucible of the "forgotten"

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[1] US Department of the Army, *Merrill's Marauders* (Washington, DC: Center of Military History, 1990), accessed October 30, 2018, https://history.army.mil/books/wwii/marauders/marauders-fw.htm.

[2] Charles Romanus and Riley Sunderland, *China-Burma-India Theater: Stilwell's Command Problems* (Washington, DC: Office of the Chief of Military History, Department of the Army, 1956), 237. Hereafter referred to as Romanus and Sunderland, *Stilwell's Command Problems*.

[3] Joseph W. Stilwell, *The Stilwell Papers* (New York: W. Sloane Associates, 1948), 301.

China-Burma-India (CBI) theater of World War II. In the forbidding environment of north Burma, disease, exhaustion, and Japanese forces all threatened Allied formations in equal measure. Operations across restricted lines of communication posed great risk, jeopardizing the provision of supply, medical treatment, and patient evacuation across the vast, non-contiguous theater. Compounding these environmental challenges, competing strategic priorities and ambiguous command relationships continually jeopardized unity of effort in the campaign, routinely frustrating the development and execution of campaign plans.

Methodology and Organization

This monograph seeks to answer the question of how effectively Army Medicine supported the United States' strategic and military objectives in CBI from their arrival in 1942 through the North Burma Campaign. In support of this aim, this paper introduces the strategic and operational context of CBI, investigates the theater's concept of medical support in historical context, and examines the actions of the theater's medical leadership in relation to their primary missions in theater.

Following an introductory discussion of the CBI theater's context, organization, and leadership, two case studies examine the Army Medical Department's primary missions in CBI: Security Force Assistance (SFA) to the Chinese medical services and provision of Health Service Support (HSS) and Force Health Protection (FHP) to the Northern Combat Area Command (NCAC). Each of these tasks was Herculean in scope, requiring the Army Medical Department to overcome a myriad of organizational constraints and environmental limitations. Considered in the strategic, doctrinal, and geographic context of the era, each case study offers a fair assessment of the Army Medical Department's efficacy in CBI.

Analysis of the case studies presented herein demonstrates that the Medical Department's leadership, specifically the Theater Surgeon and Supply of Services Surgeon, overcame a myriad of obstacles to satisfactorily accomplish their SFA mission. Though ultimately limited in scope,

the medical SFA mission produced a medical sustainment structure that was adequate to endure the rigors of large-scale combat. In contrast, the Theater Surgeon's lack of involvement in operational planning for the northern Burma campaign undoubtedly contributed to the destruction of Merrill's Marauders as a fighting force.

This study concludes by offering several salient lessons for military planners in modern day. First, the American experience in training and equipping Chinese forces provides insight into the challenges of building capacity and fighting alongside coalition forces with immature sustainment structures. Additionally, the case study of Merrill's Marauders demonstrates the inherent medical risk incurred in the conduct of operations along contested lines of communication. Perhaps most significantly, it highlights an operational planner's responsibility to balance medical and operational risk in exigent circumstances. This narrative explores these considerations, ultimately demonstrating the value of integrated sustainment planning as a means to achieve operational success.

Limitations

This scope of this monograph is limited to specifically examine the actions of key US operational and medical leaders in CBI from their arrival in theater through the completion of the North Burma Campaign (1942-1944). Though a supporting operation to the British-led campaign to reclaim Burma in 1945, the campaign was the culminating effort of Chinese and American forces under command of General Joseph Stilwell. In seizing a vital air base at Myitkyina, the campaign dramatically improved the Allied air supply effort to China, enabled the completion of an overland line of communication from India to China, and set the conditions for a broad Allied offensive later that year. The controlled scope of research in this study provides for more comprehensive analysis of two case studies with significant relevance to military planners in current day.

Chapter One: The Forgotten Theater

In January 1942, Japan undertook an aggressive campaign to seize Burma, a small but strategically significant British colony between India and China. After successfully capturing the capital of Rangoon, Japanese forces rapidly advanced a three-pronged offensive north into the heart of the country. In the following three months, Japanese forces successfully advanced over 400 miles to seize the cities of Lashio and Mandalay, both vital economic and transportation centers. This action effectively severed the Burma Road, a critical overland supply route between the port city of Rangoon and China. The defeat quickly turned into a rout as fragments of Nationalist Chinese and British Indian forces divisions hastily retreated to safety across the borders of China and India.

Arriving in Burma in February 1942, Lieutenant General Joseph Stilwell led a small advisory group charged with assisting Chinese forces in defense of Burma. Appointed to serve as Chief of Staff to Chinese leader Generalissimo Chang Kai-Shek, Stilwell nominally exercised command over Chinese armed forces in the defense of Burma. Due to his late arrival to the theater and political disputes over his authority, Stilwell lacked any meaningful capability to prevent the campaign's disastrous outcome.[4]

Shortly after the fall of Mandalay, Stilwell and his small staff joined the Allied retreat from central Burma, marching over 100 miles to the safety of Imphal, a British military post across the Indian Border. The perilous routes were congested with thousands of Indian and Burmese civilians fleeing ahead of the Japanese advance, many of whom died of disease and starvation. Upon arrival to India, Stilwell remarked, "We got a hell of a beating…We got run out

[4] Jonathan T. Ritter, *Stilwell and Mountbatten in Burma: Allies at War, 1943-1944* (Denton, TX: University of North Texas Press, 2017), 25.

of Burma, and it is humiliating as hell. I think we ought to find out why it happened and go back!"[5]

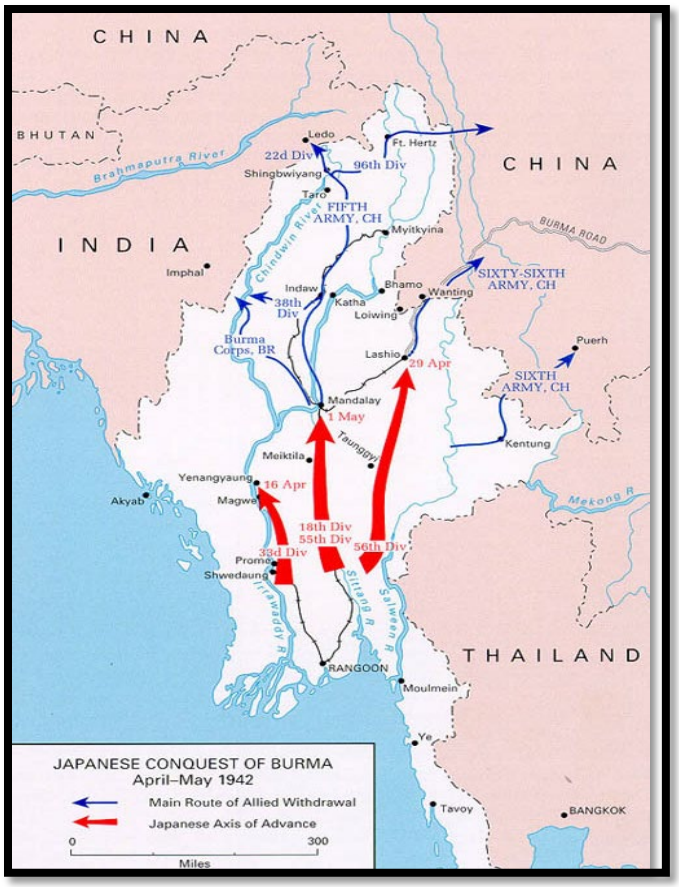

Figure 1: The Allied Retreat from Burma. Map from CMH Pub 70-72, accessed 28 October 2018, https://history.army.mil/brochures/burma42/burma42.htm.

Strategic Context

To appreciate the operational challenges faced by Allied forces in Burma, it is necessary to understand the strategic context of the region in 1942. The loss of Burma, while militarily significant, was overshadowed by concomitant defeats of Allied forces in the Philippines and Singapore in early 1942. Further, while the United States, Britain, and China ostensibly shared the same military objective, their commitment of forces in the region was complicated by

[5] Charles Romanus and Riley Sunderland, *China-Burma-India Theater: Stilwell's Mission to China*. (Washington, DC: Office of the Chief of Military History, Department of the Army, 1953), 143.

divergent strategic interests. Thus, the CBI theater emerged against a strategic backdrop of competing agendas and constrained resources, factors that relegated CBI to its status as an economy of force mission in the war's "forgotten theater."[6]

The United States' involvement in Burma reflected President Roosevelt's hope that China would emerge as a valuable ally in the war against Japan. In support of this goal, the United States provided significant Lend-Lease materiel support to Chiang Kai Shek's Nationalist government. Roosevelt believed that, properly trained and equipped, China's massive army of nearly 300 million soldiers had latent potential to frustrate Japan's military objectives. In support of a broader Pacific strategy, the Chinese mainland also offered a prospective base of operations for a bombing campaign against Japan.[7]

In the immediate aftermath of the retreat from Burma, the US military objectives were two-fold: to re-open a ground line of communication between India and China, and continue to build the capacity of the poorly trained and equipped Chinese military. To accomplish these goals, the initial advisory force of roughly 30 personnel under Stilwell rapidly burgeoned into a multifunctional command that provided supply, training, and airlift capacity for Allied forces in CBI.

Confronted with a loss of a lucrative colonial holding, the British military aim in Burma was to reclaim their lost territory. In context, however, Burma represented only one of many threatened colonies or protectorates of the British Empire. Further, British leaders shared a less favorable opinion of the Chinese than their US counterparts, viewing them as a broader threat to British interests in the region rather than a viable partner in the war against Japan.[8] Thus, while the British initially favored the idea of an amphibious operation to rapidly reclaim the country,

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[6] Williamson Murray and Allan Millett, *A War to be Won: Fighting the Second World War* (Cambridge, MA: Harvard University Press, 2000), 229.

[7] Ibid, 228.

[8] Ibid, 199.

strategic discordance and emerging requirements in North Africa and the Middle East doomed the plan shortly after its inception.[9]

In China, the Nationalist government led by Chiang Kai Shek shared little enthusiasm for offensive operations into Burma. Weakened by Japanese victories and a smoldering campaign against Communist forces on his country's soil, Chiang Kai Shek was hesitant to commit his army to offensive operations elsewhere. Saddled with the offensively-minded Stilwell as the chief interlocutor for the US government, he risked losing access to crucial American fuel and materiel if he failed to participate in the broader Allied strategy.[10] As the war progressed, Chiang Kai Shek begrudgingly supported proposals for offensive operations in Burma, though his reticent approach routinely aroused the ire of Allied field commanders, especially Stilwell.

Allied leaders met several times between 1942 and 1943 to discuss plans for an offensive operation to seize Burma from the Japanese. Amidst competing strategic requirements, the proposed operations consistently failed to gain momentum. For the Americans, opposing schemes for the Pacific theater, advanced by General Douglas Macarthur and Admiral Chester Nimitz, overshadowed the need to invest heavily in Burma. Similarly, British resources were already committed heavily in defense of other colonial holdings and the emergent "Europe First" strategy. Finally, Chinese efforts remained focused on defending their homeland from the Japanese and countering Communist guerrilla threats in a smoldering civil war. Despite the best efforts of the offensively-minded Stilwell, Allied forces would not initiate major offensive operations until late 1943, nearly eighteen months after their inglorious retreat.

Chain of Command

Unlike the major theaters in World War II, CBI never gained designation as an official "theater of operations," and thus never obtained a unified command structure. In 1942, General

[9] Raymond Callahan, *Burma 1942-1945* (Newark: University of Delaware Press, 1978), 128.

[10] Murray and Millett, *A War to be Won: Fighting the Second World War*, 197-198.

Archibald Wavell exercised control of British and Indian forces, while Chinese forces each maintained a separate command hierarchy under Generalissimo Chiang Kai Shek. Stilwell maintained distinct roles in both chains of command, nominally operating as Chiang Kai Shek's Chief of Staff and Chinese Expeditionary Force liaison to the British command. In practice, there was little coordination between the two headquarters, a condition which persisted until the separation of the China and India-Burma theaters in late 1944.

Following the Allied retreat from Burma, the composition and organization of U.S. forces in CBI reflected the United States' strategic effort to sustain and improve the military capacity of the Chinese army. Three organizations aligned under Stilwell's immediate command consisted of the Services of Supply (SOS), the 10th Air Force, and the Ramgarh Training Center. From its headquarters in New Delhi, the SOS assumed responsibility for the theater's supply, engineering and construction, and medical requirements. Due to the loss of ground supply lines in Burma, the 10th Air Force provided resupply to Chinese forces over a perilous Himalayan mountain pass colloquially referred to as "The Hump." Finally, the Ramgarh Training Center served as headquarters for the Allied effort to train and organize three Chinese divisions, known as the Chinese Army in India (CAI).[11]

In October 1943, Allied leaders established the South East Asia Command (SEAC) under the command of British Admiral Lord Louis Mountbatten. The first attempt to build an operational headquarters for all Allied forces in CBI, establishment of the SEAC brought a measure of clarity to the Allied mission. It did little, however, to clarify the role of American forces, who effectively served under both British and Chinese headquarters separated by over 800 miles.[12] Throughout his tenure, Stilwell continued to exercise semi-autonomous control of American forces in theater, further inhibiting potential efficiencies of the command arrangement.

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[11] Romanus and Sunderland, *China-Burma-India Theater: Stilwell's Mission to China*, 220.

[12] Romanus and Sunderland, *Stilwell's Command Problems*, 6.

Thus, control of key resources and infrastructure remained subordinate to "independent national baronies," rather than an integrated Allied command.[13]

Dysfunctional relationships between Stilwell and other Allied leaders further aggravated the challenges beset by the theater's ambiguous command structure and vast, non-contiguous boundaries. US Army Chief of Staff General George Marshall respected Stilwell's tactical acumen, but he conceded that, "[Stilwell was] his own worst enemy."[14] Shortly after his arrival in Burma, Stilwell betrayed his acerbic personality in a diary entry, stating, "[I am] struggling with the Chinese, the British, my own people, the supply, the medical service, etc. Incidentally, with the Japs."[15] As the war progressed, Stilwell chafed at perceived interference from British-led SEAC, and stubbornly refused to cede authority to the "limey" command. As the nominal Chief of Staff for the Chinese Army, he also shared an uneasy relationship with Chiang Kai Shek, for whom he reserved the diminutive moniker of "Peanut."[16] Against this backdrop of dysfunction, Stilwell routinely used the multiplicity of his roles to advance his agenda outside the command structure, rather than synchronize his efforts within it.[17]

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[13] Callahan, *Burma 1942-1945*, 128.

[14] Barbara W. Tuchman, *Stilwell and the American Experience in China, 1911-1945* (New York: The Macmillan Company), 1971, 543.

[15] Stilwell, *The Stilwell Papers*, 137.

[16] Ibid, 212.

[17] Callahan, *Burma 1942-1945*, 125.

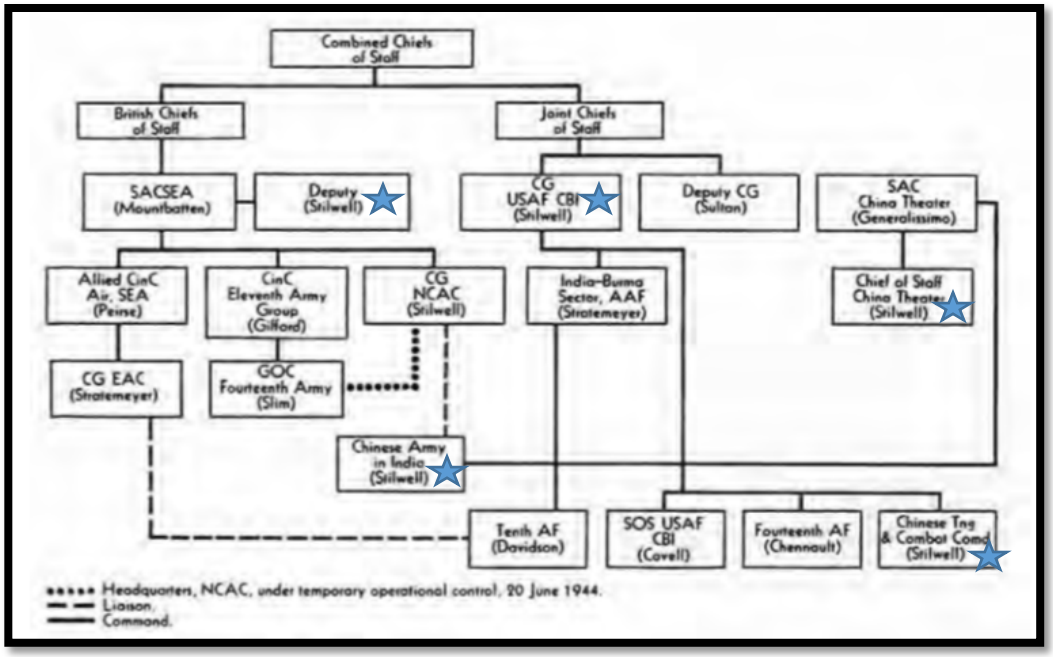

Figure 2: Allied Command Structure in CBI, 1943. The multiplicity of roles held by GEN Stilwell is noteworthy. Figure adapted from Stilwell's Command Problems, accessed 28 December 2018, http://www.ibiblio.org/hyperwar/USA/USA-CBI-Command/charts/USA-CBI-Command-1.jpg.

Theater Organization, Medical Structure, and Leadership

In World War II, theaters of operation were routinely sub-divided into *combat zones* and *communication zones* (rear areas) to facilitate activities of command, logistics, and administration. As dictated by the tactical situation, communication zones were often further arranged into *base*, *intermediate*, and *advance* sections.[18] Mirroring current practices related to unit *areas of operation*, military doctrine provided guidance for the routine realignment of these boundaries amidst changing tactical circumstances.[19]

[18] US War Department, *Field Manual 100-10, Field Service Regulations: Administration* (US Government Printing Office, 1943), 12-15.

[19] US Department of Defense, *Field Manual 3-0, Operations* (Washington, DC: Government Printing Office, 2017), 1-29.

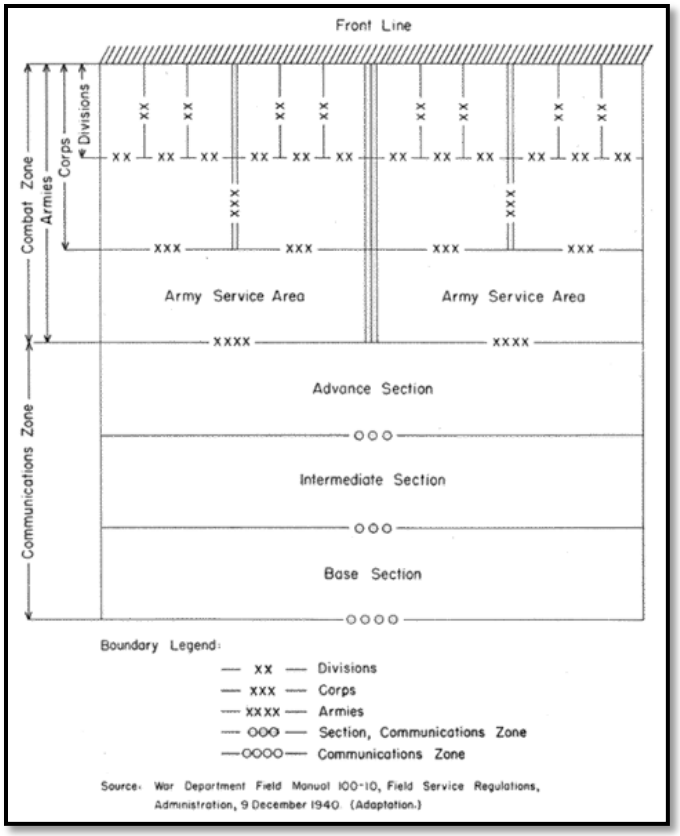

Figure 3: Doctrinal Organization of a Combat Theater in World War II. *Medical Dept. of the United States Army in World War II: Organization and Administration*, accessed 27 December, 2019, https://history.amedd.army.mil/booksdocs/wwii/orgadmin/chart12.gif

In CBI, the communication zone encompassed the entire country of India and the southwestern third of China, bisected by the combat zone in Burma. The primary advance section, located in the northeastern Indian province of Assam, contained roughly half of the theater's fixed medical facilities.[20] On a linear and contiguous battlefield, the doctrinal structure offered a logical transition of command and prioritization of effort between support activities and combat operations. For Allied forces in CBI, however, geographic constraints and dueling command structures blurred the traditional delineations of responsibility, limiting the typical advantages of this organization.

[20] John B Coates, ed., *Surgery in World War II: Activities of the Surgical Consultants*, *Vol. 2*. (Washington, DC: The Office of the Surgeon General, 1964), 899.

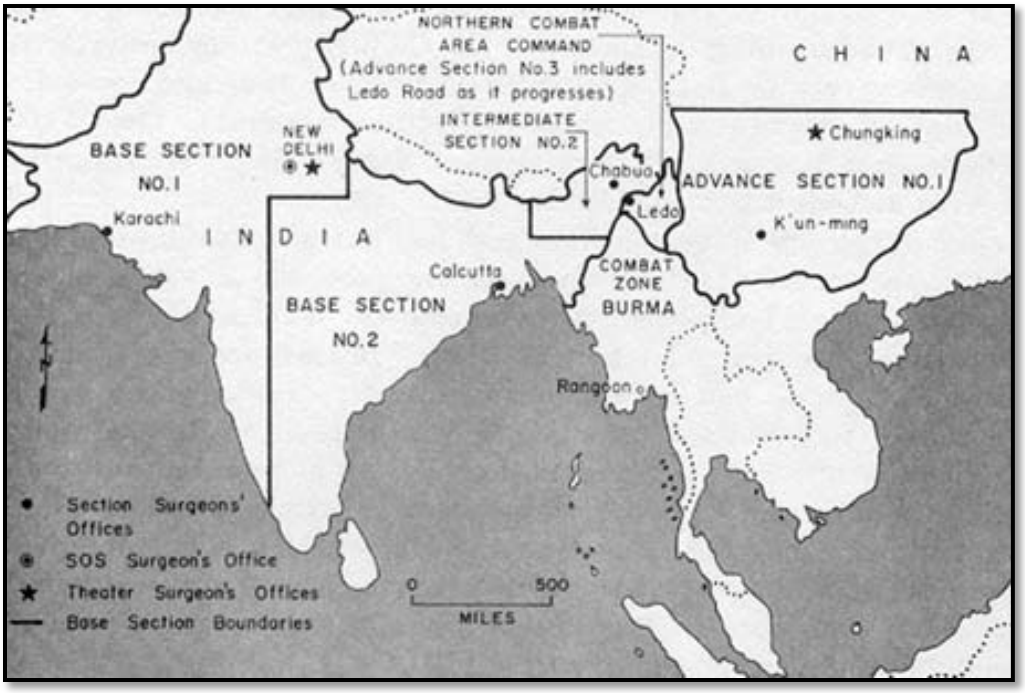

Figure 4: Theater Organization of CBI. Map from *Medical Department of the United States Army in World War II: Organization and Administration*, accessed 28 December, 2019, https://history.amedd.army.mil/booksdocs/wwii/orgadmin/map14.jpg.

Magnifying the dysfunction of the theater's multinational command structure, LTG Stilwell often consolidated traditional missions of the SOS under his theater headquarters in China, over 1500 miles from the SOS headquarters in New Delhi. At one point, General Stilwell maintained four separate headquarters, each of which independently issued orders on his behalf.[21] This organizational structure divided responsibility for a vast array of functions including communications, military police, mail, and preventative medicine, frustrating attempts to achieve a logical unity of effort throughout the campaign.[22]

[21] Blanche Armfield, *Medical Department of the United States Army in World War II: Organization and Administration in World War II* (Washington, DC: The Office of the Surgeon General, 1963), 506.

[22] Romanus and Sunderland, *Stilwell's Mission to China*, 194-195.

Medical Organization in World War II

US Army doctrine in World War II organized medical services in five functional echelons. In the combat zone, *unit* [e.g. battalion or regiment], *division*, and *army* medical services consisted of organic, mobile formations.[23] Similar to the current doctrinal model, tactical unit medical care provided immediate, life-saving medical intervention and staging for further evacuation.[24] At the *division* and *army* level, medical services were augmented by Portable Surgical Hospitals (PSH) (25 beds), Evacuation Hospitals (400 or 750 beds), and Field Hospitals (450 beds) as dictated by the tactical situation to provide a greater scope of medical care.[25] The final two echelons, those of the *theater* and *zone of the interior* (continental United States), contained semi-permanent General (1000 bed) and Station Hospitals (250-1000 bed), each designed to provide definitive and convalescent care for all medical cases.[26]

The medical infrastructure in CBI generally conformed to the doctrinal framework of the era, with two notable exceptions. First, local commanders often resorted to improvisational measures for medical treatment, evacuation, and hospitalization of the wounded. Perhaps the most notable example of this phenomenon was the routine creation of provisional medical units and construction of informal hospitals. These measures, while tactically effective, drained larger

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[23] US War Department, *Field Manual 8-10, Medical Service of Field Units* (Washington, DC: US Government Printing Office, 1942), 1-2.

[24] In current US doctrine, medical treatment and hospitalization echelons are designated Role 1, 2, 3, or 4, with higher numbers indicating increased capability. Role 1 (e.g. Battalion Aid Station) and Role 2 (e.g. Brigade Support Medical Company) generally serve the same purpose as *unit-level* medical formations in World War II. Similarly, Role 3 capabilities (e.g. Combat Support Hospitals, Field Hospitals) are generally analogous to *division* and *army* level capabilities of the era. The nascent concept of Portable Surgical Hospitals often bridged the gap between Role 2 and 3 facilities in the era, similar to the current Forward Support Resuscitative Team (FRST) model. US Department of the Army, *Field Manual 4-02, Army Health System* (Washington, DC: Government Printing Office, 2013), 1-8.

[25] US War Department, *Field Manual 100-10, Field Service Regulations: Administration* (US Government Printing Office, 1943), 64-66, 76.

[26] Ibid, 76-77.

facilities of key personnel, limiting their ability to operate at designed capacity.[27]

The second significant deviation from medical doctrine of the era related to the placement of Evacuation Hospitals. Though designed for mobile employment, the restricted terrain of CBI limited the use of Evacuation Hospitals beyond Ledo, located in the Advance Section of the communications zone on the India-Burma border.[28] Increased use of aerial casualty evacuation mitigated the medical risk of this configuration, however the presence of tactical assets in the SOS area of responsibility further aggravated theater-wide issues of medical mission command.

The Role of the Surgeon

> The medical tangle can be straightened out by the appointment of a strong man to head the service.
>
> —LTG Stilwell, *Stilwell's Mission to China*

The role of the Theater Surgeon was an emerging concept in World War II doctrine. Army Medical Field Manual 8-10 (1942) defined the Surgeon as, "[a] special staff officer charged with keeping the commander informed as to the conditions and capabilities of the medical service…As in the case of any staff officer, the commander may utilize the services of the surgeon in a purely advisory capacity, or he may delegate to the surgeon authority to act in the commander's name, within established policies."[29] This definition provided for a wide degree of interpretation in World War II. As a result, responsibilities of the command surgeon varied significantly across combat theaters.[30]

Colonel Robert Williams assumed the role of Theater Surgeon following the formal organization of CBI in October 1942. A competent administrator and physician, Williams proved

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[27] Romanus and Sunderland, *Stilwell's Command Problems*, 285.

[28] Mary Condon-Rall and Albert Cowdrey, *The Medical Department: Medical Service in the War against Japan* (Washington, DC: US Government Printing Office, 1998), 304-305.

[29] US War Department, *Field Manual 8-10, Medical Service of Field Units*, 11-12.

[30] Blanche Armfield, *Medical Department of the United States Army in World War II: Organization and Administration in World War II*, Foreword.

his worth as one of Stilwell's original staff members in the defense of Burma. Shortly after his arrival in theater, Williams notably requested the assistance of Dr. Gordon Seagrave, an American physician and missionary. Prior to the retreat from Burma, Seagrave, along with his small team of Burmese nurses, managed rudimentary medical facilities along a 300 mile front in support of the entire Chinese 6th Army.[31] Williams' decision proved prescient during the retreat from Burma, when both Major Frank Merrill and Colonel William Holcombe succumbed to heat stroke.[32] The intervention of Williams and Seagrave arguably saved the lives of both men, each of whom would go on to assume critical leadership roles in CBI.[33]

Weeks after arriving in India, Stilwell presented Colonel Williams with a photo with the inscription: "Without Bob Williams we never would have gotten this gang all out alive…and most of them still smiling!".[34] Despite this show of confidence, Stilwell betrayed a lack confidence in Williams, confiding in his diary that the "medical tangle" required the appointment of a "strong man," presumably one other than Williams.[35] Neither officer's personal records offer significant clues about their personal relationship, though the transactional nature of their interactions during periods of crisis suggests that the Theater Surgeon never gained Stilwell's full confidence. In any case, it is clear that Williams' role was never clearly defined in accordance with the doctrinal intent of the era.

Colonel Williams' counterpart in the Supply of Services organization, Colonel John

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[31] Gordon Seagrave, *Burma Surgeon* (New York: W.W. Norton, 1943), 174.

[32] Robert P. Williams, *One Man's CBI*, Robert Parvin Williams Papers, Box no. 1, Hoover Institution Archives, Stanford, CA, 40-42. Hereafter referred to as Williams, *One Man's CBI*.

[33] In 1944, Major Merrill was appointed as Commander, 5307th Composite Unit (Merrill's Marauders); Colonel (Then BG) Holcombe served as Commander of the theater Supply of Services organization.

[34] Robert P. Williams, *Personal Diary of Robert P. Williams*, *No. 3*, U.S. Army Heritage and Education Center, Medical Historical Unit Collection, Personal Papers, Williams, Box 1, 26. Hereafter referred to as Williams, *Personal Diary of Robert P. Williams*.

[35] Romanus and Sunderland, *Stilwell's Mission to China*, 257.

Tamraz, arrived in India in April, a month before the retreat of Allied forces from Burma. As SOS Surgeon, Colonel Tamraz assumed responsibility for the majority of medical operations in the communications zone, including oversight of all army and theater-level medical assets. At the time of his arrival, nearly half of the 1000 American Soldiers in theater were medical personnel.[36] This reality not only reflected the strategic priorities of the American mission in CBI, but also the magnitude of the task that lay ahead for Tamraz and the SOS.

Like Williams, Tamraz was also a competent physician and administrator; however, his personal records betray a discernable indifference to operational matters and latent distrust of the theater leadership. Tamraz dedicated "excessively full day[s] on excessively trivial administrative matters," and his tenure was punctuated by consistent disputes with SOS and theater leadership.[37] In fairness, Tamraz's organization was designed to support rear-echelon logistics, and he had little doctrinal incentive to become directly entwined in combat operations. Unfortunately, the non-contiguous arrangement of medical assets in theater demanded substantial interdependence and integration between the commands, a fact which neither Williams nor Tamraz seemed to fully appreciate. Routinely separated by nearly 2,000 miles, their relationship remained ambiguously defined for the duration of their tenure in theater.[38]

In the early months of 1943, Colonel Williams voluntarily transferred routine administration of the medical service to Colonel Tamraz. Due to the Tamraz's proximity to SEAC Headquarters, Williams believed this action would ease the requisition and movement of medical personnel in theater.[39] This development allowed Williams to focus on the labor-

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[36] Romanus and Sunderland, *Stilwell's Mission to China*, 205.

[37] James H. Stone, ed., *Crisis Fleeting: Original Reports on Military Medicine in India and Burma in the Second World War* (Washington, DC: Department of the Army, 1969), 138.

[38] Condon-Rall and Cowdrey, *The Medical Department: Medical Service in the War Against Japan*, 292.

[39] Williams, *One Man's CBI*, 65.

intensive task of providing for woefully underequipped Chinese forces, but ultimately inhibited his ability to assess how effectively medical assets were postured to support operational requirements in the coming year.

Though his role with respect to the Supply of Services was never codified by the command, COL Williams' personal records suggest that he exercised supervisory responsibility over SOS activities. As a result, Williams and Tamraz often shared responsibilities on the basis of geographic and administrative convenience, rather than doctrinal or delegated responsibility.[40] Confounded by this ambiguous relationship, Tamraz constantly chafed at perceived "interference" from the Theater Surgeon, regardless of the operational necessity of his actions.[41]

In addition to the friction induced by their ambiguous command structure, COL Williams and COL Tamraz were consistently confronted by persistent shortages of medical facilities, personnel, and supplies in CBI.[42] Compounding the persistent resource shortfalls resulting from its low strategic priority, CBI also had to overcome the tyranny of distance as the most geographically isolated theater in World War II. With aviation gasoline and ordnances supplies to China comprising nearly 90 percent of air cargo capacity, a premium should have been placed on the efficient use of remaining assets.[43] Unfortunately, disagreements over the placement of theater medical organizations were quite routine.[44]

The Theater Surgeon's final organizational challenge related to the provision of medical service for the theater's Army Air Forces. The subordinate units of the Air Transport Command

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[40] Williams, *One Man's CBI*, 65.

[41] Stone, ed, *Crisis Fleeting: Original Reports on Military Medicine in India and Burma in the Second World War*, 186.

[42] Armfield, *Medical Department of the United States Army in World War II: Organization and Administration in World War II*, 901.

[43] Murray and Millett, *A War to be Won: Fighting the Second World War*, 200.

[44] Joseph W. Stilwell, Charles F. Romanus, Riley Sunderland, eds. *Stilwell's Personal File – China, Burma, India 1942-1944, vol. 4* (Wilmington: Scholarly Resources, 1976), 1657.

(ATC), the Fourteenth Air Force (China), 10th Air Force (India-Burma), Air Service Command, and Air Forces Training Command retained Command Surgeons who exercised relative autonomy throughout the conflict. Unable to achieve unity of command within the ATC, the air surgeons developed ad hoc agreements with local facilities to support their requirements for supply and hospitalization. Interactions with ATC surgeons are noticeably absent from Colonel Williams' records, an observation that reinforces the assertion that Army Air Forces relied on "free-form competition," rather than deliberate planning, to manage their requirements.[45]

Chapter Two: Train, Advise, and Assist (1942-1943)

This job is a bitch…the usual lack of medical facilities, no medicine. Malaria, scabies, blackwater fever already appearing...

– LTG Stilwell, March 14, 1942*, The Stilwell Papers*

LTG Stilwell remarked that the retreat from Burma was "humiliating as hell." Like MacArthur in the Philippines, he intended to reclaim the lost territory at the first available opportunity.[46] Given the peripheral strategic importance of CBI in 1942, however, he lacked immediate means to accomplish the task. Stilwell's personal objectives were thus subordinated to the United States' immediate concern of sustaining the Chinese war effort. Before he could reasonably hope to initiate an offensive in Burma, Stilwell's forces would first need to train and reorganize a beleaguered Chinese army he described as, "shot with sickness and malnutrition… [and lacking] artillery, transport, medical service, etc."[47]

Stilwell's assessment of the Chinese forces, however grim, was largely correct. During the defense of Burma, much of the Chinese army's medical capability existed in name only. Beyond the services provided by Dr. Seagrave and a small cohort of non-governmental

[45] Condon-Rall and Cowdrey, *The Medical Department: Medical Service in the War Against Japan*, 295-296.

[46] Ibid, 106, 143.

[47] Ibid, 317.

organizations, the Chinese army displayed little capacity to employ effective medical services at any echelon. Remarkably, the entire Chinese 6th Army, one of two Chinese field armies defending Burma, lacked any trained medical doctors.[48] Quite frequently Chinese forces abandoned the sick and wounded to their fate, actions taken out of both cultural habit and necessity.[49] When queried about the woeful state of the Chinese medical service, one senior commander casually remarked, "One thing we have plenty of in China is men."[50]

Training and Equipping the Chinese Army

Following the retreat from Burma, COL Williams focused his efforts on the training and reorganization of the Chinese medical services. In October, Williams met with Stilwell to discuss tentative plans for the training base at Ramgarh, India, the first of three planned training bases for Chinese forces.[51] Recognizing the magnitude of the task ahead, Williams petitioned the War Department for instructors who could speak Chinese. Though initially rebuffed, his request was granted in early 1943.[52]

The first Chinese troops to arrive at Ramgarh were the remnants of the Chinese 5th Army. Following their exhausting retreat, nearly 85 percent were stricken with malaria and many others suffered from rare tropical diseases. The 98th Station Hospital, the first SOS medical asset in theater, provided initial medical care to the beleaguered troops, augmented by Seagrave's medical unit. By month's end, the facilities accumulated over 2200 patients, over six times their rated capacity.[53] Complicating these efforts, a British medical unit earmarked for the mission

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[48] Seagrave, *Burma Surgeon*, 160.

[49] Powell, *A Surgeon in Wartime China*, 30.

[50] Tuchman, *Stilwell and the American Experience in China, 1911-1945,* 340.

[51] Williams, *Personal Diary of Robert P. Williams*, 28.

[52] Williams, *One Man's CBI*, 113.

[53] Ibid, 72.

failed to arrive as promised.[54] The uneven support provided by the British to the training effort was equally a reflection of the theater's low strategic priority and a national disinterest in providing direct assistance to China.

The immediate objective of the medical training effort at Ramgarh was to provide the Chinese Army in India (CAI), designated the "X-Force," with sufficient capacity to provide their own medical support at the tactical echelons. Ramgarh was amply supplied; however, its distant location prohibited expansion of training efforts.[55] To augment the 5th Army, new recruits were flown over "the hump" from China. Given their meager provisioning, an average of 40 percent were rejected by American medical officers as medically unfit for service.[56] Though they routinely overwhelmed Allied facilities, it was notably the first time most Chinese soldiers had access to regular rations and medical care.

In February 1943, COL Williams turned his attention to the newly-established base at Kunming, China, the second major training base for Chinese Forces.[57] Optimistic Allied plans called for the "Y-Force" at Kunming to consist of thirty Chinese divisions. Unfortunately efforts to recreate Ramgarh's model were consistently marred by logistical deficiencies and competing political objectives on China's home soil. Designed to accommodate the training of 150 Chinese medical officers at a time, throughput at Kunming rarely met available capacity.[58] Thus, the mission at Kunming proceeded at a far slower pace than Ramgarh, but ultimately proved adequate to support the limited Allied offensive.[59]

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[54] Williams, *Personal Diary of Robert P. Williams*, 32.

[55] Stilwell, *The Stilwell Papers*, 137.

[56] Tuchman, *Stilwell and the American Experience in China, 1911-1945*, 418.

[57] Williams, *Personal Diary of Robert P. Williams,* 34.

[58] Tuchman, *Stilwell and the American Experience in China, 1911-1945*, 464.

[59] Stilwell, *The Stilwell Papers*, 143, 189.

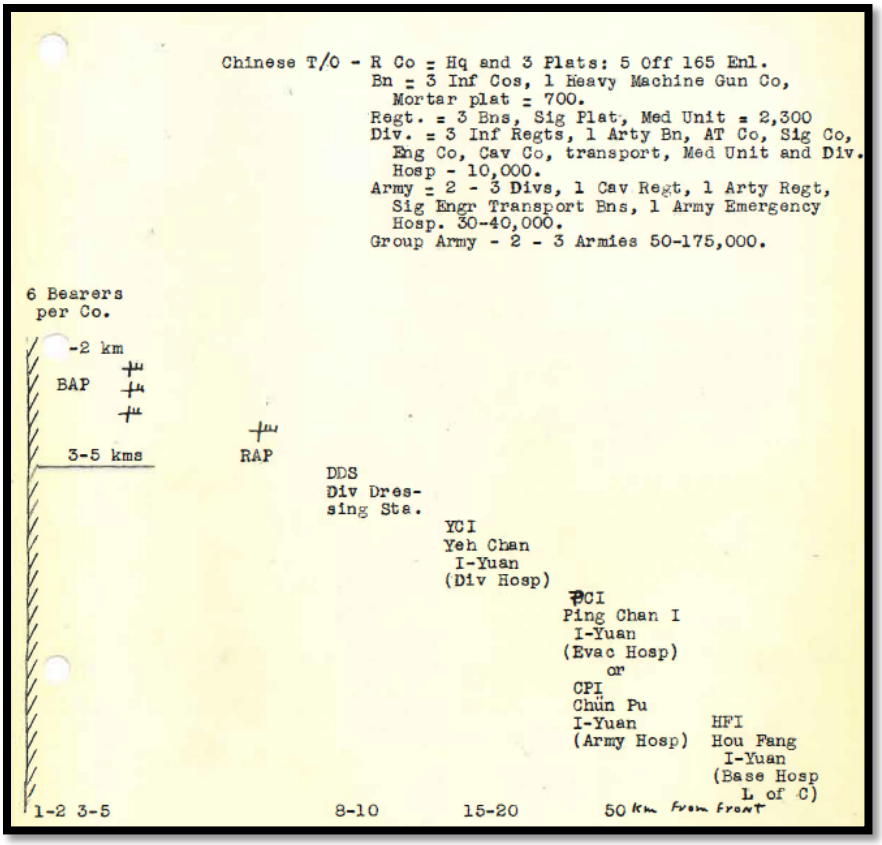

Figure 5: A sketch from COL Williams' diary reflecting the proposed battlefield employment of Chinese medical forces. *Personal Diary of Robert P. Williams*, *No. 1*, U.S. Army Heritage and Education Center, Medical Historical Unit Collection, Personal Papers, Williams, Box 1, 46.

To augment the Y-Force's meager hospitalization capability, COL Williams leveraged the capabilities of non-military medical organizations with great effect. Williams bolstered Chinese formations with diverse groups of physicians that included missionaries, conscientious objectors, and Jewish emigrants who had fled the war in Europe.[60] He also dedicated a significant amount of time to the organization and improvement of the Chinese Red Cross, an effort that strained his limited staff capability, but nonetheless produced dividends in the coming campaign.[61]

[60] Williams, *One Man's CBI*, 129.

[61] Williams, *One Man's CBI*, 117.

In April, tensions in the SOS between Colonel Tamraz and the Deputy Commanding General began to emerge. In his personal diary, Tamraz accused Brigadier General Holcombe of "unnecessarily interfering with the activities of the medical dept., such as canceling intended trips, changing policies, etc."[62] Two months later, Tamraz again clashed with the SOS Chief of Staff regarding theater personnel policies. Tamraz concluded, "I am under the impression that neither of these two gentlemen is particularly fond of the Medical Dept."[63] By August, COL Tamraz's relationship with the SOS command reached its lowest point. By his own admission, Tamraz had developed a "habit" of arguing with a Commander who "[didn't] like the Med. Dept. in general and myself in particular."[64]

Beyond the internal conflicts of SOS, Tamraz and Williams shared a strained relationship that originated from their ambiguously defined command structure. As early as September of 1942, Williams was "bawled out" by the SOS Commander over the movement of a Station Hospital in the communications zone, a decision which logically deserved his involvement, but was considered outside his scope of responsibility by the SOS staff.[65] As the North Burma offensive approached, Tamraz routinely lambasted the Theater Command for "meddling" in SOS activities and perceived snubs related to promotion and advancement.[66] In November, Tamraz sullenly noted, "Thanks to [Stilwell] who evidently does not like the Medical Dept. there will never be any [Medical] General Officers in this theater…the Medical Dept. is definitely in the

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[62] Stone, ed., *Crisis Fleeting: Original Reports on Military Medicine in India and Burma in the Second World War*, 153.

[63] Ibid, 160.

[64] Ibid, 165.

[65] Williams, *Personal Diary of Robert P. Williams*, 26.

[66] Stone ed., *Crisis Fleeting: Original Reports on Military Medicine in India and Burma in the Second World War*, 176.

"dog house."[67]

Despite the unrest amongst key leaders and staff, training efforts at Ramgarh and Kunming successfully improved the capability of the Chinese army to provide tactical medical care. US medical liaisons reconstituted a malnourished and exhausted force, overcoming the theater's ubiquitous shortages of supply and manpower. The training effort also provided Chinese formations with coherent organization and technical acumen, a critical weakness in prior campaigns. Remarking on the efficacy of their labors, Dr. Seagrave noted, "Liaison medical men had a thankless task…but [they] undoubtedly saved the lives of more Chinese soldiers than any single combat surgeon. Many of the soldiers whom the combat surgeon saved would never have reached him alive if regimental first-aid men, trained by Americans, hadn't done a really good job."[68]

In the fall of 1944, the medical capabilities of CAI forces had indeed improved significantly. Despite significant progress, large capability gaps remained beyond the unit level. Specifically, the Chinese had only a modicum of required assets required to support an offensive operation at the division or army level. As a result, the Chinese army continued to receive over 75 percent of their medical requirements from the SOS, and lacked any significant capacity for evacuation and hospitalization.[69] Recently organized Chinese "Field Hospitals" were generally only equipped as rudimentary clearing stations, requiring augmentation by American Portable Surgical Hospitals.[70] Despite these constraints, the American effort at Ramgarh dramatically improved the Chinese army's capacity to provide unit level medical care.

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[67] Stone ed., *Crisis Fleeting: Original Reports on Military Medicine in India and Burma in the Second World War*, 172.

[68] Gordon Seagrave, *Burma Surgeon Returns* (New York: W.W. Norton and Company, 1946), 89.

[69] Romanus and Sunderland, *China-Burma-India Theater: Stilwell's Mission to China*, 209.

[70] Williams, *One Man's CBI*, 74.

CAI in Northern Burma, 1943-1944

In August 1943, Allied leaders met at the Quadrant Conference in Quebec to discuss the war effort. Though CBI remained of peripheral strategic importance, the conference offered an opportunity to achieve consensus on the need to re-open the land route from India to China. Following the conference, the US Joint Chiefs of Staff instructed Stilwell to, "Carry out operations for the capture of Upper Burma in order to improve the air route and establish overland communications with China, [and] continue to build up and increase the air routes and air supplies of China."[71]

In October, LTG Stilwell met with Admiral Mountbatten and Chiang Kai Shek to discuss his operational plan to secure northern Burma. Stilwell presented a three-phase campaign to seize the Irrawaddy valley, a wide maneuver corridor that comprised most of central Burma. In the first phase, two Ramgarh-trained "X-Force" divisions would advance south from Ledo, a sustainment hub on the India-Burma border, in order to provide security for US engineers on the Ledo Road. Following that effort, the "X Force" would advance down the Hukawng Valley to seize the town of Shingbwiyang. In the final phase, Stilwell's force would seize the cities of Mogaung and Myitkyina, key access points to rail and river lines of communication. Augmented by near-simultaneous advances from the west and east by British and the Chinese "Y Force," the campaign would be the first key step to wrest Burma from Japanese control.[72]

[71] Romanus and Sunderland, *Stilwell's Command Problems*, 9.

[72] Ibid, 119.

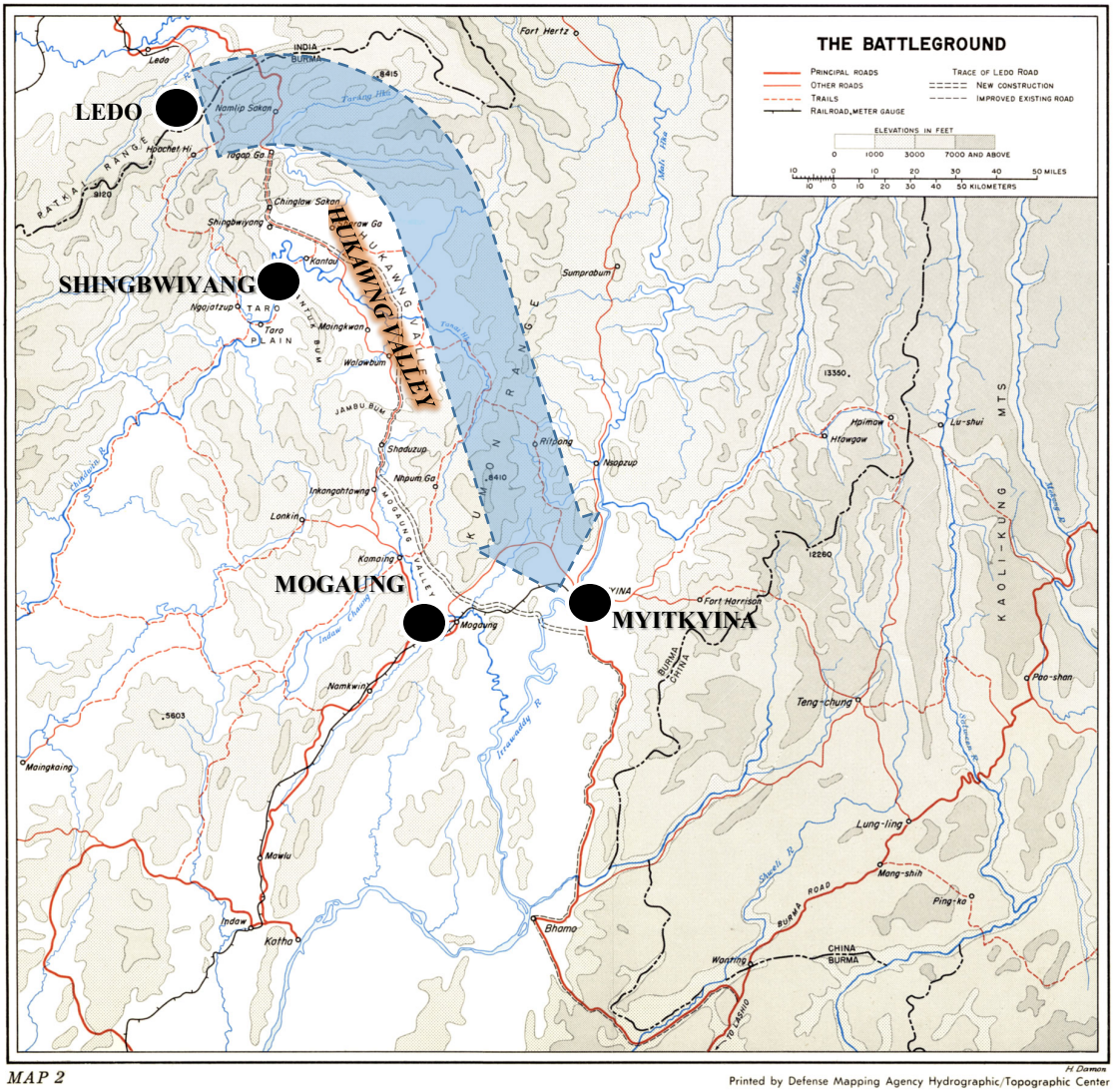

Figure 6: The Northern Burma Campaign. Map adapted from *Stilwell's Command Problems,* accessed 12 May 2019, http://www.ibiblio.org/hyperwar/USA/USA-CBI-Command/maps/USA-CBI-Command-2.jpg.

The Chinese 38th Division began its advance into the Hukawng Valley in late October, bypassing thousands of skeletons of ill-fated refugees from the 1942 campaign along the route.[73] Unbeknownst to Allied intelligence, the Japanese 18th Division had advanced well north into the Hukawng Valley in preparation for their own offensive against Allied forces in India.[74] In the

[73] Don Moser, *China-Burma-India (*Alexandria: Time Life Books, Inc. 1978), 120.

[74] Ibid, 121.

ensuing weeks, the X-Force fought a series of pitched battles, inching down the valley against stubborn resistance from experienced Japanese forces.

During the first engagements of the campaign, Seagrave's Hospital Unit and the 151st Medical Battalion augmented the meager organic capacity of Chinese forces, supported along ground lines of communications by US Portable Surgical Hospitals..[75] Initially, it took as many as fourteen days to evacuate a patient on foot to the nearest airstrip or hospital, though light liaison aircraft soon became the primary means of patient evacuation..[76] While jungle clearings, rice paddies, and riverbank sandbars continued to be used as ad hoc landing zones, the construction of a dedicated evacuation strip at Shingbwiyang dramatically reduced transportation times and improved odds of survival for wounded soldiers..[77] For Chinese forces who had grown accustomed to the prospect of being abandoned to die on the battlefield in earlier campaigns, it was a stark contrast.

By mid-December, the Chinese advance stalled near the town of Yupbang Ga against stiff resistance from the battle-hardened 18th Division. In the ensuing weeks, the Chinese 38th Division mounted several attempts to encircle the belligerent Japanese defenders. Though frustrating Stilwell's desire to achieve a decisive battlefield victory, the relative stalemate provided opportunities to refine the sustainment infrastructure, streamline the evacuation process, and reposition cumbersome medical facilities along restricted lines of communication. Beyond Chinese unit detachments, ten Portable Surgical Hospitals, as well as the Seagrave Hospital, provided forward intervention and stabilization. Patients requiring general hospital treatment or

[75] Coates, ed., *Surgery in World War II: Activities of the Surgical Consultants*, *Vol. 2*, 901.

[76] Ibid, 903.

[77] Williams, *Personal Diary of Robert P. Williams, No. 3*, 28; Seagrave, *Burma Surgeon Returns*, 40.

more than six weeks of convalescent care were evacuated from the 25th Field Hospital to Ledo through the air clearing station at Shingbwiyang.[78]

Desiring to break the stalemate, Stilwell established a headquarters near Shingbwiyang to personally oversee operations at Yupbang Ga.[79] Stilwell deliberately sequenced Chinese maneuver with integrated artillery fire, and the 38th Division gained its first major tactical victory of the campaign.

The Chinese believed that, "Japanese bullets were not so much of a hazard as the infection resulting from them."[80] Thus, the presence of prompt and capable medical treatment, in as provided by ten forward-deployed PSH's, proved of great psychological value to the CAI.[81] Despite these dramatic improvements, the North Burma offensive exposed major flaws in the CBI medical concept of support. The first issue related to the provision of medical supply for Chinese forces. While SOS controlled the flow of medical supplies in theater, it had no significant role in planning for the coming campaign. As a result, sufficient plans to requisition and distribute medical assets for the Chinese divisions never materialized. During a visit to Ledo, one of the primary logistics hubs in the Advance Section, Williams noted, "Supplies come in piece-meal, without warning, from various depots and in quantities not on requisition."[82]

The second weakness in the Allied concept of medical concept of support campaign in north Burma was that no provisions were made by the SOS to account for Chinese casualties requiring army and theater level care in the communications zone. In less than two months of offensive operations, CBI facilities had swelled to accommodate over 12,500 beds, a stark

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[78] Romanus and Sunderland, *Stilwell's Command Problems*, 142.

[79] Ibid, 78-79.

[80] Coates, ed., *Surgery in World War II: Activities of the Surgical Consultants, Vol. 2*, 945.

[81] Condon-Rall and Cowdrey, *The Medical Department: Medical Service in the War Against Japan*, 315.

[82] Williams, *Personal Diary of Robert P. Williams, No. 4,* 2.

contrast from the 8,800 requested by the theater's medical leadership.[83] At his headquarters in Delhi COL Tamraz failed to grasp the growing urgency of the situation, a reflection of his lack of involvement in operational matters. On February 7th, he noted tersely in his diary, "Requests are coming from all directions for more medical personnel, and we are giving them the same standard answer. None available."[84] Two days later, COL Tamraz departed on a two-week tour of medical installations in Calcutta. In doing so, he missed a conference convened specifically to address the logistical challenges of the North Burma campaign.[85]

At the end of February, LTG Stilwell met with COL Williams to discuss the emerging crises in the medical supply system. His patience evidently wearing thin, Stilwell bluntly remarked, "I want medical supplies for Chinese wounded and I don't give a G.D. [god damn] where they come from."[86] That same afternoon, Stilwell wrote a personal memo to CBI Deputy Commander, Brigadier General Daniel Sultan, expressing his concern. "This thing has gone hit and miss and its effects have been felt here. I would appreciate your opinion on Williams…Do you think he is capable of handling a big job?"[87]

The crises related to medical supply and infrastructure continued through the spring of 1944. Stilwell's deputy, Colonel Frank Dorn, cabled to Stilwell to complain that the SOS had requested the transfer of three PSH's back to India. This was not the first time that headquarters had clashed about the management of scarce medical resources. Noting that there was "no use in appealing to Delhi [SOS]," the tone of Dorn's correspondence suggests that no authority below

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[83] Romanus and Sunderland, *Stilwell's Command Problems*, 285-286.

[84] Stone, ed., *Crisis Fleeting: Original Reports on Military Medicine in India and Burma in the Second World War*, 181.

[85] Ibid, 181; Williams, *Personal Diary of Robert P. Williams, No. 4*, 4.

[86] Williams, *Personal Diary of Robert P. Williams, No. 3*, 4.

[87] Stilwell, Romanus, Sunderland, eds., *Stilwell's Personal File – China, Burma, India 1942-1944, vol. 4*, 1415.

Stilwell himself was qualified to adjudicate the conflict.[88]

Medical challenges in CBI ultimately gained the attention of the Army Surgeon General when Colonel Williams traveled to Washington personally to request additional medical assets for the theater. As a result of his effort, the War Department allocated four additional hospitals to CBI, reducing the theater shortage.[89] Williams' visit also prompted the Surgeon General to dispatch a team of specialists to survey of the medical supply program in CBI.[90]

Given the reactionary nature of both interventions, the improvements in the theater's medical structure came far too late to have practical use to the campaign in north Burma. While the training provided at Ramgarh undoubtedly improved the Chinese army's tactical capability and cultural regard for medical care, operational planning shortfalls continued to plague field commanders. An American liaison officer with the Chinese 38th Division captured the lingering systemic deficiencies, noting that his hospital lacked medicine and soldiers were forced to use parachutes to dress wounds. He cynically concluded his report with the request that, "if there was no medical supply system, would G-4 please create one [?]".[91]

Chapter Three: Merrill's Marauders

I told them this was our chance – our only chance.

—LTG Stilwell, *The Stilwell Papers*

By February 1944, the Chinese 22nd and 38th Divisions had driven sixty miles into North Burma, forcing the Japanese 18th Division down the Hukawng Valley.[92] Though frustrated by a

[88] Stilwell, Romanus, Sunderland, eds., *Stilwell's Personal File – China, Burma, India 1942-1944, vol. 4*, 1657.

[89] Romanus and Sunderland, *Stilwell's Command Problems*, 286.

[90] Robert S. Anderson, ed., *Medical Supply in World War II* (Washington, DC: The Office of the Surgeon General, 1968), 522.

[91] Romanus and Sunderland, *Stilwell's Command Problems*, 102.

[92] CMH Pub 100-4, *Merrill's Marauders*, 30.

lack of men and materiel, the advance had enabled the construction of over 100 miles of road from Ledo and set the conditions for the campaign's final phase – the seizure of Myitkyina. The final stage of Stilwell's plan in North Burma marked the introduction of the first American combat forces on the Asian mainland, the 5307th Composite Unit (Provisional). Though only roughly the size of an infantry regiment, the 5307th offered Stilwell his long-sought opportunity to command US forces in combat. Inspired by the tactics of the British "Chindit" forces under the leadership of Orde Wingate, Stilwell intended to use the Marauders as a long-range penetration force. As a highly-mobile formation, the Marauders would circumvent Japanese defenses and facilitate the advance of conventional Chinese forces, providing him with the decisive victory that had previously eluded his grasp.

Stilwell was insistent on exercising command of Allied forces in the spring offensive. To facilitate this arrangement, SEAC established the Northern Combat Area Command (NCAC).[93] Beyond the command structure, however, very few explicit preparations were made to support the Marauders' offensive. Lacking a replacement system or dedicated sustainment assets, support for the 5307th was largely improvisatory in nature.[94] Each battalion in 5307th contained a doctor and several aid men, but the regiment lacked any organic capacity to transport or hospitalize patients.[95] Unlike like Chinese divisions, who were aligned with American PSH's, operational plans for the Marauders included no provision for such dedicated resources.

A glaring omission, Theater Surgeon Colonel Williams was unaware of the 5307th Composite Unit's existence, much less its imminent departure into combat. According to Williams, "the whole project was so hush-hush that I did not hear of it until the day before they

[93] Romanus and Sunderland, *Stilwell's Command Problems*, 138.

[94] Ibid, 131.

[95] John M. Jones, *War Diary of the 5307th Composite Unit (Provisional)* (Fort Benning, GA: MCoE HQ Donovan Research Library, 1944), 14.

were committed to action in Upper Burma."[96] Only through a chance encounter with Stilwell's Chief of Staff did Williams learn of the existence of the Marauders, whereupon he undertook a personal effort to investigate the inadequacy of their medical support above the regimental level.[97] Regardless of their potentially grave consequences, these operational planning lapses were largely unknown to the aggressive volunteers of the 5307th. As they prepared for their first mission, one Marauder famously declared, "My pack is on my back, my gun is oiled and loaded as I walk into the shadow of death. I fear no son-of-a-bitch."[98]

Walawbum: The Marauder's First Mission

For several months, Stilwell had sought to encircle the Japanese 18th Division, continually stymied by what he deemed as "extreme caution" and "fear of going around" by the leaders of the Chinese 38th Division.[99] Stilwell believed the presence of aggressive US forces, under the command of his trusted agent Colonel Frank Merrill, would remedy this condition. In their first combat action, the 5307th would advance southeast around the 18th Division's main forces to Walawbum, cut Japanese supply lines, and block the enemy's retreat.

On 28 February, the Marauders began their advance from Tanja Ga toward Walawbum, a 40 mile march through the rugged terrain. By dawn on 3 March, the Marauders reached the outskirts of the town, encountering only sporadic resistance twenty miles behind the enemy's main lines.[100] In the subsequent forty-eight hours, the Marauders faced more active resistance as the Japanese became more alert to their presence. Platoon and company-sized elements of the Marauders continued their advance, seized an airstrip and blockaded positions along the road. By

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[96] Stone, ed., *Crisis Fleeting: Original Reports on Military Medicine in India and Burma in the Second World War*, 294.

[97] Williams, *One Man's CBI*, 172.

[98] Jones, *War Diary of the 5307th Composite Unit (Provisional), 24.*

[99] Gary Bjorge, *Merrill's Marauders: Combined Operations in Northern Burma in 1944* (Washington, DC: US Army Center of Military History, 1996), 14.

[100] US Department of the Army, *Merrill's Marauders*, 31.

7 March, the Chinese 38th Division arrived in Walawbum nearly unopposed.[101]

Unlike the Chinese forces, the Marauders lacked access to division-level medical facilities along their extended and contested lines of communication. Despite this fact, the Marauders benefitted from the improvised casualty evacuation system pioneered in the early months of the campaign. Only hours after injury, the first Marauder casualty was evacuated to Ledo on a light liaison aircraft.[102] CPT James Hopkins, a medical officer in 3rd Battalion, "The knowledge that our sick and wounded could be taken out by plane from improvised airstrips was a big boost to the morale of the men."[103]

In just over four days of combat, the Marauders killed approximately 800 enemy forces, cooperating with Chinese forces to achieve a rapid victory. The 18th Division, while not wholly defeated, yielded control of the Hukawng Valley to Allied forces. Though only forty-five Americans were killed or wounded in combat, another 200 were evacuated due to disease or non-battle injury in the short period.[104] The mission was a tactical success; however, the Marauders' attrition to disease and injury was an ominous indicator of their greatest challenge to come.

The Siege at Nhpum Ga

Encouraged by the success of the Walawbum operation, Stilwell pressed his advance toward Myitkyina. On March 12th, the Marauder's advanced south again in an attempt to envelope and block the 18th Division at Shaduzup and Inkangahtawng. To compensate for the inferior strength of his divided formation, Stilwell intended to conduct the attacks in simultaneous fashion, coupling the Marauder's advance with the Chinese 22nd Division. Before the plan could

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[101] US Department of the Army, *Merrill's Marauders*, 44.

[102] Jones, *War Diary of the 5307th Composite Unit (Provisional),* 28.

[103] Gavin Mortimer, *Merrill's Marauders: The Untold Story of Unit Galahad and the Toughest Special Forces Mission of World War II*. (Minneapolis: Zenith Press, 2013), 73.

[104] US Department of the Army, *Merrill's Marauders*, 44.

be realized, however, the Japanese mounted an attack on the 22nd Division's left flank. To thwart the Japanese advance, the Marauder's 2nd Battalion established a hasty defense at Nphum Ga on March 27th.[105]

The Marauders were besieged at Nphum Ga by overwhelming Japanese forces shortly after their arrival. They assumed a conventional defensive posture, a departure from their traditional method of employment, and one for which they were poorly equipped.[106] Threatened by incessant infantry charges, well-placed artillery, and squalid conditions within their perimeter, the Marauders were threatened by enemy force and disease in equal measure. Further complicating the situation, General Merrill suffered a heart attack on the third day of the siege, effectively relinquishing command to his deputy, Colonel Charles Hunter.[107]

As their perimeter became littered with carcasses of dead Japanese soldiers, horses, and mules, 2nd Battalion's medical situation grew increasingly bleak. Medics exposed themselves to enemy fire to retrieve the wounded from fighting positions, but lacked means to prevent their suffering. With no means of evacuation, battalion medical officers resorted to desperate measures, using maggots to clean wounds and conducting amputations on the ground with bayonets.[108] Recalling the helplessness of the situation, one doctor noted, "There was absolutely nothing we could do for him…I brought him into the hole with me…and just kept him there until he died."[109]

On April 8th, elements of the 1st Battalion engaged Japanese forces near Nphum Ga in an attempt to relieve their beleaguered comrades. Japanese forces withdrew under the pressure of the

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[105] Jones, *War Diary of the 5307th Composite Unit (Provisional),* 68-69.

[106] Romanus and Sunderland, *Stilwell's Command Problems*, 131.

[107] Charlton Ogburn, *The Marauders* (New York: William Morrow and Company, 1982), 200.

[108] Mortimer, *Merrill's Marauders: The Untold Story of Unit Galahad and the Toughest Special Forces Mission of World War II*, 139.

[109] Ibid, 129.

relieving force the following day. Following their relief, casualties were transported six miles by litter and horseback to a makeshift rest camp, many of whom had been wounded as many as twelve days prior.[110] During the ten day siege, the Marauders killed over 400 Japanese, the bodies of whom lay rotting outside their perimeter.[111] The Marauders also suffered horribly, tallying fifty-seven killed, 302 wounded, and 379 evacuated for disease, including amoebic dysentery and malaria.[112] Nphum Ga was a costly tactical stalemate, and inflicted irreparable damage to the Marauder's fighting strength.

In the wake of Nphum Ga, the Marauders were provided several days of rest, new uniforms, and ample rations. Given the challenges of their 500-mile advance in the preceding eighty days, these measures were inadequate to restore the formation's effectiveness as a fighting force. Nearly all Soldiers were afflicted with malaria or some form of dysentery, and many suffered grapefruit-sized lesions caused by untreated wounds from leeches and other parasites.[113] These concerns were perpetuated by the increasing heat and humidity of the pending monsoon season.[114]

Myitkyina: The End of the Marauders

The men of the 5307th believed that Myitkyina, the campaign's ultimate objective, was no longer a reasonable goal prior to the onset of monsoon season.[115] Driven to achieve unilateral success amidst continued Allied discord, Stilwell was committed to see the campaign to

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[110] Condon-Rall and Cowdrey, *The Medical Department: Medical Service in the War Against Japan*, 306.

[111] Mortimer, *Merrill's Marauders: The Untold Story of Unit Galahad and the Toughest Special Forces Mission of World War II*, 153.

[112] US Department of the Army, *Merrill's Marauders*, 91.

[113] Mortimer, *Merrill's Marauders: The Untold Story of Unit Galahad and the Toughest Special Forces Mission of World War II*, 99.

[114] US Department of the Army, *Merrill's Marauders*, 97.

[115] Bjorge, *Merrill's Marauders: Combined Operations in Northern Burma in 1944,* 32.

completion as soon as possible. Assurances that they were to be relieved following the seizure of the Myitkyina airstrip eased the Marauders trepidation. Though suspicion lingered in the ranks, the promise of furlough and celebration proved adequate motivation for the beleaguered force. In his memoir, Captain Charlton Ogburn expressed his concerns about the campaign's final phase: "Wondering if we would be able to make it to Myitkyina even if there were no Japanese in the way, we were convinced that someone had blundered. Unlike the Light Brigade, we did not scruple to reason why. We reasoned why with volubility and bitterness but also wearily, aware of the futility of it. There was one compensation. We probably would not reach Myitkyina, but if we did we would wind up with glory and honor and a fling that would make history. This was positively the last effort asked of us."[116]

To seize Myitkyina, Stilwell's force planned to conduct a final, "end run" maneuver traversing 65-miles, through the 6,000-foot mountain passes of the Kumon Range.[117] Due to the significant attrition of 2nd Battalion and addition of Chinese and local Kachin guerrilla forces, Merrill reorganized the 5307th into three reinforced battalion formations, designated the H, K, and M Forces. The main effort, H and K Forces would traverse Kumon Range and south to the town of Riptong. In support, the M force would screen the main advance to Riptong and be prepared to support the main assault on Myitkyina.

[116] Ogburn, *The Marauders*, 227.

[117] Bjorge, *Merrill's Marauders: Combined Operations in Northern Burma in 1944,* 36; US Department of the Army, *Merrill's Marauders*, 97.

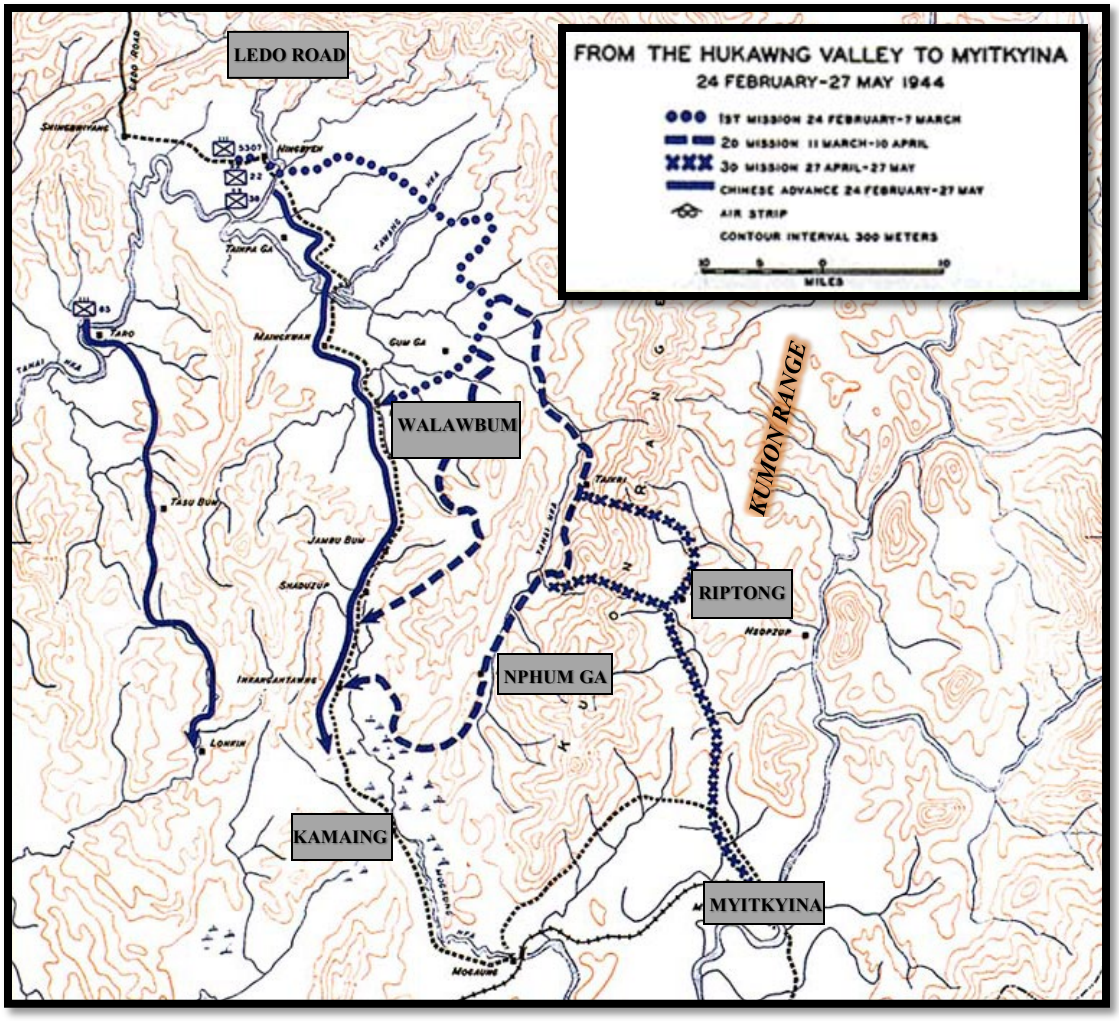

Figure 7: The March to Myitkyina. Map adapted from World War II China Burma India Theater Maps, accessed 21 March 2019, http://www.cbi-theater.com/maps/map1032.html.

The force struggled through the damp, unforgiving terrain for a week, losing men and pack animals alike to exhaustion at a steady rate. On May 5th, the lead elements of K Force closed on the outskirts of Riptong. Together with the 88th Chinese Regiment, they overcame Japanese resistance, seizing the town within three days. On May 10th, General Merrill ordered H Force to complete its final 35-mile advance to Myitkyina, employing K Force to the east to screen their advance.

The Marauders continued to build on their admirable record of tactical victories. Weakened by disease and uninterrupted combat, however, the formation began to show the inevitable signs of strain. In addition to nearly uniform infection by malaria and other tropical ailments, the first cases of typhus emerged during the battle for Riptong.[118] As men collapsed from exhaustion and disease, they were left behind on the trail with optimistic reassurances of aid to come.[119] Of the 3,000 that marched from Ledo in February, just over 1,300 remained for the campaign's decisive operation.[120]

Following Riptong, the tactical situation necessitated dramatic decisions about the evacuation of soldiers for medical care. Myitkyina was finally within reach, and the loss of combat power would jeopardize the accomplishment of the objective. At its core, the decision to jeopardize the mission's success required commanders to ignore the significant medical risk of death from non-battle ailments in their formations. On May 14th, a poisonous snake bit a local guide. As the guide's condition deteriorated, he was tied to a horse rather than evacuated to medical care.[121] The grim necessity was an indicator of the type of decisions that would imperil the Marauders in coming weeks.

The H Force attacked and seized the lightly defended Myitkyina airfield on May 17th, surprising its few Japanese defenders. The Marauders had achieved tactical surprise; however, the Japanese force in the Myitkyina garrison numbered over 3,000, far exceeding Allied estimates.[122]

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[118] Mortimer, *Merrill's Marauders: The Untold Story of Unit Galahad and the Toughest Special Forces Mission of World War II*, 170.

[119] Bjorge, *Merrill's Marauders: Combined Operations in Northern Burma in 1944,* 40.

[120] US Department of the Army, *Merrill's Marauders*, 112.

[121] Mortimer, *Merrill's Marauders: The Untold Story of Unit Galahad and the Toughest Special Forces Mission of World War II*, 177.

[122] US Department of the Army, *Merrill's Marauders*, 109.

Like their stand at Nphum Ga, the Marauders were poorly equipped for the ensuing conventional battle against a besieged force. Requesting assistance from the K and M Forces, both over twenty miles north, the H Force continued their advance to the city.[123]

The day after the capture of the Myitkyina airfield, the first medical transport plane from the 803rd Medical Air Evacuation Squadron (MAES) landed on the captured airstrip. Shrapnel from Japanese artillery struck the plane on the runway, killing one litter patient and wounding three of its crew.[124] Though the airstrip was secured for Allied aircraft, there were no replacements available to exploit the Marauders' success. In their devastated state, over 100 soldiers were evacuated daily to the 20th General Hospital, 14th Evacuation Hospital, or the 111th Station Hospital in the Ledo area.[125] As the exhausted columns of K and M Forces arrived to reinforce Allied positions, Merrill reorganized the dwindling formation into a single task force.

Following five days of indecisive combat, the Japanese counterattacked the Myitkyina airfield. Exhausted, the Marauders struggled to defend the airstrip against the superior Japanese force. With combat strength dwindling rapidly, the command implemented a new medical policy, requiring approval from a board of doctors for any evacuation to the communications zone. The board applied stringent criteria to determine medical necessity; patients were required to run a fever in excess of 102 degrees for greater than three days to be considered eligible.[126] Within the week, nearly 200 soldiers were returned as emergency reinforcements. Of those, 50 were immediately deemed combat ineffective due to their medical condition.[127]

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[123] US Department of the Army, *Merrill's Marauders*, 107.

[124] Evelyn Page, *The Story of Air Evacuation, 1942-1989*. (Dallas: Taylor Publishing Company, 1989), 122.

[125] Stone, ed, *Crisis Fleeting: Original Reports on Military Medicine in India and Burma in the Second World War*, 351.

[126] Ibid, 352-353.

[127] Bjorge, *Merrill's Marauders: Combined Operations in Northern Burma in 1944,* 111.

On May 26th, COL Williams made a solitary remark in his diary regarding the actions at Myitkyina: "Merrill's outfit is pooped."[128] The proximity of the Marauders to Chinese forces finally afforded the Marauders direct access to American PSH's and Seagrave's unit, unfortunately it was too late to defray the accumulation of ailments from months of exposure and malnutrition.[129] Exhausted soldiers fell asleep during combat, and others removed the seats of their pants to lessen the impact of unmitigated dysentery.[130] In 2nd Battalion, which suffered dearly at Nphum Ga, only twelve men remained in action.[131] Losses continued to mount, with one casualty tag famously describing the cause of injury as AOE - "accumulation of everything."[132]

Hesitant to call upon the able reinforcements from the British 36th Division, Stilwell flew in untested American engineers to augment the beleaguered defense.[133] Stilwell justified the action as a measure to "keep an American flavor in the fight," though the exclusion of British allies also served to ensure he did not share credit for the successful campaign.[134] The last survivors of the original Marauders were evacuated on June 4th. Myitkyina would not fall until nearly two months later.[135]

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[128] Williams, *Personal Diary of Robert P. Williams No. 3*, 21.

[129] Seagrave, *Burma Surgeon Returns*, 153.

[130] Louis Allen, *Burma: The Longest War 1941-1945* (London: J.M. Dent and Sons, 1984), 366-367.

[131] Stone ed, *Crisis Fleeting: Original Reports on Military Medicine in India and Burma in the Second World War*, 354.

[132] Mortimer, *Merrill's Marauders: The Untold Story of Unit Galahad and the Toughest Special Forces Mission of World War II*, 192.

[133] Allen, *Burma: The Longest War 1941-1945*, 367.

[134] Romanus and Sunderland, *Stilwell's Command Problems*, 233.

[135] Condon-Rall and Cowdrey, *The Medical Department: Medical Service in the War Against Japan*, 310-311.

The End of CBI

In October 1944, two events fundamentally altered the nature of Allied operations on the mainland of Southeast Asia. First, at the urging of Chiang Kai Shek, President Roosevelt recalled the newly-promoted General Stilwell from theater. Stilwell continued to maneuver for operational control of all Chinese forces, a position which Chiang Kai Shek did not support after two years of burgeoning animosity and mistrust. Tactfully constraining his personal animus, Chiang Kai Shek encouraged Roosevelt to remove Stilwell under the assertion that he, "[did] not possess the qualifications necessary for success."[136] Stilwell's departure paved the way for another massive reorganization, the establishment of separation of CBI into distinct theaters: China and India-Burma.

The recall of General Stilwell and reorganization of US Forces, China Theater (USFCT) and US Forces, India-Burma Theater (USIBT) ameliorated much of the friction that existed under Stilwell's "absurd" command structure.[137] Despite this progress, inefficiencies persisted. Lacking their own SOS, USFCT relied on support from India-Burma for all activities related to personnel, medical supply, and hospitalization. Reflecting the ambiguity of Williams and Tamraz's relationship in the prior year, the newly-appointed Surgeon of USFCT remarked, "[I] am now so thoroughly confused that I honestly don't know where to turn…I am unable to find out whether this office will duplicate all the things done in your office or [you] will continue to perform many functions for us."[138] Reorganized for combat on the Chinese front, medical units continued their mission, "armed with expedients and hope."[139]

In January 1945, the British 14th Army launched a major offensive to reclaim Burma with

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[136] Liang Chin-tung, *General Stilwell in China, 1942-1944: The Full Story* (Queens, NY: St. John's University Press, 1972), 267

[137] Allen, *Burma: The Longest War 1941-1945*, 387.

[138] Coates, ed., *Surgery in World War II: Activities of the Surgical Consultants, Vol. 2*, 909.

[139] Condon-Rall and Cowdrey, *The Medical Department: Medical Service in the War Against Japan*, 318.

a force of over 250,000 men.[140] The commander of the Allied forces, Field Marshall William Slim, preceded his advance with careful logistics planning, enabling the Allied forces to take full advantage of their numerical and technological superiority.[141] By May, the Allies achieved a decisive victory, routing Japanese forces in southern Burma and seizing the capitol city of Rangoon.[142]

Chapter Four: Analysis and Conclusion

Analysis

Reflecting on his experience in Burma, Marauder veteran Charlton Ogburn wrote, "Being unready and ill-equipped is what you have to expect in life. It is the universal predicament…You must always do with less than you need in a situation vastly different from what you would have chosen as appropriate for your special endowments."[143] Both case studies presented herein reflect this truth. Competing strategic agendas, harsh environmental limitations, and scarcity of resources presented challenges that routinely transcended established procedures and doctrinal solutions.

Evaluated against theater's significant constraints and limitations, the massive American-led effort to train, equip, and support the medical services of the Chinese army was remarkably successful. Historically ill-equipped to provide a modicum of medical sustainment capability, Chinese formations established access to competent tactical medical care, reliable evacuation, and adequate convalescent facilities for the first time in their history. For soldiers who feared abandonment on the battlefield more than death itself, this was a remarkable achievement. The addition of US Portable Surgical Hospitals and aerial medical evacuation assets only served to bolster the success of Chinese operations. Given the inherent organizational, environmental and

[140] Murray and Millett, *A War to be Won: Fighting the Second World War*, 491.

[141] Ibid, 492.

[142] Ibid, 491.

[143] Ogburn, *The Marauders*, 7.

cultural challenges of the Medical Department's task, this was a noteworthy achievement.

Though the CAI achieved operational success in northern Burma, two operational failures exposed the Chinese forces to unnecessary medical risk during the campaign. First, failure of the Theater and SOS Surgeons to adequately define their roles jeopardized their ability to maintain effective command and supervision of theater medical assets. As a result, persistent shortages of medical facilities and supplies jeopardized the ability to sustain offensive operations. In the communication zone, COL Tamraz's failure to anticipate the sustainment requirements of the campaign in north Burma undoubtedly contributed to the crises of supply and hospitalization that emerged in the summer of 1944.

Despite these significant lapses in oversight and planning, tactical advisors in CAI overcame theater-level failures to successfully enable the military objectives of the northern Burma campaign. Constrained by routine shortages of supply and personnel, tactical hospital commanders frequently shifted assets to support decisive efforts, creating ad hoc medical facilities and treatment teams as demanded by the tactical situation. Additionally, medical liaisons compensated for the persistent lack of *division* and *army* level hospitalization and evacuation assets in the Chinese army, effectively synchronizing US and host nation capabilities through the use of Portable Surgical Hospitals and evacuation clearing stations. Finally, the Theater Surgeon commendably employed Seagrave's hospital and other civilian organizations to augment the capabilities of the resource-constrained coalition.

Objective analysis of medical planning and support to the 5307th Composite Unit is a more complicated endeavor. Central to this discussion is whether General Stilwell intended to treat the Marauders as an expendable force from the onset of their mission. Given that the Theater Surgeon initially lacked any knowledge of the Marauder's presence, and the notable absence of discussion about their plight in his diary, one could conclude that this was the case. Regardless of intent, no evidence exists to suggest that Colonel Williams offered a clear articulation of the medical risk inherent in the northern Burma campaign. Given the peculiarities of his character, it

is debatable whether Stilwell would have entertained alternative operational approaches if such a conversation took place.

Historians have reached competing conclusions about the conduct and motivations of General Stilwell in the campaign. The most critical assessments of Stilwell's actions exist among the memoirs of the Marauders themselves. Among them, Colonel Charles Hunter, the de facto Commander during critical days at Nphum Ga and Myitkyina, suggested that the task force was exhausted, "to bolster the ego of an erstwhile Theater Commander."[144] Historian Louis Allen notes that Stilwell neglected to request available British reinforcements to preserve his "great American triumph," the long-awaited attainment of personal glory in a forgotten theater.[145]

A more generous assessment of Stilwell is provided by Historian Gary Bjorge, who argues that the suffering of the 5307th was a necessary sacrifice – the solution to the "problem of equitable burden sharing" in a multinational command.[146] In this context, he argues that the 5307th was "crucial unifying element and catalyst for action" for the historically unreliable Chinese forces.[147] This explanation, however attractive, ignores the perpetual friction that existed for years between Stilwell and multiple Allied commanders. In his memoir, Marauder veteran Charlton Ogburn asserted that Stilwell's greatest weakness was a perpetual desire to, "show 'them' – 'them' being the British and anyone Stilwell could suspect of a superior attitude."[148] Further, Bjorge's assessment ignores the similar fate of British Chindit forces, whose ranks suffered under Stilwell's command in at least equal measure.[149] Considered against Stilwell's exultation that the seizure of Myitkyina would "BURN UP THE LIMEYS," it is difficult to

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[144] Charles N. Hunter, *Galahad* (San Antonio: The Naylor Company, 1963), 1-2.

[145] Allen, *Burma: The Longest War 1941-1945*, 367.

[146] Bjorge, *Merrill's Marauders: Combined Operations in Northern Burma in 1944*, 44.

[147] Ibid, 44.

[148] Ogburn, *The Marauders*, 25.

[149] Murray and Millett, *A War to be Won: Fighting the Second World War, 378-379.*

accept Bjorge's conclusion that Stilwell's actions were borne of thoughtful reflection and respect for unified action.[150]

Regardless of Stilwell's motivations, this narrative sheds light on the precarious position of the Marauder's medical officers in the Myitkyina campaign. As the tactical situation at Myitkyina grew more perilous, "extremely heavy moral pressure, just short of outright orders, was placed on medical officers to return to duty or keep in the line every American who could pull a trigger."[151] This reality presented combat surgeons with a professional and ethical plight. In the name of tactical necessity they faced significant pressure to ignore the consequences of potentially fatal diseases. On the contrary, if they offered sound medical guidance, they were viewed with suspicion for encouraging malingering and weakening the force.

Fearing backlash in the aftermath of the campaign, both Stilwell and Merrill downplayed their role in the Marauders demise from exhaustion and disease, arguing that, "if any of our men were in action who should have been in the hospital, it was due to an error by our own doctors."[152] For the Marauders, however, this explanation was seen as an "unforgivable slur" against the medical providers who had fought bravely with them throughout the campaign.[153]

There is no debate that war often requires Soldiers to endure incredible, and often unanticipated, hardship and attrition. In CBI, however, the command's failure to plan medical support throughout the campaign, and subsequent refusal to commit capable British reinforcements to the fight, suggests that the Marauders' full measure of sacrifice was not necessary to achieve the campaign's military objective.

The 1943 edition of *Field Manual 100-10, Field Service Regulations Administration*,

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[150] Stilwell, *The Stilwell Papers*, 296.

[151] Romanus and Sunderland, *Stilwell's Command Problems*, 240.

[152] Mortimer, M*errill's Marauders: The Untold Story of Unit Galahad and the Toughest Special Forces Mission of World War II*, 201.

[153] Ibid, 201.

states, “Plans and orders for evacuation and hospitalization are made in conformity with and in amplification of combat plans and orders. Efficient execution requires that the medical service of any unit be informed of plans and orders in ample time to enable it to make necessary arrangements.” [154] Given the experience of the 5307th, one can conclude that this guidance was never articulated or appreciated at the operational level. Colonel Williams was not only unaware of the 5307th arrival in theater, there is no evidence to suggest that he played a direct role in planning or supporting the campaign’s decisive effort. Though medical providers performed heroically in combat, a lack of conformity persisted at the tactical level. Doctor Seagrave lamented that aside from one notable occurrence at Myitkyina, “not one single line officer ever told a single fact about what the blazes was going on.” [155]

Responsibility for operational oversights in northern Burma transcend any single individual. Though Tamraz’s failures “partly caused and surely increased” the crises of supply and hospital capacity in the communications zone, Williams failed to remedy the systemic failures before they gained attention of the United States Surgeon General. [156] Similarly, if one accepts the assertion that the exhaustion of the Marauders was an operational necessity, certainly Stilwell, Williams, and Tamraz share responsibility in equal measure. In both cases, tactical plans were devised with little consideration for medical risk or the conservation of combat strength.

Conclusion

Following prolonged conflicts that featured robust logistics infrastructure and nearly ubiquitous, uncontested medical treatment and evacuation, the Army is once again confronting the challenge of how to provide and sustain combat power in remote, contested environments. As

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[154] US War Department, *Field Manual 100-10. Field Service Regulations: Administration*, 65.

[155] Seagrave, *Burma Surgeon Returns*, 95.

[156] Stone ed, *Crisis Fleeting: Original Reports on Military Medicine in India and Burma in the Second World War*, 175.

such, the Allied experience in CBI offers many opportunities for further research and discussion. First, CBI is a fascinating study in joint theater logistics, given the theater's remote location at the end of an 8,000 mile supply chain. Specific to the functions of AHS, ample documentation exists to further examine the development of Force Health Protection measures in CBI, specifically the development of preventive medicine programs (e.g. medical surveillance and prevention of zoonotic disease). Finally, the British-led campaign to regain control of Burma offers an opportunity to study the integration of sustainment within a multinational command structure.

Though it is impossible to fully anticipate the character of future operational environments, the two case studies presented herein should inspire medical and operational planners alike to consider their applicability to the current environment. First, many of the organizational, tactical, and cultural obstacles encountered by liaison officers in support of the CAI are particularly relevant for Combat Advisor Teams (CAT) in the nascent Security Force Assistance Brigades (SFAB). Given their unique mission and structure, SFAB's lack any organic unit-level medical capability, organic evacuation assets, or dedicated medical logistics staff.[157] This reality demands that SFAB Surgeon Cells be capable of rapidly adjusting to changing tactical circumstances to ensure the most efficient placement and employment of organic resources.[158] Further, SFAB CATS must be capable of seamlessly integrating medical concepts of support within the US theater sustainment structure. Finally, SFAB medical planners must be expert liaisons, augmenting their meager capabilities with those of the host nation and non-governmental agencies.

While the Army habitually conducts SFA across the world, the training focus for many

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[157] Michael A. Honsberger and Michael F. LaBrecque, "Security Force Assistance Brigade and Army Health System Support," 1/1 Security Force Assistance Brigade (SFAB) Newsletter: Rotation 18-03, Joint Readiness Training Center, accessed February 12, 2019, https://www.milsuite.mil/book/docs/DOC-576885.

[158] Army Training Publication 4-02.3, *Army Health System Support to Maneuver Forces* (Washington, DC: Government Printing Office, 2014), 3-1.

coalition partners has only recently shifted from stability operations to preparation for large scale combat operations. Like the Chinese army in World War II, many coalition partners lack robust evacuation and hospitalization capabilities, reinforcing the need for joint and international integration of medical assets at the operational level.

Beyond the challenges incurred by the Medical Department in the execution of its SFA mission, the crucible of the 5307th Composite Unit offers an additional - and particularly salient - lesson for planners in present day. The command's failure to consider medical risk in planning for northern Burma not only threatened to compromise the campaign's operational success, it fully exhausted the combat capability of the NCAC's only infantry formation in theater. Though extraordinary attrition rates may be unavoidable in future conflicts, every effort must be made to mitigate medical risk throughout the operational planning process. No such integration existed in the preparation for Myitkyina, and the penalty was high.

The US military's missions in Iraq, Syria, Afghanistan, and the Horn of Africa are increasingly characterized by "complex, continuous, and dynamic" interactions of tactics and strategy.[159] Though the "forgotten theater" emerged on the strategic periphery of a global conflict, current geopolitical realities suggest that some of the challenges that defined CBI may be analogous to future operating environments. As recent, high-profile deaths of American military personnel in Niger and Syria have made clear, the provision of timely and definitive medical care in austere environments remains a pre-eminent consideration. These circumstances serve as a reminder that failures in operational and medical planning, even below the threshold of major conflict, have far-reaching strategic implications.

[159] G. Steven Lauer, "Blue Whales and Tiger Sharks: Politics, Policy, and the Military Operational Artist," accessed February 19, 2019, https://thestrategybridge.org/the-bridge/2018/2/20/blue-whales-and-tiger-sharks-politics-policy-and-the-military-operational-artist.

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