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History of the United States Air Force Nurse Corps, 1949-1954

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HISTORY OF THE UNITED STATES AIR FORCE NURSE CORPS

1949-1954

by

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ABSTRACT

History of the United States Air Force Nurse Corps

1949-1954

The Air Force Nurse Corps (AFNC) was established effective July 1, 1949, however, no history of the AFNC has been written. The purpose of this investigation was to examine the first five years of the AFNC when its initial framework, policies, and practices were established. Included in this period was the story of the AFNC response to its first great challenge of the Korean War beginning just before the corps first anniversary.

The study framework consists of the four themes of (1) dedication to serve, protect, and care for soldier patients; (2) slow advance in status;(3) need for adequate nurse preparation; and (4) need for political astuteness which were found consistently in reports of military nursing. These four themes were present in varying dimensions throughout the story of the AFNC and were organized around, (1) major factors leading to the development of the AFNC; (2) difficulties and successes in the formation of the AFNC; (3) experiences of the women who served; and (4) an explanation of the status of the AFNC within the larger Air Force (AF) structure.

Documentation of military activities was collected primarily from military history sources. Background and supplementary data were gathered from academic institutions, the Library of Congress, and the National Archives. Finally, interviews of AFNC nurses who served during the first five years of the corps provided invaluable insights and information regarding personal experiences.

Findings of the investigation showed that the Army nurses who had transferred to the AFNC had developed an identification with the air arm of the service prior to transfer and thought of themselves as AF nurses. The theme of dedication to service was strongly defined in the early years of the AFNC exemplified by the work of the AFNC flight nurses during the Korean War. The theme of need for adequate educational preparation was also clearly demonstrated particularly in the effort to train nurses in wartime skills such as flight nursing, anesthesia, and operating room practice. The themes of political astuteness and slow advance in status were present but not obvious as the AFNC devoted its efforts to creating an effective operational structure at the

same time it was coping with the demands of a major war effort.

A major difficulty for the study was the minimal written documentation of AFNC activities. This led to the recommendation that a history of the corps post Korean War be accomplished as soon as possible in order to preserve the details and rationales of AFNC actions and the experiences, thoughts, and emotions of the nurses.

ACKNOWLEDGMENTS

Successful completion of a research study involves the support and assistance of many people. In writing this history of the first five years of the Air Force Nurse Corps there have been many individuals who have generously assisted me with their time, knowledge, experiences, and encouragement. I wish to express my heartfelt thanks to each person.

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Chapter I

Introduction

The Earliest Beginnings

As nursing in the United States has endeavored to achieve full professional status, it has historically had a close relationship with the military. This association stretches from the inception of the United States when nursing was only a helping hand offered by one neighbor to another, to the present day where the profession of nursing is highly organized and requires extensive education and preparation.

Throughout the history of our country, nursing has had to endure and overcome many conflicts and debates concerning nurses' and women's roles which have mirrored the struggles of women throughout our society in an effort to attain equal rights and status. The history of American military nursing has demonstrated a similar slow progression of nursing gradually achieving more control over nursing practice as well as commensurate professional recognition. It has taken more than 170 years for military nurses to finally attain status as officers with rights and

responsibilities appropriate to their respective rank and with officers in other segments of the military.

Themes in Military Nursing

The progression of military nursing from its earliest beginnings to the present time reveal four consistent themes. The earliest theme is the strong dedication to serve, protect and care for soldier-patients often under difficult circumstances and sometimes despite resistance by military and medical superiors.

The second theme is the very slow advance in status sufficient to effectively carry out duties and responsibilities. In the military status is reflected in rank. As in civilian society, the higher the rank or position the greater the authority and responsibility. Rank also determines the level of pay and benefits. In the early years nurses had no rank, little pay, and neglibible benefits but did have great responsibility.

A third theme is the recognition of the need for adequate education of nurses. In later years this has been expressed by the need for baccalaureate and graduate preparation for professional nurses in the military just as in the civilian community.

The fourth theme, first demonstrated strongly

during the Civil War years, is the development of political astuteness. This attribute was displayed as nurses gained greater expertise in meeting needs and achieving desired goals. Military nurses developed their astuteness as they worked toward achieving their goal of permanent commissioned status.

These four themes are present in varying dimensions throughout the historical story brought together in this study and organized around, (1) major factors leading to the development of the Air Force Nurse Corps (AFNC) from its inception in 1949 through 1954; (2) difficulties and successes in the formation of the AFNC; (3) experiences of the women who served during the first five years of the AFNC; and (4) an explanation of the status of the AFNC within the Air Force Medical Service (AFMS) and the Air Force (AF).

It has been said that understanding the present is facilitated by an explanation of past trends and patterns[1], however, no organized history of the AFNC has been done. It is hoped that this history can at least partially fill this void by documenting the accomplishments of the pioneer nurses of the AFNC as well as contribute to a sense of continuity and pride among AF nurses past and present.

Study Limitations

This study was limited by the lack or

incompleteness of primary source documents. There were a number of articles about military nursing found in both professional and popular publications, however, only a few pertained to the AFNC. The annual reports of the Air Force Surgeon's Office provided an overall picture of medical and health care. However, in the volumes pertaining to the first five years of the AFMS the space devoted to the nurse corps was very brief. The United States Air Force Historical Research Center, Maxwell Air Force Base (AFB), Alabama does maintain copies of squadron and higher headquarters monthly, bi-annual, and annual histories which proved to be an important source of information and were utilized extensively. The Historical Research Center also maintains a collection of reports and books written by AF historians which provided an excellent picture of the AF, the history and development of aeromedical evacuation, and the Korean War.

The use of interviews of surviving AF nurses who had served during the first five years of the AFNC provided an additional source of data rich in personal insights and experiences. Participation was voluntary and the women could withdraw or decline. Several nurses chose to decline based on ill health or because they asserted they had only done their work and had no information concerning the development of the corps.

Unfortunately several of the nurses who had worked in the chief nurses' office during the first years, and were instrumental in developing the early organizational structure were deceased.

Data for this study were collected from military history sources at the U.S. Army Center for Military History, Washington, District of Columbia; the USAF Historical Research Center, Maxwell AFB, Alabama; Maxwell AFB Library, Maxwell AFB, Alabama; Headquarters Office of Air Force History Bolling AFB, District of Columbia; Hangar 9 Museum, Brooks AFB, Texas,; Military Airlift Command (MAC), now Air Mobility Command (AMC) History Office, Scott AFB, Illinois; the Uniformed Services University of the Health Sciences (USUHS) Library, Washington, District of Columbia; the School of Aviation Medicine Flight Nurse Branch, Brooks AFB, Texas; USAF Hospital Sheppard AFB, Texas; the USAF Medical Service School, Sheppard AFB, Texas; and the United States Air Force Academy Library, Colorado.

Research Libraries at academic institutions provided a source of background and related information. The libraries of The University of California at Los Angeles; Mount St. Mary's College, Los Angeles, California; The University of San Diego; The University of Pennsylvania, Philadelphia,

Pennsylvania; and the Center for the Study of The History of Nursing at the University of Pennsylvania were utilized. Additionally, the resources of the Library of Congress and the National Archives, which include material from the earliest beginnings of the United States, were included in the search for relevant data.

Finally, this study is indebted to Colonel Verena Zeller Seberg, first AFNC Chief Nurse; Colonel Ethel Kovach Scott, fourth AFNC Chief Nurse; and the chief nurses of both aeromedical evacuation squadrons directly involved in the Korean War aeromedical evacuation, Captain Louise Bainbridge Lawton of the 801st Medical Air Evacuation Squadron (MAES) and Major Lillie U. Crow of the 1453rd MAES, for providing their insights about the organization of the AFNC and the demands and stresses on flight nurses during the Korean War.

Chapter I Notes

[1]Myrtle Matejeski, "Historical Research: The Method," Nursing Research: A Qualitative Perspective, ed. P.L. Munhall and C.J. Oiler (Norwalk: Appleton, Century, Crofts, 1986) 181.

Chapter II

Factors Leading to the Development of the AFNC

Status of the AFNC

The AFNC is an integral component of the Air Force Medical Service (AFMS) which functions within the United States Air Force (USAF). Understanding the status of the AFNC within this structure is facilitated by a brief review of the development of the USAF whose achievement of autonomy within the military structure preceded the establishment of a separate AFMS by 22 months. The structure of the AFMS and its largest component, the AFNC is explained to a large extent by the historical development of the USAF.
Further, the timing of the Korean War 11 months after the creation of the AFNC was a factor forcing the young corps to maturity.

The Beginning of the USAF

The United States Army did not actually buy an airplane until 1909, but it had been using balloons since the Civil War and had begun to learn how to steer them over desired courses by the early years of the 20th century.[2] By 1912, the Army had 17 living aviators.[3] In 1913, the first bill was introduced into

the House of Representatives proposing to remove aviation from the Signal Corps and establish an Aviation Corps under the Army Chief of Staff.[4] This legislation was opposed by the War Department but in May, 1918, due primarily to the potential shown by the airplane in World War I, the Air Service was formed.[5]

During World War I, another event occurred which influenced the founding fathers of the Air Service with respect to autonomy of their service. That event was creation of a unified, independent, permanent Royal Air Force separate from the British Army and Navy.[6]

With the onset of World War II, the drive toward autonomy had to be temporarily delayed due to the demands of the war. However, the end of the war marked the resurgence of efforts to create an autonomous Air Service. In December, 1945, President Harry Truman recommended establishment of a Department of National Defense and creation of a separate Air Force, on an equal footing with the Army and the Navy.[7] The Navy strongly opposed this plan, fearing the loss of its air arm and thus a loss of its power.[8] As a result Congress made concessions and on July 26, 1947, President Harry Truman signed bills creating both the Department of Defense and the Air Force.[9,10,11]

The AFMS

Even though concessions were made to achieve

autonomy the AF planned to organize its own technical and professional services after a two year period. The question of which services proved to be a sensitive and controversial subject.[12] The Army had historically used the large military unit of at least two divisions called a corps as their basic structure. By September 1947, the Army had a total of 28 corps of which one of the two oldest was the medical corps.[13] Over the years the separate corps had gained considerable power and influence but during World War II the Army Air Corps (AAF) had been successful in integrating the corps groups into function organizations under the overall umbrella of the AAF.. The AF leaders elected to follow the lead of the AAF in regard to the various technical services and chose not to adopt a corps structure. Instead the AF decided on maximum integration of personnel while also providing for specialized functions. The consensus was that there could be no question about placing the "controlling reins in the command structure where they belong rather than in separate corps."[14]

This historical decision is the reason that the medical service is referred to as the AFMS rather than AF Medical Corps. Nevertheless, the term "corps" is frequently used in the AFMS even though there is technically no such structure. This might well have to

do with brevity since, for example, it is easier to say Nurse Corps than the more correct Nurse Officers of the AFMS. Another factor contributing to the common usage of the term "corps" might also be that the Army people who transferred to the Air Force were used to using the term and the practice was simply continued.

Just as the USAF had to struggle to attain its status and autonomy so did the AFMS struggle to separate from the Army and become a part of the USAF. The idea of unification of military medical services was being proposed by many in the Army command structure at the end of World War II.[15] One of the earliest proponents of a unified or single medical service was the Army Surgeon General (SG) Major General Norman Kirk who "presented a vigorous argument for amalgamation in a statement before the Senate Armed Forces Committee" in April, 1947.[16] Not surprisingly this proposal was opposed by the Navy Surgeon General, Rear Admiral Clifford Swanson, and the Air Surgeon, Major General Malcomb Grow. Their rationale was that the plan "would create a single and powerful super-organization, would emasculate the Surgeons General, and would violate a fundamental military principle by removing support forces from the direct control of the operational forces."[17] The Air Surgeon, Major General Grow, strongly supported a separate

medical service within the USAF and devoted his efforts to achieving that end.

The struggle to achieve an AFMS took almost two years and can best be described as a knockdown, dragout political battle. Finally the political battle was resolved in favor of the AF position justifying General Grow's position.[18,19] Twenty two months after the USAF became a separate service the AFMS, of which the AFNC is an equal component, was officially created on July 1, 1949.

On May 12, 1949, the Secretary of Defense, Louis Johnson, issued Joint Army and Air Force Transfer Order No. 36 followed by Joint Army and Air Force Adjustment Regulation (JAAFAR) No. 1-11-62 dated 16 May 1949.[20,21,22] On June 8, 1949, the long awaited U.S. Air Force General Order No. 35 was issued establishing the AFMS and the position of Surgeon General, USAF, effective July 1, 1949.[23,24]

The Beginning of the AFNC

To provide nursing care for the patients in the 73 medical facilities with a total bed capacity of 6200[25], 1199 army nurses transferred to the AFNC. Of these 1199, there were 3 majors, 200 captains, and 102 first lieutenants for a total of 307 Regular Army Nurse Corps (ANC) officers plus 892 Reserve ANC officers, ranks not specified, to complete the 1199 total.[26,27]

A formula was developed to calculate "tentative maximum distribution by permanent grade for Regular Army personnel to be transferred to the Air Force," with the proviso that the numbers could be adjusted between regulars and non-regulars up to the quota maximum. This formula was stated in rather complicated terms but can be better visualized in the following formula:

$$\frac{\text{active duty permanent grade officers for transfer to the DAF}}{\text{Authorized strength per permanent grade in the DA}} \text{ equaled } \frac{\text{\# of permanent grade officers transferred to DAF}}{\text{authorized strength per permanent grade in the DAF subsequent to transfer.}}$$ [28]

However, no record was located that indicated how quotas were determined. One can only have sympathy for the personnel people who had to do these computations before the days of personal computers and calculators!

Both the Air Surgeon Major General Malcolm Grow and the Army Surgeon General R.W. Bliss, stated that no officer would be transferred from the Army to the Air Force without the request of that officer.[29,30] The AF added the proviso that acceptance would also be based upon consideration given to overall AF requirements.[31]

In addition to the overall quota and authorization

by rank, authorizations were also specified by the classification code known as military occupational specialties (MOS). For the nurse corps these groups were (1) administrative; (2) neuro-psychiatric; (3) operating room; (4) anesthetist; and (5) general duty.[32] No record of the numbers actually transferred in each MOS were located. However, by the end of the calendar year 1949, numbers reported were (1) administrative, 90; (2) operating room, 70; (3) Anesthesia, 30; (4) general duty, 925;, and (5) neuropsychiatric, 14. There was an additional listing of 79 nurses serving as flight nurses in air evacuation units and 91 nurses designated as flight nurses not actively engaged in air evacuation duties.[33]

Nurses Selected to Serve in the AFNC

The AFNC wanted nurses with good records who met the highest professional standards in each functional area and the ANC wanted to be sure that people who met those standards were permitted to transfer.

Lt Colonel Katherine Hayes, who was deputy chief of the ANC from 1946-1951, recalled Army Chief Nurse, Colonel Mary G. Phillips, saying that she wanted to be sure that only good people would be sent to the new AFNC.[34] She particularly didn't want any"problems" to be sent off to the new corps.[35]

A notice was sent to all chief nurses of Army hospitals that nurses who were interested in applying for a transfer should send in an application.[36] In an August 1949 bulletin, Colonel Phillips commented that many questions were still being asked about transfer to the AFNC and stated that, for those interested, transfers could occur any time within a two-year period.[37] Florence Houle Howarth, who had been in charge of Army nursing personnel assignments recalled that her section was advised by the Department of Defense (DOD) that they could transfer 648 nurses and that she personally reviewed all 648 files before they were sent on.[38]

The identification that nurses had formed with the AAF during World War II was reflected by the ease in which they transferred over to the Air Force with the mindset already in place that they were Air Force and not Army. Colonel Ethel Kovach Scott indicated that a few nurses had transferred back to the Army for reasons that she believed had mainly to do with assignment availability. For example, anesthetists would prefer to remain with the larger Army hospitals because there would be more surgeries done and thus more opportunity for them to remain proficient in their specialty.[39] Colonel Frances Bryant, USAF, Ret, also knew of some nurses who, after they transferred to the AFNC didn't

like it and went back to the ANC. She believed that in some instances that had to do with family concerns.[40]

However, by and large, most of the nurses at AAF bases transferred to the AFNC. Most were younger nurses and those who wanted to be in aeromedical evacuation, "perhaps for the glamour of it."[41] Regardless of the motivation, however, the nurses did identify with the Air Force and still do. This sentiment of dedication and pride in the AFNC is exemplified by the the comment of one retired nurse, Lieutenant Colonel Mary Hoadley, when she said that she has kept her uniform and silver wings and planned on being dressed in them when she is buried.

Flight Nurses Assigned to Aeromedical Evacuation

As of 30 June 1949, on the eve of the creation of the AFNC, there were only a few ANC nurses actually assigned to flight nurse duty. Most of those were assigned to Military Air Transport Service (MATS) squadrons. The majority of the nurses were assigned to units based in the United States which provided aeromedical evacuation support to American forces in most of the world except for the Pacific.

The MATS aeromedical unit in the Pacific was the 1453rd Medical Air Evacuation Squadron (MAES) located at Hickam Air Base (AB), Territory of Hawaii. Assigned to the 1453rd were 12 Army flight nurses and 12 Navy

flight nurses. The senior flight nurse was Captain Alta R. Clark who in later reports was listed as the adjutant.[42] At that time it was the practice to have both ANC and Navy Nurse Corps (NNC) nurses flight nurse qualified and eligible for assignment to aeromedical evacuation squadrons particularly in the Pacific.

The patient population that required aeromedical transport was not large but was sufficient to require the 24 nurses assigned to the squadron primarily because of the large distances traversed throughout the far flung Pacific region. The 1453rd squadron report for the month of June 1949 reported a total of 313 patients airlifted which reflected a typical monthly requirement for a peacetime environment in the Pacific.[43]

MATS, however, did not have responsibility for all of the aeromedical evacuation squadrons. One of the original World War II aeromedical evacuation squadrons, the 801st MAES, was located at Tachikawa Airbase (AB) on the island of Honshu in Japan.[44] The unit was assigned to the 374th Medical Group, 374th Troop Carrier Wing (H), Fifth Air Force and was responsible for air evacuation of sick and wounded throughout the Far East Command.[45]

In addition to their aeromedical duties, unit personnel were also assigned to assist in the operation

of the base dispensary.[46] There were ten flight nurses assigned to the 801st MAES with Captain Louise Bainbridge as the Chief Nurse. Common to the choice so many of the AAC nurses made, all ten 801st MAES flight nurses transferred from the Department of the Army to the Department of the Air Force effective 1 July 1949.[47]

The patient population aeromedically transported by the 801st during the peacetime months of 1949 through early 1950 was small but consistent. The squadron histories for the months of October, November, and December of 1949 revealed totals of 19, 23, and 19 patients respectively evacuated by air within the Far East Command and can be taken as a typical aeromedical patient workload.[48,49,50] Those numbers would soon be massively increased and provide a significant challenge to both the 801st MAES and the 1453rd MAES.

Although their numbers were small at the beginning of 1950 the flight nurses of the 801st and the 1453rd MAES would be the AF nurses faced with the responsibility of absorbing the immediate impact of tremendously increased aeromedical evacuation needs when the Korean War began in June, 1950.

When the war started there were only 170 qualified flight nurses out of the total 1157 AFNC membership. Of that number of flight nurses 79 were already

assigned to aeromedical units which meant that the remaining 91 designated flight nurses not on flying status constituted the entire pool of qualified nurse medical crew members[51] available to supplement the two Pacific squadrons. Included in that number were higher ranking nurses in administrative and flight school positions who were not available for active flying duty.

Compounding the shortfall problem was the fact that only small numbers of nurses were graduated in any given class from the flight nurse course. For example, in December 1949 there were eight graduates[52] which was a typical peacetime number.

Given that the participation of the AFNC in the Korean War was primarily one of aeromedical evacuation the shortage of qualified flight nurses constituted a major difficulty in the first big challenge for the AFNC only 11 months after its creation. The efforts and dedication to service of the many women who distinguished themselves as flight nurses during the war were critical to saving lives and meeting the demands placed on the AFNC.

The Partition of Korea

After World War II the separation of Korea into two distinct political divisions set the stage for the conflict which would occur in 1950. It had been the

intent of the United States that an international commission representing the United States, Great Britain, China, and the Soviet Union would help Korea prepare for independent statehood. On 8 August 1945 there was a formal agreement to this offered by the Soviet Union.[53]

The capitulation of Japan sooner than expected, however, resulted in an emergency partition of Korea in order to accept the surrender of Japanese troops in Korea. This partition allowed for the Soviet Union to accept Japanese surrender north of the 38th parallel and the United States to accept their surrender South of the 38th parallel.[54] Although the United States considered this a temporary division the Soviet Union did not. The United States did ask for United Nations assistance in providing for free elections in Korea but with opposition by the Soviet Union the effort was unsuccessful.[55] Finally, in May 1948 elections were held South of the 38th parallel and the democratic Republic of Korea (ROK) was formed.[56]

The next move on the chessboard was the announcement by the Soviets that all Russian occupation forces would be withdrawn by 1 January 1949 accompanied by an invitation to the United States to withdraw its forces. The United States was more than happy to do so

since its military forces, which had been downsized after World War II, were severely strained by keeping 45,000 troops in Korea.[57] As a result both the Americans and the Russians moved to a position of economic support and military training and equipment support to their respective sides. This situation persisted for the next year and a half and set the stage for the conflict which would begin in June 1950.

The USAF and Korea

The Air Force organization responsible for the the Southwest Pacific was the Far East Air Forces (FEAF, an acronym pronounced to rhyme with leaf). It was the USAF component of General Douglas MacArthur's U.S Far East Command (FEC).[58] Although its primary mission was air defense within the theater of operations FEAF was also tasked with responsibility to provide air support of operations as arranged with appropriate Army and Navy commanders.[59] It was this latter mission which would involve the AFNC in its aeromedical evacuation role.

FEAF was commanded by Lieutenant General George Stratemeyer who had command and control of a number of subordinate commands.[60] Largest of these subordinate units was the Fifth Air Force under the command of Major General Earle Partridge with units at Itazuke Air Base (AB) on the southernmost island of

Japan, Kyushu; Misawa AB on the northeastern shore of the main Japanese island of Honshu; and the major concentration of units centered in the Kanto Plains area of Honshu around the City of Tokyo with three units: one at Yokota AB which included jet aircraft, one at Johnson AB, and the third at Tachikawa AB.[61]

Although AFNC flight nurses would fly on missions in and out of all of these air bases it was at Tachikawa AB that the C-54 transport aircraft of the 374th Troop Carrier Wing, used for aeromedical evacuation by the 801st MAES, were based.[62] There were also C-54 aircraft belonging to FEAF based at Clark AB in the Philippines.[63] These two locations then, Tachikawa AB and Clark AB, provided the aeromedical airlift aircraft for aeromedical evacuation flights.

Air Rescue and Aeromedical Evacuation

FEAF also had attached to it flights of the 2nd and 3rd Air Rescue Squadrons who were located at the various bases where they could best perform their search and rescue missions.[64] The Air Rescue Squadrons would prove to be of great value in battlefield aeromedical evacuation during the Korean war soon to begin. Flight nurses did not fly on these air rescue helicopter missions. The nurses were utilized on the fixed wing aircraft transporting patients from one location to another. However, enlisted crew members

did assist patients on the relatively short helicopter flights to the nearest medical facility.

War in Korea: Surprise Attack

In accordance with the earlier agreement with the Russians, the last American military unit, with the exception of a small U.S. Korean Military Advisory Group (KMAG) of about 500 persons, departed Korea on 29 June 1949.[65] The KMAG was the small group left in the country to support the training of the ROK military force.[66] The only nurse assigned to the KMAG was from the Army, Captain Viola McConnell.[67] A handful of AF personnel were also assigned to assist with liason and training but no AF nurses were included among this group.[68]

As a result of the transfer of U.S Forces out of Korea in 1949 the military situation in the country on Sunday 25 June 1950 was one of a total absence of American combat forces. At 0400 hours (4 a.m.) the unexpected happened. Taking advantage of the concealment afforded by bad weather the North Koreans launched an all out attack across the 38th parallel.[69]

As might be expected much confusion existed as to what was really happening and subsequently news of the attack did not reach FEAF headquarters in Tokyo until 0945 hours. In addition no one was able to reach the acting commander of FEAF, General Partridge, until

1130 because he and his family were visiting in Nagoya and he was out of his quarters.[70] The inability of intelligence to predict the attack and the early lack of organization was a reminder of similar problems in 1941 at Pearl Harbor.

However, the delay did not directly affect the reaction of FEAF since at the time the only mission it had concerning Korea was to provide for safety of American nationals in the country and then only if requested by the American ambassador.[71] Since Ambassador John Muccio was not immediately aware of the true situation no request was forthcoming.

It was not until shortly before midnight that Ambassador Muccio learned that North Korean tanks were only 17 miles from Seoul and notified General MacArthur that he had decided to evacuate women and children on freighters which were in Inchon harbor.[72]

With the beginning of an evacuation FEAF finally became involved. At this point though it was only to provide fighter cover to protect the ships making the crossing to Japan from the possibility of attack by North Korean aircraft. Of all the American airbases in Japan the closest to Korea was Itazuke AB in Southern Japan.[73]

Since FEAF was not involved, at this time, in the actual transport of refugees the decision was made to

move the transport aircraft out of Itazuke to make room for sufficient fighters to provide protection for the refugee ships.[74] Since there were still no casualties to be transported the 801st MAES was not yet involved.

By midnight of 26 June it was realized that Seoul would fall and South Korean President Syngman Rhee and his government left the city.[75] At this point a full scale emergency air evacuation was ordered from FEAF. Unfortunately the cargo C-54 transports which had been removed from Itazuke had scattered to other duties and had to be returned which took time. Eleven smaller aircraft plus two of the C-54 aircraft, which were the first reprocured, began the airlift and by midnight of the 27th 748 people had been flown from Seoul, using Kimpo airport and the smaller Suwon airfield located about 20 miles south of Seoul,[76] to Itazuke. This evacuation was carried out by the airlift crews. Again, since no casualties were involved no flight nurses of the 801st MAES were involved. It was not until after 1 July, 1950 when the first Army ground units landed in Korea[77] and casualties began to occur that the aeromedical evacuation system became needed.

Military Nurses and the Challenges of the Korean War

While nurses were clearly needed in the Korean War effort there was concern among nurse leaders that once again, as had happened during WW II, the needs of the

military during the war would cause a general exodus of nurses leaving civilian hospitals for military service resulting in severe problems of understaffing for civilian nursing service.[78,79]

Those concerns of the nursing leaders turned did not materialize. Although nurses, as they always have, responded to the need for service in the military the numbers required were relatively low. In addition the numbers of nurses actually assigned to Korea were relatively small even when all three services were included. The scale of the Korean War effort was significantly less than that of the recently concluded WW II worldwide conflict. In turn, the level of demand for increased nursing support was also less.

At the onset of the Korean in June 1950 the AFNC numbered a total of 1,170 nurses with only 181 of them holding the designation of Flight Nurse.[80] Ten of those 181 were assigned to the first aeromedical evacuation unit to feel the impact of war, the 801st MAES. Eventually the AFNC reached a maximum total strength of 2,816 on June 30, 1952[81] including 463 nurses trained as flight nurses. Although the numbers showed the result of a maximum effort to train flight nurses, increasing the available trained flight nurses by approximately 60%, there were still only 160 nurses actually performing that duty in an aeromedical

evacuation squadron[82] even during the peak casualty periods. Most of those performing flight nurse duties were not assigned to units flying in Korea. Instead they were assigned to units throughout the United States which also had greatly increased numbers of patients to transport because of the Korean casualties. In addition increased numbers of nurses were assigned to flight duty in Europe to meet the needs of patient transport in that part of the world which could no longer be handled by U.S. based units.

The ANC and the Navy Nurse Corps NNC also increased their respective strength during the Korean War although, similar to the AFNC increase, the numbers involved were not sufficient to cause undo hardship on civilian nursing.

The ANC reached its maximum strength of 5,397 officers in July 1951,[83] of which only 540 or approximately 10% of ANC officers served throughout the Korean peninsula[84] where they had the primary responsibility for staffing the military hospitals.

The NNC had a smaller presence in the Korean theater of operations than either of the other two military nurses corps but still required an increase in nurse strength up to a peak strength of 3,238.[85] NNC members served on one of three hospital ships, Repose, Consolation, and Haven, which rotated duty in Korean

waters.[86]

Air Force Nurses Become Involved in the Korean War

With the involvement of American combat forces in the Korean fighting and the onset of American casualities AFNC flight nurses became directly involved in the conflict. Later in the conflict there were, in addition, a small number of AFNC nurses assigned to new medical facilities established within Korea.

The ten flight nurses of the 801st MAES based at Tachikawa AB, Japan became the first AFNC members to become directly involved in the Korean War effort soon to be followed by their counterparts in the MATS aeromedical unit based in Hawaii, the 1453rd MAES.

Unless the nurses had had previous wartime experience during WW II, as had 801st MAES Captain Lillian Kinkela Keil, the demands placed upon them would be far in excess of their previous experience gained during peacetime aeromedical duties. The number of hours flown, increased numbers and severity of patient injuries and illnesses, lack of equipment, and the high probability that no large numbers of additional flight nurses would be available to supplement crew numbers were all factors that would have to be dealt with especially in the early days of the Korean conflict.

The maximum numbers of flight nurses assigned to

the 801st MAES were 34 in April 1951 and 35 in March 1952.[87,88] This meant that during the difficult early days of the Korean War the large number of casualties evacuated by the AF air evacuation system was accomplished by relatively small numbers of nurses and aeromedical technicians flying, in some instances, around the clock.

No report was located of numbers or names of AFNC officers stationed in Korea until later in the war although one nurse flying with the Military Air Transport Service (MATS) recalled that two nurses at a time would be sent to Korea for a period of two months in order to organize patient loads prior to flight, provide information to the inflight crew and assist with the onloading of patients aboard the aircraft.[89]

The MATS Pacific aeromedical unit, the 1453rd MAES, had more nurses assigned than did the 801st MAES. This was primarily because of the large geographic area of responsibility covered by the squadron and the vast distances traveled. The 1453rd MAES began the war with a total of 16 AFNC flight nurses plus 10 NNC flight nurses assigned.[90] By September 1950 the 1453rd had increased their numbers to 35 AFNC, including the newly arrived chief nurse Major Lillie U. Crow, and 20 NNC flight nurses[91] reflecting a rapid buildup to meet mission demands generated by the increased numbers of

patients.

Because of the continuing demands for increased aeromedical missions as hostilities increased 1453rd MAES nurse numbers continued to increase up to 55 AFNC flight nurses by August 1951, 19 NNC flight nurses, and two Royal Canadian Air Force (RCAF) flight nurses who reported to the squadron for preceptorship training.[92]

Because the Korean War effort was under the auspices of the United Nations, personnel from allied countries served along with American forces. This included flight nurses, most of whom had been trained at the USAF Flight Nurse Course. Some of these nurses, such as the two RCAF nurses with the 1453rd MAES, flew with the MATS squadrons.

With the beginning of truce talks in July 1951 casualties declined[93] and the numbers of flight nurses required by the squadrons decreased accordingly.

Air Force Medical Services

All hospitalization in Japan, Korea, and Okinawa was provided in U.S. Army hospitals until 1 February 1951 when the Air Force established a 50-bed facility at Itazuke AB, Japan.[94] The Air Force did have a hospital at Clark AB in the Philippines which by the end of 1951 was authorized 250 beds[95] and was able to relieve some of the demand on the hospitals in Japan. On 1 April 1951 the Air Force assumed

responsibility for operation of three former Army hospitals at Nagoya, Japan, and at two facilities near Tokyo, Johnson AB, and FEAMCOM (Tachikawa) AB.[96,97] The ability of the AF to take over these facilities provided relief to the Army who operated almost all of the military hospitals in Korea and was faced with the demand for increased hospital personnel to care for the patients in Korea.

By the end of 1951 FEAF was operating six hospitals in Japan and had opened a 50-bed facility in Korea.[98] MATS had also opened three infirmaries to serve the medical air evacuation route from Japan to the United States. These infirmaries were located in Japan, Guam, and on Johnson Island.[99] By June, 1953 there were four 50-bed facilities run by the Fifth Air Force component of FEAF located in Korea at Kunsan (K-8), Suwon (K-13), Osan (K-55), and Kimpo (K-14).[100]

The opening of these facilities created an increased demand by FEAF for medical personnel. By 31 December 1951 AFNC numbers assigned to FEAF had increased almost seven times up to a total of 210.[101] By 25 June 1952 the Fifth Air Force had 16 nurses assigned to the two hospitals it had open at Kunsan and Kimpo.[102] These numbers increased the following year with the opening of the other two facilities Suwon and Osan. By the end of the war a total of 24 AFNC

officers were assigned to Korea.[103] The opening of the Suwon and Osan facilities and the assignment of AFNC officers reflected the recognition by the AF of the need for inpatient care in the theater of operations and the importance of AF nurses in providing that care. That policy would be followed again in future conflicts.

Air Rescue Responsibilities in Aeromedical Evacuation

Before the Korean conflict air rescue had not been thought of as a part of aeromedical evacuation. This normal function which heretofore had been search and rescue was expanded in Korea and became an important part of patient evacuation from the battlefield. Although nurses did not fly on the helicopters technicians did and were able to provide patient care in larger helicopters.

The small H-5 helicopters, which carried a pilot and technician and could carry two patients in external litter capsules, were called on to evacuate critically wounded soldiers from front-line aid stations to Mobile Army Surgical Hospitals (MASH) at Miryang and Pusan, Korea.[104] However, because the patients were carried in the external litters technicians could not reach them inflight to provide any care. Nevertheless, these small helicopters of the 2nd and 3rd Air Rescue Squadrons had by 29 August 1950 evacuated 83 soldiers

whom the 8th Army Surgeon said would never have survived the required ten-to fourteen hour ambulance ride to the MASH units.[105]

Capabilities improved in February 1952 when the units started to receive the larger H-19 helicopters which could carry eight litter patients or ten ambulatory patients in addition to the pilot and medical technician.[106] With patients inside the cabin the medical technician could now provide inflight care and attend to any emergencies which might occur providing a considerable improvement in battlefield patient transport. The Army recognized the benefits of helicopter transport and in the late Spring of 1951 obtained its own helicopters enabling it to take over a large proportion of the front-line medical air evacuation missions.[107]

After taking over the major part of the front-line evacuation duties the Army then organized helicopter ambulance detachments[108] whose primary function was to accomplish these missions and attached them directly to MASH units.[109] Assumption of this responsibility by the Army had a major effect on the organization of aeromedical evacuation. Essentially a tacit decision had been made that the Army would handle aeromedical evacuation forward of its MASH units while the Air Force would provide aeromedical evacuation rearward of

the initial points of medical treatment in the combat zone which in Korea were the MASH units.[110] This organizational structure remains in existence to this day.

Development of Aeromedical Evacuation in Korea

During WWII aeromedical evacuation had always been thought of as an emergency method of transporting the wounded when the customary means of stretcher bearers, field ambulances, and hospital trains and ships were unavailable or insuffient in numbers.[111] The Korean War provided an opportunity to demonstrate that air evacuation was more desirable than surface evacuation in every way.[112,113]

Prior to the Korean War, when American troops still occupied the Korean peninsula, air evacuation was an important phase of medical activity but after withdrawal of American combat forces it became a comparative non-function[114] since the only American military personnel in country were those assigned to the Korean Military Advisory Group (KMAG). However, even when American troops had been in Korea in large numbers aeromedical evacuation had not been a scheduled operation. Cargo had priority and the convenience of patients and the shipping hospital was not considered.[115] The patients were picked up when the aircraft was available and the hospital was responsible

for transporting them to the flight line regardless of the hour. However, during the Korean War, experiments were conducted giving patients and hospitals priority for transport and were so successful in improving the system that air evacuation became a scheduled operation.[116]

Factors Decreasing Korean War Mortality

Aeromedical evacuation, including helicopter front line evacuation of wounded, was considered one of the major factors in reducing by almost 50% during the Korean War the mortality rate for the hospitalized wounded to 2.5% compared to the rate during WWII of 4.5%.[117,118] Other factors were the use of whole blood, antibiotics, and the development of Army MASH units located within eight to twenty miles of the front lines.[119,120]

Few people had heard of antibiotics in the 1940's although penicillin was first used clinically in 1943[121] By the 1950's the list of antibiotics had increased and many lives were saved because of their effectiveness. The use of these drugs altered nursing care requirements and diminished the importance of supportive nursing care measures.[122] Until the advent of the antibiotics, which could actually combat infections, treatment was almost entirely dependent on supportive measures to help the patients own immune

system overcome the disease. Nursing care was expanded by the need to understand how to give these new drugs, become familar with possible reactions to them, and know what results to expect. The survival of many of the patients air-evacuated from Korea was greatly facilitated by use of these antibiotics.

Prior to aeromedically evacuating patients out of Korea they were initially treated in Army MASH units. These units can be considered the forerunner of the modern day intensive care unit. The MASH unit was designed to be highly mobile and located within the closest practical distance to the front lines[123] Their mobility allowed them to move as the front lines moved. This mobility meant that the unit could remain close to its potential patients and provide skilled medical (including specialty care) and nursing care to the wounded as soon as possible after injury.[124]

The casualties were initially evaluated in the MASH admissions area and then provided with appropriate immediate care, diagnostic measures, and surgery[125] which was frequently required. The Army utilized half a dozen of the MASH units in support of front-line divisions throughout the Korean campaign.[126] After treatment patients could then could be moved to Japan and thence to the United States via the AF aeromedical evacuation system if required. The use of aeromedical

evacuation virtually eliminated the use of hospital ships as a means of transporting the wounded.[127] The hospital ships were instead used as off-shore hospitals and remained in Korean waters.

The combination of early aeromedical evacuation, immediate front line treatment in MASH units, and antibiotic therapy made for a major improvement in the survival of patients with battlefield injuries compared to that seen in previous wars.

Organization of the Korean Aeromedical Evacuation System

Air evacuation in Korea was eventually organized into three phases: Intra-Korea, Out of Korea, and Intra-Japan.[128] The aircraft commonly employed were cargo aircraft (thus the "C" designation) C-46, C-47, C-54, C-119, and C-124 which served the dual purpose of flying cargo to the war zone and then carrying patients on the return trip.[129] These aircraft, although being admirable for their cargo carrying ability and facility in landing and taking-off in small fields under difficult conditions, presented considerable problems when used for carrying patients in the aeromedical evacuation role. They were unpressurized, noisy, cold in the winter and hot in the summer, and cabin conditions after off-loading cargo made it difficult to maintain much in the way of

medical asepsis. Nevertheless these aircraft were the state of the art in the early 1950's and they were what the aeromedical squadrons had to work with. As nurses have done in previous situations where difficult conditions existed they made do and carried on with providing the best possible care to their patients inflight. That they did so very well is attested to by the fact that aeromedical evacuation was one of the three factors contributing to the decreased mortality of Korean War wounded.

Intra Korea Aeromedical Evacuation

There were four pick-up points for forward air evacuation along the 38th parallel[130] which were sometimes very dangerous both from the standpoint of enemy action and from the rough terrain.[131] Colonel Allen D. Smith, MC, colorfully described these landing fields as "most no better than stateside cow pastures, and some of them infinitely worse."[132] The C-47 aircraft was used for these small rough terrain fields and both flight nurses and technicians flew on these flights until January 1951 when the nurses were taken off due to hazardous conditions of the landing strips and lack of adequate housing facilities in the country. The flights were then manned by the aeromedical technicians based at Taegu (K-2).[133]

Patients would be taken from one of the forward

pickup points to the K-16 airfield outside of Seoul for further evacuation either back to Japan or to Central Korea for hospitalization in country at Taigu.[134] From South Central points patients, including South Korean casualties and prisoners of war, were flown to either Pusan or back to Japan.[135]

The forward pick-up points were ill equipped for the needs of female personnel and privacy was non-existant. Lieutenant Colonel Mary Hoadley commented though that the value of the flight nurses was so appreciated that soon "attractive little blue rooms" appeared at the pick-up areas with trustworthy guards assigned to the detail.[136]

Out of Korea

The patients flown out of Korea presented all types of medical conditions necessitating hospitalization of more than 30 days or requiring specialized treatment.[137] The patients were moved from the general hospitals in Korea directly to three main debarkation points in Japan. Those areas were Kyushu where the Army's 122nd Station Hospital and Fifth General Hospital specialized in treating hepatitis and hemorraghic fever patients; Osaka where the Army General Hospital specialized in treatment of cold weather injuries such as frostbite; and Tachikawa Air Base from where patients were sent to the Army General

Hospital in Tokyo which specialized in head and chest injuries.[138,139] When the AF opened a hospital at Tachikawa AB AF casualties were usually sent there.[140]

Flights from Korea to Japan varied in length from one and one half to four hours preferably using the C-54 aircraft which was larger and more comfortable. The medical crew enroute was comprised of one flight nurse and a medical technician.[141]

Intra Japan Aeromedical Evacuation

Flights were flown within Japan when patient conditions required their transfer between the smaller station hospitals to the larger general hospitals mainly using C-54 or smaller and less comfortable C-47 aircraft, again with a flight nurse and medical technician providing care enroute.[142] It was not uncommon for patients to be transferred back and forth more than once. When their treatment, for which they were transferred to the larger hospital, was completed they were often moved back to the original hospital for their convalescence.

Volume of Patients Evacuated

AF records for the period between 1 July 1950 and 1 July 1954 report aeromedical evacuation of patients between Korea and Japan totaled 333,370.[143] The numbers for the period of active fighting which ended in July 1953 show a total of 311,673 patients

airlifted[144] The flight nurses and medical technicians of the 801st flew more than 14,000 flights into and out of more than 35 Korean airstrips, transporting over 313,000 patients within the Korean theater (the number does not reflect actual casualties since some were moved two or three times), with only 15 inflight deaths none of which were attributed to the conditions of flight itself.[145] The assumption was that these patients would have died even if they had had remained in the hospital. It was not uncommon to evacuate the patient in the hope that if they could get to a larger facility with more treatment capability perhaps something could be done to save the person. The very low rate of 15 deaths per 313,000 patients indicates that the evacuation effort was extraordinarily effective in safely transporting often severely injured and sick patients. This achievement was a testimony to the efforts of the medical and nursing personnel.

Aeromedical Inflight Crew Casualties

Although aeromedical crew members accumulated large numbers of flying hours, often under difficult conditions the numbers of crew casualties were low. On 26 September 1950 a C-54 took off from Ashiya AB, Japan enroute to Kimpo, Korea carrying ground troops to Korea as well as a medical crew who would be bringing

patients back to Japan on the return flight. Shortly after take-off the aircraft crashed into the Sea of Japan not far from shore resulting in the death of one flight nurse, Captain Vera M. Brown, and one aeromedical technician.[146] The other flight nurse, Lieutenant Jonita Bonham, although injured was able to assist the other survivors by directing them as to how to inflate the life rafts which kept them afloat until rescued three hours later. For her effort Lieutenant Bonham was awarded the Distinguished Flying Cross.[147] Captain Brown was posthumously also awarded the Distinguished Flying Cross.[148]

The 801st MAES and its Achievements

During the first two months of the war when the Eighth Army was indecisive and hesitant about the use of aeromedical evacuation the numbers evacuated by the 801st MAES reflected this hesitancy. In July 1950 831 patients were air evacuated followed by 800 in August 1950.[149] Beginning in September 1950 two factors contributed to a significant increase in those numbers. FEAF was improving organization and exploiting centralized control plus continuous field liason to make aeromedical evacuation the standard method of transporting sick and wounded personnel.[150] September 1950 also saw the waterborne landings at Inchon and the subsequent battle for Seoul.[151] As a result the

numbers of patients air evacuated out of Korea made a huge jump in September to a total of 7,246. The 801st MAES responded to this tremendous demand by evacuating a total of 1,449 battle casualties from the Suwon and Kimpo airstrips, located near the fighting, under conditions of heavy enemy fire.[152]

Intra Korea aeromedical evacuation was not authorized until 1 October 1950 when three of the small and cramped C-47 aircraft were allocated to bring patients from various outposts into Taegu (K-2) or Pusan East (K-9).[153] The AF utilized the practice of designating the airstrips with the letter K for Korea and J for Japan followed by an identification number. During the first month of the intra Korea operation in October 1950 the 801st MAES moved a total of 2,867 patients.[154] This demonstrated effectiveness removed any hesitancy to transport patients by air.

The Chinese Communist attack in November 1950 and the evacuation from the Chosin Reservoir in the frigid weather of early December imposed the heaviest aeromedical evacuation burden of the war upon the 801st MAES.[155,156,157] During the single day of 2 December 1950 968 patients were airlifted from Hagaru and for the first time no nurses were sent on the mission because of its extremely hazardous nature.[158] Aeromedical technicians from the 801st MAES provided

medical care for the 4,689 wounded and frost-bitten Army and Marine troops evacuated from the besieged airstrips at Hagaru-ri and Koto-ri.[159] One C-47 aircraft crashed during the operation as a result of enemy fire but both crew and patients were safely removed.[160] Throughout December 1950 the 801st MAES evacuated the astonishing total of 13,959 patients out of Korea and 6,357 intra Korea.[161] This effort was accomplished by 27 flight nurses and 43 aeromedical technicians who comprised the total medical crew personnel of the 801st during that time period.[162]

On 18 December 1950, for their efforts, the 801st MAES was awarded the Distinguished Unit Citation for "gallantry and heroism" in battle casualty operations during the periods "21 September to 30 September 1950" and 1 December to 10 December 1950.[163] They were the first USAF unit in the Korean theater to receive the citation.[164] No list of the total number of citations awarded during the Korean War was located.

1453rd MAES

Just as the 801st MAES had been the first USAF unit to receive a Distinguished Unit Citation, the 1453rd MAES was the first to receive a Meritorious Unit Commendation.[165] The commendation referred both to the performance of the unit in the combat zone in September 1950, when it had evacuated 950 casualties from Pusan

under threat of eminent attack, and to its outstanding service in evacuating 16,604 battle casualties between the Far East and hospitals in the United States between 27 June 1950 to 31 December 1950 without a single fatality.[166]

The various awards and citations are initiated by supervisory personnel, depending on the level of the award, and approved by higher headquarters. The Distinquished Unit Citation would be considered a higher level award then the Meritorious Unit Commendation, however, both carry significant status and attest to the achievements of those receiving them.

The 1453rd MAES was the aeromedical component of the Pacific Division of the Military Air Transport Service (MATS). Prior to the beginning of the Korean War it had been air evacuating an average of 350 patients per month.[167] There were 26 flight nurses assigned at the end of June 1950, 17 from the AF and nine from the Navy.[168,169] The chief nurse, Captain Alta Clark, was also assigned duty as adjutant.[170]

With the rapid increase in medical personnel required because of the war the number of personnel reporting for duty at the squadron in September 1950 had increased to 96 nurses and 137 medical technicians[171] There was also a new chief nurse, Major Lillie U. Crow.[172] Although this was a large number of

nurses it is important to remember that many of them had not had flight nurse training.[173] The standard inflight medical crew was two nurses and three medical technicians.[174] This inflight structure allowed for nurses without flight nurse training to be paired with experienced flight nurses. In addition the increased numbers allowed nurses to be utilized for additional roles. For example, because of the need to better organize aeromedical flights out of Korea, it became the practice to station two nurses at a time in Korea to do preflight organization of missions and then help with the onloading of patients to be flown.[175] Prior to this change the originating medical facility would be responsible for needed organization and patient preparation.

The MATS flights were primarily between Japan to the United States with intermediate points at Guam, Manila, Okinawa, Kwajalein Island, Johnson Island, and Hickam AB, Territory of Hawaii (T.H.)[176] As would be expected the number of patients aeromedically evacuated by the 1453rd MAES demonstrated the same rate of increase as experienced by the 801st MAES. The first month of the war the 1453rd transported 535 patients into the continental U.S. at Fairfield (Travis, AB) California. By September this number had jumped to 3,410[178] reflecting the greatly

increased number of patients. Fortunately the month of September also was the month when the number of 1453 MAES nurses and medical technicians had also significantly increased thus providing the squadron with more medical crew members to manage the increased demand.

From the beginning of hostilities in July 1950 through June 1953 the MATS 1453rd MAES aeromedically evacuated 60,965 patients from the Pacific area and provided regular air evacuation service to Tokyo, Manila, Guam, Kwajalein, Johnston, Eniwetok, and Hawaii.[179] The flight nurses and medical technicians had established an impressive record in the safe transport and care of those patients over long distances and many hours of flight.

Aeromedical evacuation had progressed greatly during the war and the flight nurses and medical technicians of the 801st MAES and the 1453rd MAES had made a great contribution to the effort.

Air Force Development within the United States 1950-1954

Although the major impact for the AFNC during the Korean War was in aeromedical evacuation an increased demand was also placed upon hospitals. By 1 July 1950 the number of AF hospitals had been decreased to 56 within the United States (referred to as the Zone of

Interior or ZI) and 17 overseas providing a total patient bed capacity of 6200.[180] Six months later, reflecting the needs of the Korean War casualties, the bed capacity had been increased to 8560 with no increase in hospitals although 17 infirmaries had been established.[181] At the time there were still AF nurses assigned to Army hospitals but the increasing patient care needs in AF hospitals facilitated the transfer of AF nurses to AF facilities. By June 1951 all AF nurses were placed on duty in AF installations.[182] The separation of AF nurses from the Army was finally complete.

Of all the AF medical facilities in the ZI one of the heaviest burdens was placed on the hospital at Travis AB in Fairfield, California since it was the debarkation hospital for the west coast receiving the patients air evacuated in from the Pacific.[183] To meet the increased demand personnel were assigned on a temporary (TDY) basis and extra space from adjacent barracks buildings and part of the old temporary hospital were utilized.[184] By the end of 1950 the Travis hospital was operating with a full staff and a bed capacity of 525.[185]

Other AF hospitals were also faced with the problem of establishing and staffing additional medical treatment facilities to care for evacuated patients.[186]

To meet this need a plan for temporary hospitals was developed which enabled AF to provide structures but most were inadequate compared with the facilities of the Army and Navy hospitals.[187]

Continental Division of MATS

The rapid increase in evacuated patients arriving into the ZI necessitated a corresponding increase in the ability of MATS Continental Division to move patients on to their respective medical facility destinations within the United States.

Prior to the onset of the war Continental Division provided air transport within the United States plus airlift to Alaska, the Caribbean, and South America.[188] However, its primary peacetime mission was that of training.[189] The flying units assigned to the Division were located at Kelly AB, Texas; Great Falls AB, Montana; Brookley AB, Alabama; Fairfield-Suisan AB (Travis), California; Washington National Airport, District of Columbia; and a Navy unit, VR-3, at Moffett Field, California.[190]

1 July 1950 found Continental Division having to rapidly switch most of its resources to a fully operational support of a portion of the airlift to Japan plus increasing domestic air transport to support the Pacific airlift.[191] The immediate need for transport aircraft resulted in wholesale shufflings of

personnel and units to meet the demand. Domestic and Caribbean schedules were practically eliminated to concentrate on the need to provide air evacuation for Korean wounded and to transport supplies to Korea.[192] MATS detachments in the Pacific Northwest were pitifully undermanned when faced with the tremendously increased air traffic across Alaska and down the Aleutians across the Pacific Ocean to Japan. Personnel and aircraft were drained from other units to support that effort.[193]

Continental Air Evacuation

Medical Air Evacuation Units were discontinued as separate squadrons and instead assigned directly to Air Transport Squadrons in an effort to improve efficient utilization of manpower.[194]

Fortunately for the organization of patient distribution the AF had recognized in late 1949 that a joint medical regulating office was needed to control the flow of patients to and from the various armed service facilities within the United States and from overseas areas.[195] This system was designed during the first part of 1950, and approved by the Secretary of Defense on 25 October 1950, with tri-service operation beginning in December 1950.[196] The new system was an important factor in efficient air evacuation operation.

Continental Division was expected to be able to

move 212 patients a day from Travis AFB using the large C-54, C-74, and C-97 aircraft. Following the Chinese Communist attack in late November 1950 when casualties skyrocketed the Continental air evacuation program was stepped up to 300 patients per day.[197] The domestic air evacuation routes were fairly stable since basically the same destination hospitals were used as in peacetime. These hospitals included the 56 AF facilities plus those of the Army and the Navy. The hospitals of the other two services were used mainly for their specialty services. In addition an effort was made to transfer the patients to a facility near their home. Although all the medical facilities in the United States were utilized as needed to manage the increased patient numbers the patient flow constantly fluctuated depending on the events in Korea.[198] Even with the new organization system to help cope with the rapidly changing influx of patients and a stable route system the war placed significant stress on the ability of the Continental Division to move all the patients to their destinations as efficiently as possible. To help cope with the greatly increased demand Lackland AB, Texas was designated as a debarkation port beginning in December 1950[199] and began receiving patients direct from Hickam AFB Hawaii. This practice relieved part of the workload from Travis AFB and helped to facilitate

patient movement to their destinations.

The peak workload of the Continental Division was reached in December 1950 when 13,189 patients were transported throughout the United States.[200] In addition MATS Continental Division C-74 and C-97 heavy transports were used to help move large numbers of patients from Japan.[201] While the Division was primarily concerned with the influx of Korean War patients it also had to continue to service other areas of responsibility. Scheduled flights from Alaska and the Caribbean frequently carried patients who required treatment in the United States.[202]

After the late 1950 peak patient loads from Korea air evacuation became a more stable operation and the patient workload varied only a few hundred from month to month.[203] This stabilization of workload facilitated the organization of the aeromedical system and allowed for improvements in the system. For example, in April 1951 authority was requested to offload all patients at Travis for rest and medical care prior to sending them on to their destination hospital.[204] This opportunity for the patients to rest at least overnight was important after the long Pacific flight. Patients were less exhausted when they finally arrived at their destinations. It also allowed for better administrative coding of patients to

expedite their arrival at the correct destination hospitals.[205]

In addition to its other routes the Continental Division also made flights to Europe flying into the Azores, England, France, and Tripoli North Africa.[206] The Divisions global area of responsibility was indeed vast.

During the first half of 1952 the domestic air evacuation capability alone utilized 330 medical facilities and 285 air facilities of all the armed services plus civilian agencies.[207] There were six aeromedical evacuation units responsible for air evacuation in the United States. They were located at Scott AB, Illinois; Westover AB, Massachusetts; Travis AB, California; Kelly AB, Texas; Brookley AB, Alabama; and Brooks AB, Texas.[208] During the first half of 1953, shortly before the end of the Korean War, these squadrons provided inflight care transporting a total of 19,356 patients.[209] The efforts of Continental Division flight nurses and aeromedical technicians were an essential component of the successful development and implementation of the worldwide aeromedical evacuation system.

U.S. Air Force in Europe (USAFE)

During the Korean War years attention was focused on the war and related events. However, the AF

maintained a sizeable presence in Europe for support of the still large American military presence on that continent.

There was one large AF hospital, the 7100th AF Hospital, at Wiesbaden AB near Frankfurt Germany and another one located at Burtonwood, England.[210] Those two hospitals plus the Army's 97th General Hospital in Frankfurt, Germany served as the three hospitals from which patients were collected for evacuation to the ZI.[211]

1454th MAES

Although the major drain on the limited number of flight nurses available was in the support of the air evacuation effort in Korea the large number of American personnel in Europe also required the presence of air evacuation personnel. The MATS MAES squadron in Europe was the 1454th MAES which was originated under the Atlantic Division of MATS and activated at Rhein Main AB, Germany, located near Frankfurt, effective 20 August 1950.[212] It authorized nine officers and 12 enlisted personnel to be transferred on an individual basis primarily from U.S. based air evacuation squadrons of the Continental Division, MATS.[213] The initial personnel arriving on 27 August 1950 consisted of one medical service corps (MSC) officer and three enlisted personnel with three additional officers of

the AFNC and nine enlisted personnel joining on 31 August 1950.[214] Offices and supply space were obtained in buildings under the control of the local medical group (61st Medical Group). Quarters for the flight nurses were in the family housing area called "Gateway Gardens" while the enlisted personnel were quartered with the local air support squadron personnel.[215]

As personnel reported in they brought with them necessary items, such as litter straps, restraints, air mattresses,and air ambulance chests, obtained from their previous Continental Division squadrons to provide the new squadron with sufficient equipment to begin operations.[216] The personnel on flying status brought their flight clothing and other equipment in their possession at the time of receiving their transfer orders. However, the new commander, Captain Fred Goodman, MSC pointed out that certain controlled items (e.g. narcotics) and those peculiar to air evacuation, such as suction equipment, needed to have been arranged for and been present at the time of activation.[217]

Even with the concerns about sufficient equipment and supplies Captain Goodman did state that morale was good and that all personnel had volunteered for duty with the new organization.[218] The presence of all volunteer personnel with high morale was a positive

factor helping to get the new squadron operational despite difficulties associated with getting a new group functional.

By 8 September all five flight nurses were on station with the senior nurse, First Lieutenant Olga Williams, appointed as flight nurse supervisor.[219,220] The other flight nurses were First Lieutenants Pearl M. Bielak, June H. Freedman, Margaret J. Mills, and Velma J. Underwood.[221]

The mission of the 1454th MAES was to provide inflight medical care and treatment for patients evacuated from Europe to the Continental United States.[222] The squadron began its flying missions in September 1950 with five aeromedical flights.[223] On the initial flight an extra medical team, consisting of one flight nurse and two medical technicians, departed with the aircraft in order to stage a crew in the Azores to provide for future crew changes.[224] A staged crew is one who is sent to an enroute destination to await the next mission when they would then relieve the originating crew and continue the flight. The crew which deplaned would rest and in turn relieve and replace the next mission originating crew and so on. If there were patients at the enroute medical facility scheduled to be transported on the next mission the staged crew would visit them, brief patients about what

to expect inflight, review medical records, devise a boarding plan for the new patients, and often accompany them to the flight line. The crew bringing the mission into the United States would generally return as passengers to Rhein Main AB unless there were patients returning to Europe who required medical crew accompaniment. Upon arrival back at Rhein Main AB the crew members would have a rest period before going back into the rotation schedule with each subsequent crew repeating the process.[225]

The long distances requiring many flying hours made this staging of crews necessary so that the personnel providing care would be as rested as possible. In addition AF regulations required a minimum of 15 hours of rest before flying. Although the medical crew members accumulated many flying hours they were not able to log their passenger time (deadhead time) as official flying time[226] on their records. Since a minimum number of flying hours per month was required this could potentially present a problem for personnel who were primarily involved in administrative duties. However, the long flight time from Europe to the U.S. virtually assured that one flight would garner more than sufficient flying hours.

The first 1454th MAES flight transported 34 patients and by the end of September 1950 the squadron

had moved a total of 184 patients.[227] The patient numbers gradually increased and over the period from activation through June 1953 a total of 2,510 patients were evacuated over the Atlantic routes.[228]

1454th MAES Aircraft

The type of aircraft utilized necessarily had a significant impact on the organization and delivery of inflight patient care. The number of aircraft seats versus number of litter spaces determined the number and type of patient categories which could be transported in various aircraft internal configurations. It was proposed that the 1454th MAES use C-97 aircraft but a problem arose in that all patients, even ambulatory, would have to ride on litters, and the squadron did not have a sufficient supply to meet demand.[229] The reason for the aircraft seat deficiency was not documented by the squadron. However, litters used on aeromedical aircraft are uncomfortable when one has to be on one for any period of time and ambulatory patients could be expected to be distressed and unhappy at the prospect of spending an entire flight confined to a litter. It is possible that sufficient aircraft seats were not available in the European theater. Whatever the reason the 1454th MAES switched to using the C-54 transport aircraft for inter-European theater flights and the C-118 transport

for flights to the ZI which solved the litter vs seat problem.[230]

Arrival of a Partner in European Air Evacuation

The responsibility for air evacuation in the European, North African, and Near East areas became a shared one in June 1951 with the activation of a tactical medical air evacuation squadron, the 1st MAES, also located at Rhein Main AB, Germany.[231,232] Traditionally the MATS squadrons provided aeromedical evacuation inter-theater and to the U.S. while the tactical squadrons provided intra-theater support.

The 1454th MAES, with its larger and more powerful aircraft capable of a greater range, provided service to both the ZI and to the more distant intertheater areas such as Rome, Athens, the Near East, Tripoli, North Africa and Nouasseur AB in French Morroco.[233] The standard medical crew on the ZI flights was two flight nurses and three medical technicians while the crew on the Rome, Athens, Tripoli flight was one flight nurse and two medical technicians.[234] The size of the medical crew was a reflection of the size of the patient loads being carried on the respective missions. Additional crew could be added if needed for heavy patient loads or if a patient needed continuous individual care.[235]

Close liason was maintained with nursing service

at the originating facility and the day prior to flight the flight nurses and aeromedical technicians would visit the patients to be transported and coordinate with medical and nursing staff concerning any particular requirements for the flight.[236] In-flight meals maintained the tradition of hospital and inflight food. The squadron comment on the box meal lunchs was that they were only adequate and did not offer the "ultimate solution to inflight feeding for patients.[237]

The 1st MAES is Formed

The 1st MAES was activated at Rhein Main Air Base, Germany effective 11 June 1951 and assigned to USAFE, 12th AF, and further attached to the 60th Troop Carrier Wing (Medium) for flying support.[238] The AF designates its transports according to size. For example, a large four engined transport would be referred to as (Heavy) in the unit description. The designation (Medium) means that the aircraft used were smaller and lighter.

The first chief nurse was Captain Margaret A. Richey who was transferred from her assignment at the 495th USAF Hospital at nearby Wiesbaden AB, Germany on 5 July 1951.[239] This was surely one of the shorter travel distances for a change of assignment in the AF.

By 31 August 1951 the squadron consisted of the commander, five flight nurses, and seven enlisted members.[240] With that number of personnel the 1st

MAES was able to fly 52 aeromedical missions, evacuate 414 patients, and transport 188 recovered patients back to their stations during the reporting period of 1 July 1951 to 31 August 1951.[241] Missions were flown to Brussels, Belgium; Lyncham, England; Trieste and Pisa, Italy; Bordeaux. Chateaurox, Verdun and Metz, France; Luxembourg; and Bern, and Geneva, Switzerland.[242]

The type of flying the 1st MAES was performing was not for long distances but made for many hours of flying between small facilities. An indication of this was that between 1 July 1951 to 31 August 1951 the squadron missions accounted for 1407:30 patient hours (number of patients times number of hours they were airborne).[243] That kind of flying makes for a very long and tiring day on a noisy and vibrating aircraft with many landings and take-offs.

1st MAES Historical Reports

The monthly historical reports of the 1st MAES differed from all the other squadron historical reports located in that they were written by an AFNC officer. The responsibility for writing squadron historical reports is an additional duty assignment and normally delegated to a unit MSC officer. However, all of the officers assigned to the 1st MAES were nurses with the exception of the squadron commander, Captain James W. Hice (MSC).[244] Therefore the officer assigned

to the duty of historical officer came from the ranks of the flight nurses. For the 1st MAES that person was Captain Adele M. Ball (AFNC).[245] The monthly historical reports of the squadron reflected the orientation of the historical officer with considerably more detail concerning individual nurse and enlisted personnel then was usually seen in most AF squadron histories.

Captain Ball commented, in the historical report, on the C-82 aircraft that was being used by the squadron. She stated that it was the desire of the squadron to procure a better type of air evacuation plane, such as the C-54, which had better characteristics for crash landing and ditching and less vibration and noise than the C-82.[246] The problem was reported to higher headquarters with the expectation that it would be considered and a change made in assigned aircraft. It took several months but eventually this expectation was realized.

1st MAES Achievements

In the first historical period of the squadron Captain Ball described one outstanding flight that had occurred. Two of the 1st MAES medical crews were sent to Verdun and Metz, France to evacuate the dead and injured in the Frankfurt-Paris Express train crash which occurred near Metz. The injured military

personnel and their dependents were flown to the 98th Army General Hospital in Munich and the dead flown to Frankfurt, Germany. A medical officer, two flight nurses, First Lieutenants Rose S. Montgomery and Dorothy C. Barrows, and two air evacuation technicians, Sergeants Gerald T. Dobbins and Robert G. Purcell cared for the injured inflight. Staff Sergeant William J. Jones and Corporal Paul R. Barbere accompanied the bodies of those killed to Frankfurt.[247]

In September 1951 the squadron gained a new commander, Captain Stanley B. Westort (MSC) and an additional flight nurse, Captain Conchita S. Bobbitt.[248] Regularly scheduled flights had been established to Paris and Bordeaux, France returning the following day via Paris; Burtonwood, England; Berlin, Germany; and Pisa, Italy.[249] However, approximately half of the flights flown by the squadron were so called special flights to multiple areas in Europe where an emergency required evacuation. During the 1 September 1951 to 31 October 1951 reporting period the squadron evacuated 451 patients, returned 148 recovered patients to home stations and flew 64 missions[250] These numbers were similar to the previous reporting period.

Throughout the next year the squadron strength remained consistent as did patient loads and

missions. On 23 November 1952 Captain Rosalie Bacior replaced Captain Margaret Richey as senior flight nurse.[251] Captain Rose S. Montgomery had replaced Captain Adele Ball as squadron historical officer[252] so the unit histories were still being written by an AFNC officer who continued to describe squadron activities in specific detail.

Compared to the Korean War missions being flown on the other side of the world the European flights would probably have been considered very unglamorous and not worthy of much attention by the public. However, to the military personnel stationed in the European theater, many in small facilities, who required air evacuation due to illness or injury they were a lifeline to needed medical care. The small numbers of flight nurses and aeromedical technicians provided the inflight care for their patients flying many hours in often unfavorable conditions with as successful a record as their more publicized colleagues in the Pacific.

Korean War Truce: Cessation of Combat Operations and Prisoner of War Repatriation

As the combat operations drew to a close in Korea, which occurred on 27 July 1953,[253] the operation of transporting released prisoners of war began. Flight nurses and medical technicians of the 801st MAES, the

1453rd MAES, and the Continental MATS MAES squadrons were involved.

Operation Little Switch

The first operation was called "Operation Little Switch" and began on 21 April 1953 with the movement of the first contingent of released prisoners of war (POWs).[254] The first 36 released POWs were traded at Panmunjom the day before and then taken by helicopter to Seoul.[255] On the 21st this first group was flown to Tachikawa AB, Japan by large C-124 aircraft accompanied by four 801st MAES flight nurses and four medical technicians plus the 801st MAES squadron commander who was a physician.[256]

The following week 234 more repatriated POWs were flown to Japan and within a few days continued home via MATS[257] accompanied by 1453rd MAES nurses and medical technicians. It was reported that the men were enthusiastic about their flight on the C-124 where they had been given such luxuries as white sheets and pillows with pillow cases which had never before been given to patients on the aeromedical airlift plus hot soup, juices and broth in small doses so as "not to ruin their digestive systems."[258] Undoubtedly they would have been enthusiastic regardless of the aircraft or the amenities given because, most important, they were free and on the way home.

The MATS phase of "Little Switch" began on 28 April 1953 when the 1453rd MAES moved eight litter patients and 35 ambulatory patients in the first group.[259] There were a total of six groups moved with the last flight on 5 May 1953 to Hickam AB, Hawaii continuing on to Travis AB, California on 6 May 1953.[260] A total of 149 repatriated prisoners was transported by the 1453rd including eight United Nations patients, two from Canada and eight from Columbia.[261] The men were treated as VIP patients, met at Hickam AB by ranking officers of the various services, given a flower lei, and entertained by a hula troupe of six Hawaiian girls.[262] The welcome given was a warm one but perhaps most important for the former prisoners was the knowledge they were once again on American soil.

The airlift was dubbed the "Freedom Airlift" and on 6 June 1953 35 of the flight nurses, medical technicians and air crew members who had participated were presented with personal letters of appreciation from the AF Chief of Staff during a parade and review at Hickam AB.[263]

After arriving at Travis AFB the patients then continued on to their individual destinations throughout the U.S. via MATS Continental Division.

During this period of increased casualties one

C-124 set a record by carrying 419 patients in a 24 hour period shuttling between Seoul and Taegu with more than 100 patients per load, many requiring considerable medical care by the three nurses of the 801st MAES on board.[264] After the four loads were completed the three nurses supervised the loading of 100 more patients on another aircraft and flew with them to Tachikawa arriving totally exhausted but still caring for their patients.[265]

Operation Big Switch

Operation Big Switch was the exchange of sick and wounded POWs commencing after the end of combat operations and began on 5 August 1953.[266] Early in August the Defense Department announced that American military personnel released from prison camps, who were physically unable to make a sea voyage home, would be moved to the United States by air and be channeled into the normal scheduled aeromedical evacuation flights.[267] The same procedures used in Operation Little Switch were implemented for Big Switch.[268] Patients were, as in Little Switch, flown to Japan by the newly designated 6481st MAEG (formerly 801st MAES), moved from Japan to the United States by the 1453rd MAES, and from there flown out to destinations throughout the United States. The MATS phase of Big Switch began on 10 August 1953 with the movement of the first 17

patients from Japan and ended with the last patient evacuated on an individual basis on a routine mission on 27 November 1953.[269] When Big Switch ended the final count was 508 of which 419 were ambulatory patients and 88 litter patients.[270]

The 1453rd during this period had 12 AFNC flight nurses plus 6 Navy flight nurses to fly the aeromedical missions. Major Constance Corbett, who had replaced Major Lillie U. Crow, was Chief Nurse.[271] At the squadron detachment in Japan were six additional AFNC flight nurses plus three more Navy flight nurses with Captain Marion Dorsey as Chief Nurse.[272] The combined totals of 27 flight nurses comprised the available MATS nurse crew members to fly all of the aeromedical missions.

801st MAES

On June 18, 1953 the 801st squadron designation, which had been in existence since WW II, was retired and the squadron was reconstituted as the 6481st Medical Air Evacuation Group and given additional responsibilities and personnel to establish and operate medical holding and clearing facilities at bases in Korea and Japan.[273] By this point in its history the 801st efforts in Korea had established an outstanding air evacuation record. It had airlifted over 300,000 patients during the course of the war without a single

one being lost to air crashes although six patients were killed when a Royal Hellenic Air Force C-47 was involved in a ground accident with a jet fighter-bomber at Suwon Airfield on December 22, 1952.[274,275] With the war effort being a United Nations effort aircraft and crews from allied countries were utilized in addition to the United States military personnel.

Although the fighting in Korea had ended the war was not technically over, and in fact, continues to the present day. However, with the completion of Big Switch the armed conflict had effectively ended and the AFNC had successfully met its first great challenge and carried out its air evacuation responsibilities with great courage and dedication.

At the conclusion of active fighting in Korea the AFNC had just passed its fourth birthday. It had been busy developing its organizational structure and operating procedures when the Korean conflict intervened and forced the AFNC to meet a crisis with significantly increased demands on its members, particularly those in aeromedical evacuation. The need for providing a sufficient number of trained flight nurses within the AFNC to meet any future crisis had been clearly demonstrated and would continue to be a factor in future planning.

Post Korean Conflict Demands on the AFNC

As the AFNC moved back to a peacetime operation status it was reminded in less than one year of the need to be prepared for future events and the importance of the, now well developed, aeromedical system and highly trained flight nurses.

The Korean War had effectively ended with the 1953 armistice and the resultant end of hostilities but the AFNC and the rest of the USAF would continue to be involved in Asia.

Operation Wounded Warrior: Herald of the Vietnam Conflict

In retrospect Wounded Warrior could be considered a harbinger of the future for the AFNC and the United States. It originated in Southeast Asia during the Indo-China War shortly after the fall of Dien Bien Phu on 7 May 1954. On 10 June 1954 France requested possible assistance by the United States to fly wounded French soldiers back to France and other portions of the French colonial empire.[276]

The initial report was that 2000 patients were to be moved over a route from Indo-China to Japan thence to the United States and on to France. The evacuation flights were cleared through the Philippines, Japan, Newfoundland, Iceland, the Azores and finally on into France.[277] However, the evacuation was slow in being

organized. The 6481st operations officer assigned the responsibility for coordinating the operation from Saigon, believed the French were holding back, perhaps from pride, hoping to find a solution to handle the operation themselves.[278], There was a French hospital ship in port that would be taking some of the patients with another one due the following week.[279]

However, after three days the difficulties were resolved and on 13 June 1954 Captain Edith Bond, AFNC went to Saigon where she remained to supervise the outbound loading of patients and preparation of manifests. She was later joined by three other members of the 6481st MAEG, two of whom, 1st Lieutenant Jeanne La Coste and A/1C Edward J. Thibault spoke French fluently.[280] These first aeromedical crew members were the forerunners of many more who would serve in the next decade in Southeast Asia.

The first of five flights, all crewed by 6481st aeromedical personnel left Tan Son Nhut Airport in Saigon thirteen days later on Saturday 26 June with 30 litter and 69 ambulatory patients on a C-124 aircraft with its first stopover at Clark Air Base, Philippines arriving in Japan on 28 June where the patients would be picked up by the 1453rd MAES.[281] The final flight arrived in Japan on 11 July and the sum total of patients moved comprised 502.[282] The differences in

had been compensated for by assigning one French medical officer and one French flight nurse to every 50 patients. In addition a briefing form was furnished to each patient, printed in French and English, giving a description of the trip, emergency equipment, and emergency procedures.[283]

One of the French flight nurses on the first trip was Mademoiselle Nichelle Clermont-Tonnarre, who had graduated from the USAF air evacuation course at Gunter AB, Alabama and had spent some time during the Korean War as a MATS flight nurse with the Continental Division working out of San Antonio, Texas.[284] The practice at the flight nurse program of including nurses from friendly countries had rapidly proven of value during the Wounded Warrior mission.

The first MATS flight departed Japan on 29 June 1954 and the last flight on 13 July 1954.[285] The patients were given 12 hours of rest in Hawaii at Tripler Army Hospital before continuing on to Travis AB, California. They were then air transported on to Westover, AB Massachusetts where the MATS Atlantic Division crews took over for the final segments of the flight.[286] Four of the ten MATS flights were destined for Orly Airport in Paris, France with the remainder going to LaSenia Airport, Oran, Algeria bringing the large number of French Colonial troops

home.[287]

The missions were completed without problems and with a high degree of efficiency[288] reflecting the maturing of the aeromedical system and the hard earned experience of the nurses and medical technicians. In five years the AFNC had developed rapidly and proven its worth by demonstrating the ability to effectively respond to unexpected demands The knowledge and experience gained during the Korean conflict and the immediate post war period would be passed on to new flight nurses and provide a base for future development of aeromedical evacuation squadron policies and procedures. The next conflict in Southeast Asia would prove the value of what had been learned in Korea.

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Chapter III

Difficulties in the Formation of the AFNC

In the first year of its existence the AFNC was faced with the challenge of creating an entire organizational structure and at the same time continue to provide a high level of nursing care to patients. One of the difficulties encountered by the AFNC in carrying out this process was that the corps was not an independent entity and thus lacked complete control of its structure and function. Although nursing in the United States was progressively working toward more control and independence in its practice and organizational structure this was not true of the military nurse corps which functioned within a military structure.

As discussed earlier in Chapter II the AF organizational structure was directed toward a functional corps structure. The AFNC was, and still is, expected to function within the AF command structure as a component of the AFMS. The corps has the same status as the other components of the AFMS and comes under the overall umbrella of the AFMS which is

led by the AF Surgeon General (SG). Each component has its own chief who reports to the SG. In this manner the organization and function of the components[289] are all integrated under the AFMS. In turn the AFMS comes under the overall AF command structure. This organizational format thus effectively puts control at the level of the AF rather than at the individual corps level as is the practice in the Army and the Navy.

Given the AF organization under which the AFNC would function the nurses set about the business of forming an effectively functioning AFNC. From a practical standpoint the immediate order of business was to continue to provide quality nursing care to the patients. In order to provide the care needed the newly designated AF nurses continued to follow the Army procedures and protocols and did things in the same pattern with which they were already familar.[290] The nurses, for the most part, basically remained at the stations where they had been assigned when in the Army and continued their usual duties providing patient care with the assistance of enlisted corpsmen.

Interestingly, at about the same time, changes began in civilian nursing to incorporate one of the organizational practices already used in the military. This practice was the increase in use of ancillary nursing personnel in the form of nursing aides and

practical or vocational nurses in an organizational arrangement called team nursing.[291,292] This team concept included direct supervision of patients and team members by the professional nurse and on-site training and in-service education for team members.[293] Military nursing had been functioning in this manner, using enlisted corpsman, ever since its earliest beginnings. In actual fact the use of enlisted care-givers had been preferred by the Army medical establishment in its early years resulting in a decreased level of patient care and negative effects on morale of soldiers and female nurses alike. The use of the enlisted care givers predated the professional military nurse by almost 150 years. The military now uses highly trained and skilled enlisted medical technicians who function under the direction of professional military nurses in providing patient care. As a result a nurse coming into the military with civilian experience in team nursing would find the organization of patient care relatively familar.

Another difficulty the AFNC faced in the first years of its existence was that a significant number of its nurses remained assigned to Army hospitals effectively placing them out of direct AF control. This number totaled 398 which was about 20 percent of Air Force nurses and it was not until June, 1951, that

joint staffing was terminated and all Air Force nurses were placed on duty at AF facilities.[294] This change undoubtedly contributed to a climate of togetherness as members of the AFNC and increased pride in their AF identification.

All of the original AF nurses were transfers from the ANC although many had been assigned to AAF facilities. It was not until August 24, 1949 that the first two nurses to be granted direct commissions in the U.S.A.F. Nurse Service Reserve from civilian life were commissioned.[295] The nurses were D.Zay Cowden, commissioned a First Lieutenant, and Dorothy Mae Horton, commissioned a Second Lieutenant. Both were sworn in before the AF Surgeon General, Major General Malcolm Grow and AFNC Acting Chief Nurse, Captain (soon to be confirmed as Chief Nurse and eventually Colonel) Verena Zeller.[296]

The Challenge of AFNC Organization

While the majority of the new AF nurses continued on with their usual duties, the nurses assigned to the chief nurses' office began the task of creating an AFNC organizational structure with policies and procedures to replace those of the Army ones still being used by AF nurses. This task was complicated by the fact that the majority of nurses transferring to the AFNC tended to be relatively junior in rank. The decision to

quickly send nurses to management courses reflected the need for more senior trained and experienced personnel for leadership positions within the AFNC.

After the initial screening done by Captain Zeller and her initial assistant Captain Inez McDonald, two additional nurses were assigned to the office to assist with the organizational work. Captain McDonald got married and left the service and she was replaced by Captain Helen Ely who eventually transferred back to the Army and went to Walter Reed Army Hospital. Colonel Zeller believed it was because she liked working in larger hospitals and the AF facilities were relatively small.[297]

Lieutenant Colonel Ruth Weidner came into the office and served as Colonel Zeller's Deputy Chief. Colonel Zeller stated Lieutenant Colonel Weidner's duties were "about the same as mine. What I couldn't do she did, or what she couldn't do I did."[298] A third person, Lt. Colonel Margaret McKenzie, came in a little later and was the person who developed all of the job descriptions for all of the AFNC specialties. In essence, she developed the career program.[299,300]

Lt. Colonel Weidner also filled in doing procurement (now called recruiting) until Colonel Dorothy Zeller (no relation to Verena Zeller) was brought in for the procurement assignment.[301]

Colonel Dorothy Zeller stated that the work involved reviewing applications and also going out to various schools of nursing[302] to talk about the AFNC and try to interest students in joining the AFNC. Colonel Dorothy Zeller would eventually become the third Chief of the AFNC. She was moved up to the Deputy Chief Nurse position to replace Lieutenant Colonel Weidner and Colonel Vivian Gersema was brought in to the procurement position.[303] Colonel Wanda Fill, who was a Major at the time, came into the office to replace Captain Helen Ely in the assignments position.[304] Colonel Fill and Colonel Gersema belonged to the second group to come into the chief nurses' office and their tour overlapped two years into the tenure of the second Chief of the AFNC, Colonel Frances Lay.[305]

Although there was a progressive turnover of personnel in the first years of the AFNC Chief Nurses Office, the nurses were all very senior in experience in the military and were able to effectively bring their considerable knowledge and experience to the task of establishing a workable and effective organizational system for the AFNC.

Eventually all the personnel transfer decisions were made and the AFNC was officially created with actual people assigned to fill the designated manning spaces depending on specialty and rank. Most of the

newly assigned nurses were younger and relatively junior in rank and many wanted to be flight nurses. Colonel Frances Bryant only recalled five that had achieved regular, as opposed to reserve, status.[306] She also recalled that the Negro nurses assigned to AAF bases transferred over to the Air Force just as did the other of the original Air Force nurses.[307] As a result the AFNC was an integrated corps from its very beginning.

The effort during the first year of the AFNC was primarily directed toward developing the AFNC organizational structure and then, beginning in the second year, organizing and managing the response to the challenges generated by the Korean War. It would not be until after the end of the Korean War that the AFNC would be able to devote any great effort to improving job opportunities and increased rank opportunities for nurses. That effort continues to this day.

Educational Development of AFNC Nurses

During World War II, the ANC had recognized that, as a general rule, nurses had not been adequately prepared for military service and accordingly, during the post war period steps were taken to develop a comprehensive education program.[308] The AFNC followed this approach and early in its existance assigned

nurses to programs of instruction in nursing specialties. This was particularly important because so many of the nurses who had transferred to the AFNC were junior in rank and had not had an opportunity to acquire specialized training. There were three AFNC nurses enrolled in courses in anesthesia at Army General Hospitals from 1 July 1949 - 1 December 1949; eight nurses completing the Hospital Administration Course at the Medical Field Service School and two in the Advanced Hospital Administration Course at Ft. Sam Houston, Texas during the same time period. An additional eight nurses attended the Flight Nursing Course at the School of Aviation Medicine at Randolph AFB, Texas at the same time the other specialized courses were in progress.[309] The anesthesia course and the flight nurse course met two of the critical wartime skill needs and were early priorities. The lack of administration skill by the young nurses transferred from the Army resulted in the need to obtain training for them as soon as possible. The first eight were in their classes right at the beginning of the AFNC.

In addition to the nurses attending specialty courses that first year there were three AFNC nurses attending civilian institutions to complete their baccalaureate education. One of these nurses was at the Catholic University of America and the other two

nurses were at the University of Minnesota.[310] At this time the AFNC followed the ANC practice of only authorizing one year of education at a civilian institution.[311] This presented a significant difficulty to military nurses attempting to complete the requirements for a baccalaureate degree. The degree of difficiculty can be better understood by considering that on the average 126 units were required for the baccalaureate degree. The maximum possible number of credits that could be earned in one calendar year were 45 with 12 months study and no vacation time. This meant that the nurse had to complete courses for the remaining 85 units on her own time during off duty hours until she had reached the point where one year of full time study would complete degree requirements. One of the first AFNC nurses to meet the requirements and graduate was Colonel Frances Lay Wilson, who graduated magna cum laude, from the University of Minnesota before assuming the position of Chief of the Flight Nurse School[312] and eventually becoming the second Chief, AFNC.

By 1952-53 a career program for AF nurses had been established which included courses in the specialties of anesthesia, operating room technique and management, nursing administration, neuropsychiatric nursing, and flight nursing,[313] all courses involving critical

wartime skills. The AFNC was making significant progress in correcting its deficiencies in specific skills.

It was also during this same time period that AF nurses were authorized to attend university programs for the longer periods of time to complete baccalaureate degree programs. They were no longer limited to a single year of attendence. Lieutenant Colonel Dorothy Menge, USAF, Ret. recalled being stationed at Selfridge AB, Michigan after serving as a flight nurse during the Korean War.[314] She did not remember any formal encouragement by the AFNC to attend school but said that rumor and word of mouth comments were that the AFNC was going to go to an all degree corps. A friend said to her "why not go for a degree?" and so after two years of night classes she attended Wayne University (now Wayne State University) in Detroit, Michigan full time for two years under AF sponsorship to complete degree requirements.[315] She took general education courses alongside generic baccalaureate nursing students and influenced at least one young nursing student to enter the AFNC after graduation.[316]

It would be several years before the AFNC actually established an all baccalaureate corps as a goal but in the early years baccalaureate education appeared to

have unofficial support. Colonel Kovach Scott had heard the same rumor that Lieutenant Colonel Menge had that an all baccalaureate corps would eventually occur.[317] She said that the word was that if you didn't have a degree you wouldn't be promoted to higher ranks and those planning to stay in the AFNC had better start working on their degrees.[318] However, Colonel Verena Zeller stated that during the time she was Chief of the AFNC a baccalaureate degree was not included among the promotion criteria.[319]

Education efforts in all of the military nurse corps reflected the efforts in civilian nursing. Minimal education standards for nurses were being increased by the development and implementation of a common state board test pool and the launching of an aggressive school accreditation program.[320] The largest number of baccalaureate prepared nurses were found in the field of public health nursing reflecting the assistance for academic study in public health nursing supported by the Social Security Act of 1936.[321] It would not be until 1956 that renewed federal aid to nurses would be forthcoming in the form of the Health Amendments Act of 1956.[322]

In the meantime, the National League for Nursing Education (NLNE) officially endorsed the basic baccalaureate program in 1948.[323] However, in 1950,

they changed their endorsement to a long-term goal and in 1954 diluted it further to an encouragement of articulation among all levels of nursing because of concerns of causing animosity among nurse educators.[324] The fact that the organization consisted of a majority of diploma and Associate Degree programs compared to the number of Baccalaureate Degree programs undoubtedly contributed to the changes in organization endorsement. It was not until 1982 that the executive board of the National League for Nursing (NLN) would publish an endorsement of collegiate nursing education.[325] The American Nurses Association (ANA) did not do any better. The issue was introduced at the 1960 convention and caused so much controversy it was not even brought up at the 1962 convention. However, in 1965 the ANA did officially endorse generic baccalaureate education.[326]

The long period of confusion and vacillation in direction by the national nursing organizations, and individual nurses themselves, on the question of baccalaureate education can be attributed to multiple factors. One factor was the practice of educating nurses on several different levels. Traditionally nurses had been trained in three year hospital based programs. The advent of four or five year collegiate based baccalaureate programs plus the development of

year associate degree programs meant that graduates from three types of programs were taking the same state licensing examinations and competing for the same beginning nursing positions in the job market. Individual nurses supported their own particular type of school as being the best. There were considerable anti-educational and anti-intellectual feelings generated about who was a professional nurse. The understanding of what constituted the education of a professional was confused and colored by personal emotions.

The question of what constituted a professional nurse generated confusion as to the nature of the profession and how students could be best educated to meet the demands of the profession. Comments overheard at national meetings often were in the nature of vigorous and emotional statements that the members of one particular group were just as professional and as good or better nurses than members of another group. The identification of the "best nurse" was often used in the context of who was the most professional. The result was the long standing presence of what could be called an anti-intellectual bent in nursing. Even in the present day when baccalaureate education is officially accepted as the desired beginning level of nursing preparation coffee table comments can still be

heard reflecting the feelings, fears, and defenses of those who have not had the benefit of higher education. The need to be considered a professional of equal standing and a good nurse is important to all and is reflected in comments from nurses from all educational backgrounds.

In 1949, when the AFNC was created, there were 86,700 students enrolled in nursing schools and of these only 11,700 were in 111 collegiate schools of which only 61 offered a program leading to the baccalaureate degree.[327] Given the controversy over collegiate education versus diploma education it was impressive that military nurses believed the nurse corps would eventually become all baccalaureate and began efforts to increase their personal educational preparation. Military nurses did have a role model, however, in that the rest of the military officer corps required a baccalaureate education for commissioning. It was not until 1977 that the AFNC established the goal of an all baccalaureate nurse corps.[328] The rumors about the desire for a baccalaureate prepared AFNC that the nurses heard in the first years of the AFNC were finally coming true even though it took almost 20 years. In comparison civilian nursing still has not committed itself to the same goal. In retrospect perhaps 20 years can be considered a

relatively short period of time and a positive reflection on the efforts of military nurses.

Associate Degree nurses who had graduated from junior and community colleges in a program begun in 1952 were not accepted into the AFNC.[329] At one point there had been a suggestion that they be accepted in the rank of Warrant Officer but the decision was made not to do this.[330] The AF was moving away from use of the Warrant Officer rank and it was decided not to try and reverse this practice.

Challenges to the AFNC Presented by the Onset of the Korean War

The difficulties faced by the AFNC during its first year of organization paled when shortly before its first birthday the Korean War abruptly began. Although organizational work would continue the focus of the corps efforts now shifted to meeting the challenges brought about by the onset of the war. The AFNC had had only 11 months to begin training its personnel in war related skills which was not sufficient for its soon rapidly increasing needs. That need would be particularly apparent in the numbers of qualified flight nurses immediately available.

The Korean war impact for the AFNC would most immediately and directly fall upon the corps aeromedical evacuation personnel stationed in the Far

East Theater of Operations. The squadrons were relatively small and required missions were limited to peacetime needs.

Captain Louise Bainbridge, Chief Nurse of the 801st MAES based in Japan, recalled that before the Korean War there had been no regular aeromedical flight schedule. Missions were flown only when someone needed to be evacuated.[331] Squadron monthly historical reports for the first three months of 1950 report numbers of patients evacuated from various points within FEAF for each preceding month as 19, 21, and 38 respectively[332,333,334] These were typical numbers reflected throughout the various monthly reports. When the nurses were not flying they were assigned to work at the dispensary at their home base Tachikawa AB, Japan.[335]

In addition three of the 801st MAES nurses were stationed in other areas of the Southwest Pacific. One nurse was in Guam, one in the Philippines, and one in Okinawa.[336] The nurse at Clark Air Base in the Philippines, Colonel Florence Deegan, recalled that she was supposed to be working at the hospital when not flying, however, the flight surgeon had her assigned to the flight surgeons office so she would not have to be working any night shifts.[337] This assignment gave her the opportunity to have a normal day/night schedule and

be better rested when an aeromedical mission requirement occurred. When the Korean War began all three of the nurses were sent back to Tachikawa AB, Japan to join the rest of the squadron[338] since the Korean missions would primarily originate out of Japan. The addition of even these three nurses was a significant supplement to the numbers of the squadron.

The MATS 1453rd squadron at Hickam AB, Territory of Hawaii was similarly relatively small in numbers although larger than the 801st MAES. The squadron did have a regular schedule although it too was limited based on peacetime needs. Additionally the 1453rd MAES was faced with a very large area of responsibility to cover. It had the responsibility of flying patients throughout the vast Pacific region from the Far East to the United States. The approximately 36 hour time factor involved in these long flights, before the use of jet aircraft for patient evacuation, was very large and a significant factor in mission planning.

Conflicts in Development of the Korean War Medical Evacuation System

At the beginning of the Korean War the Army policy was to keep a casualty as far forward as feasible in order to return him to combat as soon as possible. It was apparently believed that this was the most effective way to manage the more minimally injured

soldier who could be expected to recover quickly and be able to return to the war. The medical system was thus geared to keeping wounded men forward.[339] The normal sequence of events when a soldier was wounded was to transport him to a battalion aid station by litter or by jeep, then to a regimental collecting station and from there to a division clearing station.[340] At that point he would be moved either to an evacuation hospital or a MASH for emergency surgery and a short period of hospitalization. The more seriously wounded would be moved by either ambulance or hospital train to hospitals farther back from the front lines for more care.[341]

Although it was recognized that airlift provided the best means of moving patients between theaters of operations and to the United States no one had given much thought to aeromedical evacuation within the theater of operations.[342] FEC did not have a regulation governing medical air evacuation until 18 December 1951 and at that point the regulation only served to confirm existing policies and procedures which had been informally developed.[343]

When American combat troops landed in Korea in July 1950 the Eighth Army implemented its traditional evacuation system and as a matter of policy stated that patients expected to return to duty within 30 days

would be hospitalized in Korea; those requiring more than 30 days or needing specialized treatment would be hospitalized in Japan.[344] The FEAF commander, Lieutenant General Stratemeyer, recognized that the speed with which a casualty received care was instrumental in survival, and knowing the limited surface transportation available in Korea,notified General MacArthur on 4 July 1950 that FEAF was prepared to air evacuate casualties from Korea.[345]

At the time the only aeromedical capability in the theater was the 801st MAES Flight Three to which were assigned all of the flight nurses and enlisted aeromedical technicians. There were usually nine to ten flight nurses assigned plus normally about 20 aeromedical technicians. The 801st belonged to the 315th Air Division (Combat Cargo) and the 315th Surgeon, Colonel Allen Smith (MC) reported to the FEAF Air Surgeon that air evacuation of patients out of Korea began on 2 July 1950, nine days after the start of the war, [347] which was actually two days before Lieutenant General Stratemeyer officially advised General MacArthur that FEAF could do the job. Colonel Smith stated that the activity was not well organized mainly since the numbers of personnel were sufficient only for peace time operation; that supplies and equipment were inadequate; and that there was no

theater directive on medical air evacuation to give guidance to organize the effort.[348] All of these factors made for great difficulty in organizing an effective aeromedical system.

Not surprisingly during July and August 1950 the Army made only a token use of medical air evacuation, preferring to move its casualties south by train to the evacuation hospital at Pusan and then on to Japan by ship.[349] The reasons given were that there were no medical holding facilities at Pusan East Airfield; patients often had to wait excessive periods of time until air transport could be arranged; and the Army could not afford to rely on an uncertain "catch as catch can" air system and preferred to use more reliable and orderly surface transport.[350] Colonel Smith also commented on the reasons that the Army was reluctant to use air transport stating that the Army people had complained the airstrips were too far from hospitals and ambulances were in short supply. However, he also added that the Army gave no consideration to locating hospitals where they would be more readily assessible to airstrips.[351] Colonel Smith also stated that the AF had not adequately convinced the Eighth Army Surgeon, who was distrustful of air evacuation and loathe to diverge from established practice, of the advantages of medical air

evacuation.[352] The result of this inability to persuade the Army to utilize air evacuation delayed both the movement of patients to appropriate medical facilities and the implementation of an effective air evacuation system.

FEAF's Surgeon, Colonel F.C. Kelly, and Cargo Command's assistant director of traffic went to Korea in September 1950 and found the Army would like to use aeromedical evacuation if it could be put on an orderly basis.[353] From that point efforts were made to improve the system and procedures but it was not until November that adequate organizational changes were actually effected.[354]

Aeromedical Aircraft Utilized

A major challenge for flight nurses was to provide adequate inflight care in aircraft not ideal for patient transport. The aircraft utilized for aeromedical evacuation during the Korean War were non-pressurized and had to fly at low altitudes which exposed patients and crew to the effects of weather as well as to that of pressure changes. Patients with chest wounds, eye injuries, and neurological injuries were among those particularly susceptible to the environment effects of altitude related pressure changes. Gravity suction devices and intravenous equipment functioned less than optimally at higher

altitudes.

Another factor was the high noise levels which not only made communication difficult but exposed the patients and crew to potential ear damage from noise plus stress from the high sound levels which were disruptive to rest and communication with others.

Additional factors were poor temperature control in the aircraft and the jolting of everyone on board when rough weather was encountered. Wounded patients especially needed sufficient pain control medications in order to tolerate conditions on a poor flying day.

Nevertheless the aircraft used were the best that were available. It must be kept in mind that these aircraft were designed mainly for the transport of cargo. Some of the aircraft were additionally designed to also carry passengers. Their use for aeromedical evacuation was an added responsibility since there were no aircraft primarily designed for air evacuation.

Among the aircraft used for aeromedical evacuation were the C-46 Wright Commando, a twin engine aircraft with a capacity of 38 ambulatory or twenty or 24 litter patients or a combination of the two; the C-47 Douglas Skytrain, also a twin engine aircraft with a capacity of 27 ambulatory or 27 litter patients; and the C-54 Douglas Skymaster, a four engine aircraft with a capacity of 20-36 litter patients depending on its

model.[355] Later in the war the very large C-124 was utilized. The C-124 is a four engine transport first used in October 1951 on four dates, the 2nd, 12th, 13th, and 18th. It had the greatest capacity of any of the aircraft used for aeromedical evacuation. On the mission of the 18th the aircraft carried a record load of 165 patients, 103 litter and 62 ambulatory, requiring a medical crew of three nurses and three medical technicians.[356] The aircraft had a capacity of 127 litter or 200 ambulatory patients, however, in the routine evacuations in 1952 and 1953 it never again carried as many patients as it had on October 18, 1951 mainly because there were never that many casualties at one time in one place.[357]

Difficulties in Organization of Pacific Route Aeromedical Evacuation

One of the major problems faced by MATS in returning to the United States the greatly increased number of patients was the scheduling of arrivals and departures to facilitate loading and unloading at the originating and destination medical facilities.[358] This problem occurred because of the vast distances traveled and the multiple time zones crossed. It was desirable to originate the flight at a time when the originating medical facility could provide the most support of personnel and equipment. In the same way it

was also a preference to arrive at the destination medical facility when the same conditions existed. Additionally schedules were developed with the goal of staggering departure and arrival times so that any one facility was not overwhelmed with same time arrivals and departures. The problems of weather and aircraft maintainance at times made it difficult to achieve that goal.

Studies were done to identify the most efficient routes considering all of the above factors. The Tokyo-Wake Island segment was considered unsafe because of inadequate fuel, aeromedical ground facilities, and search and rescue equipment at Wake Island.[359] The Tokyo-Midway Island segment was considered marginal because of limited navigational aids.[360] However, when additional navigational aids were put in place in October the Midway flight was considered safe and had the advantage of a shorter distance. The previous trans-Pacific routing (Tokyo-Guam-Kwajalein Island-Johnston Island-Hickam AB-Travis AB) covered 7,850 miles with a total flying time of 42 hours.[361] Using a routing of Tokyo-Midway Island-Hickam AB-Travis AB covered "only" 6,600 miles.[362] In addition, with favorable weather conditions, the C-97 aircraft, which was one of the few aircraft available that had the advantage of being pressurized, was able to make the

flight nonstop from Tokyo to Hickam AB in slightly over 13 hours which decreased the total enroute time by about five hours. These nonstop C-97 flights began in November 1950.[363,364]

Although the hour difference seems small the five hours saved was a long time with patients in the air, particularly for those in marginal condition. Also saved was the usual ground time used whenever the aircraft landed. Additionally the use of a pressurized aircraft provided a much improved environment for crew and patients alike but especially for those patients with medical conditions negatively impacted by altitude related pressure changes.

In December 1950 another long range aircraft, the C-74 was added to the mix of aeromedical aircraft and began transporting patients directly from Hickam AB directly to Kelly AB, Texas moving a total 742 patients to the AF hospital at nearby Lackland AB, Texas.[365] This routing saved many patients much time and deleted transfers between additional medical facilities involving more flights. Kelly AB, Lackland AB, where the largest AF hospital was located, and the large Army hospital and burn center at Fort Sam Houston are all located in San Antonio, Texas within a few miles of each other. These medical facilities, because of their size and availability of specialty, were the

destination of many of the Korean War casualties.

Although the 1453rd MAES, by this time, had a large number of nurses assigned to flight nurse duty the long distances traversed on the aeromedical missions involving crossing multiple time zones and many hours in the air required large numbers of medical personnel. Anyone who has ever flown long distances, even in the present day with jet aircraft decreasing the actual number of inflight hours, is aware of the weariness and disruption of normal sleeping patterns involved. The aeromedical crew members were not just passengers able to sit in a seat and nap when they desired. They were involved in the effort of providing direct care to large numbers of patients throughout the trip.

At the end of the mission the crew members were extremely tired. By the time the patients were deplaned and transported to the hospital; report given to the nurses at the hospital; and equipment removed from the aircraft and secured the nurses and technicians arrived at their quarters with little energy left. Most tried to have a meal before going to bed but some just skipped food. The minimum ground time required before the crews could be scheduled to return to their home stations was 15 hours. However, this 15 hours was calculated from the time the aircraft

parked to when the flight home was scheduled to depart. This scheduling meant that actual resting time was several hours less than 15. Crew scheduling thus had to consider not only the mission time but also the crew rest time plus the time to return to their squadron and then once again travel out to the Far East for another aeromedical mission.

Because of the vast distances in the Pacific region aeromedical crew members, at any given time, were scattered throughout the system. Although the numbers of MATS aeromedical personnel were greatly increased after the beginning of the Korean War, those numbers were necessary in order to adequately staff all of the missions. When in February 1951 patient loads decreased all of the extra nurses sent out to provide temporary help were able to return back to their home stations.[366]

The 1453rd, in November 1950, initiated the use of civilian commercial contract aircraft carriers to help with patient airlift.[367] The aeromedical crews, however, were still MATS aeromedical personnel. During the month 24 contract flights from Haneda AB, Japan airlifted 827 patients to Hickam AB and an additional 22 flights moved 743 patients on to Travis AB in California from Hickam AB.[368]

Helpful as the additional airlift support was

there were problems with the contract carrier aircraft such as poor sanitary facilities, cabin cleanliness with a lack of trash disposal receptacles, and frequent instances of broken equipment intended for patient litters which often eliminated usable space and caused an increased workload on the medical crew.[369] The squadron made a strong recommendation that contract carriers be required to furnish the same facilities, equipment, and service standard as was required in MATS aircraft.[370] Since emergency planning has, even to the present, included the expectation of utilization of civilian airlift capability the experience gained during the Korean airlift provides much information of the areas and potential difficulties to be closely assessed.

Difficulties with Aeromedical Equipment

While the squadrons were working hard to manage the increased patient load there were also efforts being made to improve aeromedical equipment. One important development was the assembling of a standardized flight nurse kit. The Department of Air Evacuation at the AF School of Aviation Medicine designed and assembled six initial kits with medications, instruments, dressings, and other essentials to care for and treat patients.[371] Prior to this it had been the practice for the flight nurse

to carry any items she deemed necessary in her pockets, purse, or any other way she could.[372]

Colonel Frances Thomas, one of the nurses who had been assigned to the aeromedical unit at Travis AB, recalled flying patients on the unpressurized C-54 aircraft.[373] They carried low pressure oxygen bottles and everyone had to be on oxygen when the aircraft reached an altitude of 10,000 feet.[374] The nurses also had to manually pump up the Wangensteen suction device (a continuous gastrointestinal suction) when it was needed.[375] Colonel Thomas also reported that sometimes the nurses used large syringes as a means of providing suction. However, if they were flying on the small C-47 aircraft there was another method developed by the nurses in WW II to provide continuous suction. There were small air ports in some of the C-47 aircraft windows and if the end of a suction tube was stuck out the port the air moving across the fuselage would provide enough suction (Venturi effect) to maintain stomach decompression.[376]

Colonel Thomas also remarked on the problems transporting patients with head injuries or any other problem negatively affected by altitude. The first flight she made on a pressurized aircraft was transporting a number of patients with head injuries

to the east coast and she commented that it was a great flight and she was convinced "right then and there" of the value of pressurization.[377] It is understandable why she was so impressed. Removing the impact of altitude pressure changes from her patients made the flight so much more tolerable for the patients and much easier for the nurses to manage.

Difficulties in Maintaining Current Professional Education

While the nurses were carrying out their professional nursing responsibilities they still had the need to keep up with advances in the nursing profession as well as those in medical science and treatment. These requirements presented difficulties to nurses stationed in all of the overseas areas since no nursing educational program was in effect in those areas. The eleven nurses of one of the aeromedical evacuation squadrons, the 1454th MAES stationed at Rhein Main AB, Germany took steps in 1953 to alleviate some of their concern about the lack of professional education.[378] In response to their expressed concern the squadron subscribed to the American Journal of Nursing (AJN) and also purchased reprints of pamphlets from the AJN for the use of the nurses.[379] Although a small

step this intervention did provide the nurses with information current changes and progress in nursing and nursing care.

The problem of maintaining current professional knowledge was a problem shared by nurses in overseas units without ready access to the normal channels of conveying professional nursing information. There was no internet available as there is today. The use of professional journal subscriptions, reprints and pamphlets, paid by squadron education money, was a common method used to help manage the continuing education needs. Another source of education was the use of inservice training particularly in the operation of aeromedical equipment.

1st MAES Difficulties with Aircraft

Although managing to deal effectively with the problem of arranging for a means of maintaining some educational currency in professional nursing nurses also had other challenges to meet. One small aeromedical evacuation assigned to the European theater, the 1st MAES, had a problem peculiar to itself.

When formed in the Fall of 1951 the squadron was assigned to use an aircraft, the C-82 which was totally unsuited for aeromedical evacuation. This small aircraft not only had a

history of many mechanical problems but the nurses considered it very unsafe for patients. The squadron historical report indicated that the situation was reported to higher headquarters and a request for a different aircraft had been initiated. The report identified the many delays in flights because of mechanical difficulties with the aircraft and the resulting inconvenience to patients and medical facilities.[380] It took persistence and specific documentation to justify the continuing requests for a change but the squadron personnel were able to provide specific examples. At times a C-47 aircraft had to be used for some of the aeromedical missions when it was not possible to land a C-82 on the air strip nearest the patient point of origin.[381] The need to use another aircraft in order to carry out a mission was but another fact to be used to justify the request for a change in aircraft assignment.

The 1st MAES persisted and shortly were able to list as the outstanding accomplishment during the reporting period of 1 November 1951 to 31 December 1951 the cancellation of the C-82 aircraft for air evacuation.[382] 12th AF higher headquarters had listened to the people of the 1st MAES and done a finally done a survey which concluded that the

aircraft was not ideal for evacuation of sick, wounded and disabled patients. In fact, the study conclusion stated that facilities for crash landing or ditching a C-82 are practically nil for survival for persons in the cabin of the plane.[383] The nurses judgment about safety of the aircraft had been vindicated. The mechanical difficulties, delays, and inconvenience were also mentioned but the major determining factor for not using the aircraft was that of safety.[384] The squadron had been successful in its persistent appeals and now switched to using the C-47 aircraft on a regular basis.[385] Although small this had proven itself a very safe aircraft. Civilians would be more familiar with its civil designation of DC-3. There are undoubtedly parts of the world where this aircraft is still flying safely. Certainly the flight nurses of the 1st MAES were pleased with the change of aircraft assignment.

Although the aircraft assignment problem had been solved the 1st MAES soon had other difficulties to contend with. During the Spring of 1952 the number of flying hours had been curtailed because of gasoline rationing. The Korean War effort had the priority for supplies and equipment. Squadrons in other areas of the world had to carefully conserve.

This necessitated close screening of patients to obtain maximum utilization of flying hours available.[386] The technique used was to hold back on patients not requiring immediate evacuation until a reasonable number had accumulated.[387] This practice allowed the squadron to evacuate all those requiring transfer with a lesser number of flights. The negative part of this practice, of course, was that patients would have a longer wait to be evacuated unless they had emergency needs.

Complicating the situation during the Fall of 1952 was poor weather at pick up points in November and December which prevented the squadron from completing 10 of the missions. The 1st MAES squadron then used the same technique they had during the Spring gas crisis and concentrated patients for pick up.[388] Even though the patients had to wait for a flight all patients requiring evacuation were moved and the care of patients was not jeopardized.[389]

There were always problems to be solved and the efforts of this one small squadron to resolve theirs demonstrated the effectiveness of the nurses working with their administrators and other personnel to resolve problems of equipment and scheduling plus effectively navigate the intricacies of the military

bureaucracy in order to promote patient care as well as to provide for the needs of squadron personnel. Their efforts were mirrored by other units regardless of the locale or the circumstances. The nurses, medical technicians and administrators worked together and did their best.

Chapter III Notes

[289]The original components of the AFMS included the medical corps, dental corps, veterinary corps, nurse corps, and medical service corps. Enlisted components of the medical services also came under the overall supervision of the AFMS.

[290]Colonel Vivian Gersema, USAF, Ret., Telephone interview with Sharon Vairo, 14 April 1991.

[291]M. E. Lambertson, Nursing Team Organization and Function (New York: Teachers College Press, 1953), Quoted in M. Louise Fitzpatrick, Prologue to Professionalism (Bowie, MD:Robert J. Brady Co., 1983) 34.

[292]Kalisch & Kalisch, Advance, 576.

[293]Lambertson, quoted in Fitzpatrick, 34.

[294]First Report, 115-116.

[295]AFCSG, Memorandum No. 35, "Comments for United States Air Force Surgeons," (HQ USAF, Office of the Surgeon General: Washington, 25, D.C., September, 1949) 4.

[296]Ibid.

[297]Colonel Verena Zeller Pettoruto, Interview by Colonel Dolores J. Haritos, 30 November 1982, Transcript, Office of Air Force History, Headquarters USAF, Washington, D.C., 61.

[298]Ibid., 56,59-60.

[299]Ibid., 80.

[300]Zeller Seberg, 14.

[301]Colonel Dorothy N. Zeller, Interview by Colonel Dolores J. Haritos, 23-25 March 1983, Transcript, United States Air Force Historical Research Center, 55.

[302]Ibid.

[303]Kovach Scott, 18.

[304]Zeller Seberg, 13.

[305]Gersema.

[306]Bryant, 3-4.

[307]Ibid., 9.

[308]Roberts, 33-34.

[309]"Statistical Study of Air Force Nurse Corps 1 July 1949-1 December 1949," Directorate of Staffing and Education, Office of the Surgeon General.

[310]Ibid.

[311]Zeller Seberg, 25.

[312]Lay Wilson, 39.

[313]Second Report, , 33.

[314]Menge.

[315]Ibid.

[316]The author was one of the young students who attended a chemistry course with then Captain Menge and eventually did join the AFNC.

[317]Kovach Scott, 37.

[318]Ibid.

[319]Zeller Seberg, 23.

[320]Kalisch & Kalisch, Advance, 605.

[321]Ibid., 644.

[322]Ibid.

[323]J.B. Brown, :History of Masters Education in Nursing in the United States, 1945-1969" (doctoral diss., Teachers College, Columbia University, 1978). Quoted in M. Louise Fitzpatrick, Prologue to Professionalism (Bowie, MD: Robert J. Brady Co., 1983) 77.

[324]Ibid.

[325]Ibid., 78.

[326]Ibid.

[327]Margaret West and Christy Hawkins, Nursing Schools at the Mid-Century (National Committee for the Improvement of Nursing Services: New York, 1950) 1.

[328]Brigadier General Claire M. Garrecht, Interview by Colonel Dolores J. Haritos, 8 December, 1982, Transcript, United States Air Force Historical Research Center, 59.

[329]Zeller Seberg, 23.

[330]Ibid.

[331]Louise Bainbridge Lawton, Telephone Interview by Sharon Vairo, 21 November 1992.

[332]Unit Historical Report, 1 December 1949 through 31 December 1949, Headquarters 801st MAES, 1 January 1950. File MED-801-HI, Jan-Feb, 1950, USAF Historical Research Center, Maxwell AFB, Al.

[333]Unit Historical Report, 1 January 1950 through 31 January 1950, Headquarters 801st MAES, 1 February 1950. File MED-801-HI, Jan-Feb, 1950, USAF Historical Research Center, Maxwell AFB, Al.

[334]801st MAES, 1 March 1950.

[335]Bainbridge Lawton

[336]Ibid.

[337]Colonel Florence Deegan, Conversation with Sharon Vairo at Lackland AFB, Officers Club, 11 November 1992.

[338]Ibid.

[339]Futrell, Korea, 585.

[340]Ibid.

[341]Ibid.

[342]Ibid.

[343]Ibid.

[344]Ibid.

[345]Ibid., 586.

[346]The phrase "combat cargo" was part of the unit designation and included in the organization of the squadron title. It indicated that the unit assignment was movement of combat related cargo.

[347]Colonel Allen D. Smith (MC) and Major Charles E. Peterson, "Summary of Medical Air Evacuation Activity in the Korean Conflict," A Report Prepared for the FEAF Air Surgeon, Typewritten.

[348]Ibid.

[349]Futrell, Korea, 586.

[350]Ibid.

[351]Smith & Peterson.

[352]Ibid.

[353]Futrell, Korea, 587.

[354]Smith & Peterson.

[355]U.S.Air Force, Flight Nursing (Gunter AFB, AL: School of Aviation Medicine, 1957) 208-209. In Rumianek, 39.

[356]Historical Data for Period 10 October thru 31 October 1951, 801st MAES, Oct, 1951, 3.File K-MED-HI, USAF Historical Research Center, Maxwell AFB, Al.

[357]Futrell, Korea, 591-592.

[358]Historical Data, MATS, 1 July to 31 December 1950, 100.

[359]Ibid.

[360]Ibid., 101.

[361]Ibid., 100, 102.

[362]Ibid., 102.

[363]Ibid.

[364]Historical Report for December, 1950, Headquarters 1453rd MAES, 12 January 1951. File K-MED-1453-HI. USAF Historical Research Center, Maxwell AFB, Al.

[365]Ibid.

[366]Historical Report for January 1951, Headquarters 1453rd MAES, 14 February 1951. File K-MED-1453-HI, USAF Historical Research Center, Maxwell AFB, Al.

[367]Historical Report for December 1950, 1453rd MAES, 12 January 1951.

[368]Ibid.

[369]Squadron Historical Report for Period 1 through 30 September 1951, 1453rd MAES, 12 October 1951. File K-MED-1453-HI, USAF Historical Research Center, Maxwell AFB, Al.Ibid

[370]Ibid.

[371]History Continental Division, 1 July - 31 December 1950, 64.

[372]Ibid.

[373]Colonel Frances Thomas, Interview with Sharon Vairo, October 5, 1991, Reno, Nevada.

[374]Ibid.

[375]Ibid.

[376]Ibid.

[377]Ibid.

[378] History 1454th MAES, 1 January 1953-30 June 1953, 15-16.

[379]Ibid.

[380]Historical Data for the 1st MAES, 1 September 1951 to 31 October 1951, 5.

[381]Ibid., 7.

[382]Historical Data for the 1st Medical Air Evacuation Squadron from 1 November 1951 to 31 December 1951. Copy at USAF Historical Research Center, Maxwell AFB, Al.

[383]Ibid.

[384]Ibid.

[385]Ibid.

[386]History of 1st MAES, 1 November to 31 December 1952, 3-4.

[387]Ibid., 4.

[388]Ibid., 3-4.

[389]Ibid., 4.

Chapter IV

Experiences of the Founders-the Women Who Served

The experiences of the first members of the AFNC help to provide a more personal picture of the triumphs and achievements as well as the difficulties and disappointments of the first years of the corps.

Nurses who made the transfer to the AFNC have varying memories of their first experiences with the new corps. Not all of the nurses recall whether or not they ever had any official notification that transfer was an option or even how to go about the process. Colonel Vivian Gersema transferred to the AFNC because she wanted to be "part of something new." She thought she filled out an application but remembers that she remained assigned to an Army hospital for awhile after the AFNC was formed.[390] That also was the experience of a number of other nurses, some of whom remained at Army facilities until the Korean War demands on nursing, facilitated the transfer of AFNC nurses to AF facilities.

Colonel Gersema was in the second group of senior nurses to come to the chief nurses' office to assist Colonel Zeller with all the organizational and administrative tasks that were required. Her responsibility was in the area of recruiting and she

remembers going out and speaking to people at state nursing organizations, nursing schools, and anywhere else nurses met "trying to convince people that there was now a third military nursing service."[391] Included in the information that Colonel Gersema provided to all those people was, of course, the message that nurses should join the AFNC if they were interested in military nursing service. Today's recruiters continue the same message.

Major Lillie U. Crows' recollection of her introduction to the possibility of transfer to the AFNC was that a friend said to her "come on and transfer to the Air Force" and so she did![392] She did not recall any official announcement but simply went with her friend on the spur of the moment. Her AF career soon turned out to be a rather challenging one since she became the chief nurse of the 1453rd MAES during the major part of the Korean War.

Lt. Colonel Dorothy Menge recalled the first time she encountered the possibility of transferring to the AFNC. She had been stationed overseas and was returning to the United States by ship. As she and others debarked and reached the dock there was a Sergeant directing traffic who told the nurses arriving to go into the Air Force or the Army line. She thought to herself "why not?" and went over to the Air Force

line.[393]

Colonel Ethel Kovach Scott who would become the fourth Chief, AFNC, stated that she transferred to the new corps because "I was in the Air Force. I was in the AAC originally at Chanute Field, Illinois and I would not think of doing anything else but transfer to the Air Force. That was almost automatic."[394] Colonel Kovach Scott went on to say that "we felt Air Force, we did not feel Army. We wore the Army uniform and were under Army regulations but most of us were stationed at Army Air Corps (AAC) bases and felt sort of separate from the Army, even before the transfer."[395] This was not an unusual response from the nurses stationed at AAC bases. Colonel Kovach Scott believed that the majority of nurses that were assigned to the Army Air Corps automatically expected to stay in the Air Force and were of the opinion that eventually the AF and the AFNC would be formed as a service separate from the Army.[396]

The process of reviewing all of the records and deciding on which nurses would be transferred to the AFNC was a long and challenging task. Once all the applications for transfer had been received, Colonel Verena Zeller, the first Chief AFNC, recalls reviewing records for "weeks and weeks", with the help of an assistant, Captain Inez McDonald, who initially was

brought into the office under temporary duty status (TDY)."[397] TDY status meant that the person was assigned on a short term basis until the required duty was completed and would then return to her permanent duty station. Colonel Zeller indicated that many factors had to be considered in selecting the nurses. Quotas had to be filled in accordance with rank, clinical specialties which were affected by hospital requirements, and officer efficiency records with the emphasis on taking those with the best records.[398] Matching up all of the requirements with those who had the best records was a time consuming task but was eventually completed and the selections were made.

Selection of the First Chief AFNC

With the creation of the AFNC then Captain Verena Zeller was appointed as Acting Chief AFNC.[399] Later on that first year she did get some help with the authorization of three additional nursing positions in the Office of the Surgeon General. The authorizations were for an Assistant Chief Nurse, a nurse for Procurement (recruitment) and Nurse assignment, and a nurse for Medical Liason and Selection.[400]

Colonel Zeller recalled the landmark day when a separate AFMS was finally officially authorized. She said that it was on a Saturday morning that Surgeon General Malcolm Grow called all the department heads

into his office for a meeting. Colonel Zeller said that he was so excited about it that he had all of them get to work immediately on the transition. That was probably one Saturday that no one minded coming into work. The creation of a separate AFMS had been a prolonged effort on the part of many people and success was something to celebrate. Colonel Zeller remembered that General Grow looked at her, a captain, and said "I want our chief nurse to be a Brigadier General."[401] The formation of the AFNC had been achieved but General Grow was not one to rest on his laurels. He immediately stated a new goal. However, it would not be until the fifth chief of the AFNC that the brigadier general goal would be realized but the seed was planted and would remain viable until success was achieved.

Colonel Zeller was first assigned to the Air Surgeon's Office in January, 1949 while it was still part of the AAC. When she arrived, Colonel Elizabeth Mahoney, ANC was the nurse assigned to that office and had been in the position for four years or more. She was the senior nurse in the AAC during the transition period when the USAF itself had been officially created but the medical service status was still in limbo.[402] She was reassigned elsewhere after Colonel Zeller arrived. When Colonel Mahoney left she said that she

had been told by General Grow that he wanted a nurse assigned who had graduated from the flight nurse course and had also had flight nurse experience.[403]

Colonel Zeller was probably the most senior nurse on duty with the AF that had those qualifications and she believed that was why she was selected for the position. There were several nurses in the grade of Major serving in AAC hospitals but none of them had attended the flight nurse course.[404] Colonel Zeller said that when the transfer officially took place she was just told she would be the chief AFNC. She said that she had no idea that would be done and, in fact, had been sure the AF would transfer a more senior nurse from the Army.[405] At the time she was 36 years old and said that "I was kind of young for the job but I had a lot of experience and I survived."[406] Colonel Zeller had had previous experience as a chief nurse in three different assignments, and added to the Air Evacuation experience that General Grow required, was quite probably very correct in believing that she was the most senior nurse with the qualifications needed.

Colonel Kovach Scott, a contemporary of Colonel Zeller, agreed about her seniority but added other reasons for her selection. Colonel Kovach Scott said that Colonel Zeller was a very capable, strong, and great person who had the backing of the AF surgeons and

did very well in the position. She went on to say that Colonel Zeller really was the one to develop the AFNC in its beginning years which contributed greatly to where it is today.[407]

Military nurses of today might wonder how one jumps from the rank of captain to colonel in a few short years. Colonel Zeller was a captain at the time she was appointed as Acting Chief Nurse. The reason why she was not made a major had to do with the specific requirements of the promotion system. Colonel Zeller explained that the requirement for promotion to the permanent grade of major was 15 years of service and she had not yet accrued that amount of time.[408] Instead, on April 27, 1950, Colonel Zeller was promoted to the temporary grade of lieutenant colonel and in August, 1951, to the temporary grade of colonel.[409] Apparently there was not a year requirement for the higher ranks. She explained that as soon as she had accrued the necessary time in service for eligibility for the rank of major she received the permanent grade but never wore the gold leaves emblematic of the rank.

However, once Colonel Zeller had achieved the necessary number of years for promotion to the permanent rank of major she became eligible for promotion to the temporary rank of colonel since she now held a permanent field grade rank (major and

above).[410] In essence achievement of permanent field grade status functioned as a gatekeeper for eligibility to higher rank. Colonel Zeller recalled being promoted to full colonel but having no idea it was about to occur since no one had talked to her about it. She remembered being called to the Surgeon General's Office and when she arrived there were quite a few people present. The order was read and eagles were placed on her shoulders. Her comment was that she was "quite thrilled."[411] That was a low key response to a happening that was a significant milestone. The rank of full colonel is the highest rank that could be achieved in the AFNC at that time and represented the pinnacle of professional success that an AF nurse could achieve. Still today it is the highest rank that can be achieved in the AFNC except for the brigadier general rank of the Chief, AFNC.

Although many of the senior rank nurses were directly involved in working with Colonel Zeller a number of the senior AFNC nurses were out working in other areas helping to implement the organization structure and policies that were being established. Colonel Kovach Scott was Chief Nurse of the air evacuation squadron at Hickam AB, Hawaii.[412] Her experiences there would prove of great value when she was later teaching at the Flight Nurse Course during

the Korean War period. Lieutenant Colonel Mary Hoadley was Chief Nurse at the flight nurse school then which was then located at Randolph AFB, Texas.[413] Colonel Frances Lay Wilson, who would become the second Chief of the AFNC, was at Kelly AFB, Texas doing an apprenticeship flight nursing course when a message was received about the opportunity to apply for the AFNC.[414] She recalled losing a night's sleep about the decision but said "I was with the Air Force and I was happy."[415] This was yet another example of the identification that AAC nurses had established as being AF and different from the Army. Colonel Lay Wilson went on to the University of Minnesota to finish her degree and upon her return was assigned to Gunter AFB, Alabama as Chief Nurse of the flight nurse course.[416]

Colonel Frances Bryant was Chief Nurse at Maxwell, AFB, Alabama and recalled that all of the nurses at Maxwell decided to go with the Air Force. [417] She also remembered the many requests for references from nurses applying to transfer. Colonel Bryant said that because she had been a Chief Nurse since 1942 and had worked with so many nurses she kept getting reference requests, some from nurses she had never heard of. It seems that there was another Chief Nurse named Colonel Ruby Bryant, in the ANC, and requests kept getting to the wrong Bryant. So the two of them solved the

problem by sending the requests to each other until they got them straightened out and determined "who we wanted to recommend and who we didn't."[418] This system worked very effectively undoubtedly because the two Colonel Bryants had both been in the military long enough to know what the new AFNC would need and which people would best fill those needs.

AF Uniforms-a Subject of Great Interest to AF Women

When the ANC nurses transferred to the AFNC they not only continued to do their usual jobs in the installations to which they were assigned but they also continued to wear their army uniforms. Air Force Letter (AFL) No. 35-48 prescribed the wearing of the Army type uniform in olive drab (OD) pending completion of a study to develop a new Women's AF uniform.[419] Typical of any bureauracy a problem was handled by forming a committee to carry out a study. This particular subject, however, was one of great interest to AF women. An early decision was that AF buttons would replace Army buttons when available.[420] However, the question of when they would be available depended on assignment location. For example, supplies could be expected to be available in the Washington D.C. area long before any would be seen in overseas assignments.

Progress was relatively rapid in determining the new uniform specifics and on 15 November 1950, AF

Regulation (AFR) 35-14 was published stating the regulations pertaining to the new prescribed AF uniform. The color of the new uniform was described in typical military fashion as blue shade 156 for overcoats, shade 157 for raincoats and assorted other numbers for the particular shade of blue for any given article of uniform.[421] Brigadier General Claire Garrecht recalled when she first saw the uniform she was disappointed in the color because the pictures she had seen made the color look more like the current day AF blue color and the actual color was not what she had expected.[422] She described that original color as a light blue with almost a salt and pepper thread going through the material. However, she went on to say that the nurses wore them proudly.[423] They finally had an AF uniform and could dispense with the Army ones they had been continuing to wear. The white hospital uniform was essentially the same as the ANC uniform, except that the AF cap featured a blue band. There was no band on the ANC cap.[424]

Colonel Verena Zeller recalled that when development of the uniform was going on a WAF officer was assigned to the job and worked with both Colonel Zeller and the WAF director, Colonel May.[425] The designer Hattie Carnegie met with the WAF officer and did design a uniform in blue. At that point the Army

decided to change their uniforms to something "more feminine" and requested that both Army and AF have the same uniform but in the respective colors.[426] However, the AF didn't go along with that idea. Colonel Zeller recalled that the Army did actually finally end up using the Carnegie design.[427] The AF decided to work through the Research and Development branch at Wright-Patterson AB, Ohio to develop their uniform although Colonel Zeller recalled that Johns Fredericks designed the AF hat.[428]

Colonel Zeller commented that the nurses were very excited when she first wore it on a trip to Japan with the Surgeon General. Especially being in an overseas area they would not have had much opportunity to see one before. She said that one nurse said to her patients "this is our Chief Nurse from Washington, but look at her new blue uniform." Implied was that the nurses were more excited at seeing the new uniform than they were at seeing the AFNC Chief! Colonel Zeller said that all the nurses were "dying to get the uniform"[429] but as would be expected it would take a while for supplies to be available for everyone. In fact women officers were authorized to wear the Army type uniform until 1 July 1952[430] by which time sufficient supplies of the new uniform would be available.

Development of AF Flight Nurse Wings

A source of great pride to flight nurses is the silver wings they earn upon graduation from the AF flight nurse course. They represent a great deal of hard work and achievement and demonstrate the nurses qualification to be assigned as an aeromedical crew member.

When Army flight nurses first transferred to the AFNC they continued to wear their ANC wings just as they did the rest of the ANC uniform. Just as changes were needed to differentiate the AF uniform from the Army uniform so changes were needed in the appearance of the flight nurse wings to reflect the fact that they now represented the AF.

Colonel Jack Walker, at the time Chief of the AF flight Nursing Course, presented a brief review of the development of flight nurse wings during the 50th Anniversary Celebration of Flight Nursing program in November 1992.[431] The original ANC wings had a superimposed N in either a brown or maroon color. In the first year that the Army awarded wings when they operated the Flight Nurse Course the wings were gold. After that year the wings were changed to silver. Colonel Walker stated that with the creation of the AF a blue N replaced the previous colors.[432] However, no official documentation was located confirming this

change. Colonel Walker commented that one of the donated flight nurse wings on display at the School of Aerospace Medicine had the blue N superimposed on the wings.

The color choice for the superimposed N became a moot point, however, in 1956. In that year the AF designed their own flight nurse badge which is described as "silver colored wings two inches in width with the AFNC insignia, consisting of the AF shield with the staff of Aesculapius superimposed over a burning lamp, in the center.[433] It is these wings which have ever since been awarded to graduates of the AFNC Flight Nurse Course. Officers of foreign military services and officers of the U.S. Army or Navy who complete the course are awarded the same wings as the AFNC graduates.

Expectations Placed on AF Flight Nurses

There were many expectations placed upon flight nurses assigned to aeromedical evacuation units. Not all of those expectations could be considered to be realistic. Colonel Kovach Scott described a typical problem encountered during the time when she was Chief Nurse of the 1453rd MAES at Hickam AB, Hawaii. She recalled that there was always the conflict of the hospitals wanting the flight nurses to work when they wern't flying.[434] Colonel Kovach Scott said that the

nurse might have just come in from a 24 hour flight but the people at the base seemed to have the idea that the nurses should be working 24 hours a day whenever it was thought they were needed.[435]

Not only hospital administrators but individual AF members also had the apparent belief that the nurses should always be available. Colonel Kovach Scott recounted one incident where a nurse had come in from a flight during the morning and had stopped at the base exchange to pick up some things. An officer approached her and said "what are you doing here at the BX in the middle of the day? You should be over taking care of my children." When the nurse came in crying Colonel Kovach Scotts' response was "why didn't you ask him what he's doing there, why isn't he taking care of his own children on the lunch hour?" When the nurse responded that she would have if she had thought of it but she was so mad she didn't. Colonel Kovach Scott told her "think of it next time."[436] She added that this was the type of thing flight nurses had to put up with and regardless of how dedicated they were they still needed their rest, and food, and everything else.[437] This was a good example of the need for nurses to improve their assertive skills and that need continues to this day. Flight nurses no longer are expected to work in base medical facilities during the

time they are not flying. That advance can be credited to the efforts of the nurse corps leadership which worked to develop more reasonable policies. In addition the onset of the Korean War and the tremendous increased demands on flight nurses helped to bring about recognition that flight nursing was a full-time effort.

War in Korea: AFNC Nurses Face the Challenge

The increasing need for aeromedical evacuation precipitated a sudden requirement for increased numbers of flight nurses for Korean service. Unfortunately there were a limited number of flight nurses in the AFNC. The AFNC Chief, Colonel Verena Zeller, recalled that the MATS Surgeon, General Hall, came in one day and said "I need 100 flight nurses as of yesterday."[438] She responded to him that "because of the war every flight nurse we had was already assigned to air evacuation duty."[439] Regardless, however, more were needed and an answer had to be found to the problem of providing additional flight nurse support. Colonel Zeller said that she and her staff came in on the Saturday and worked on a solution to the problem. Their solution was to pull nurses from the large Army hospitals, like Walter Reed and Letterman General, who had transferred to the AFNC but had not yet been assigned to an AF facility. These nurses were then

assigned to air evacuation duty to work as apprentices with trained flight nurses.[440] As soon as possible afterwards these nurses were then given the option to go to flight nurse training.[441] This solution provided additional professional nurses to help with inflight patient care under the direction of the qualified flight nurses. Although not an ideal arrangement it did meet the needs of the moment and provided a stimulus to authorize the training of large numbers of additional flight nurses.

The two aeromedical squadrons in the Pacific region, the 801st MAES and the 1453rd MAES, were the recipients of the additional flight nurses assigned to aeromedical duty. All of the nurses that were assigned to the 801st MAES were graduates of the flight nurse course[442] but many of those who were assigned to the 1453rd came from the flight nurse apprentice group.[443,444] The 1453rd chief nurse, Major Crow, remembered that many of those transferred from hospital duty had never been on a plane before their initial trip to squadron headquarters at Hickam AB.[445] Colonel Menge commented that some of the new arrivals couldn't handle the stress of flying and had to be sent back to other nonflying assignments.[446]

It was the practice in the squadron for the new nurses in the apprentice group to be paired with an

experienced flight nurse for approximately two flights before they were able to fly in a crew position by themselves on a mission.[447,448] Since a standard medical crew configuration was two nurses and three medical technicians[449] there was always an experienced flight nurse present on the flight. This arrangement provided additional professional nursing personnel for the squadron to meet increased patient care needs and at the same time made sure that an experienced flight nurse was present on the flights. The experienced flight nurse was the person responsible for providing direction in the event of problems specifically related to aeromedical concerns such as altitude effects on patients conditions and emergency aircraft related procedures as well as directing the normal routine of inflight care. Although not an ideal situation the use of this apprentice system did meet the immediate needs of the AF for flight nurses to care for the large numbers of casualties stemming from the Korean War.

Educational Preparation of Flight Nurses

Although the stop gap measure implemented to provide flight nurses for the Korean War effort met the immediate need it did not address the the problem of providing large numbers of nurses trained in aeromedical evacuation. However, the increased demand for flight nurses and aeromedical technicians did

result ina a transfer of the flight nurse and aeromedical technician schools from their location at Randolph Field, Texas to a larger facility at Gunter AB, Alabama.[450,451] The school facilities at Randolph Field simply were not large enough to accommodate the increased numbers of students being sent to the school. The faculty and support personnel simply moved lock, stock, and barrel from Texas to Alabama. The chief nurse of the school at the time of the transfer was Lieutenant Colonel Mary Hoadley. She recalled that all of the staff drove from Randolph Field, near San Antonio, Texas, to Gunter AB in Montgomery, Alabama and opened up the base upon their arrival.[452] Gunter was a temporary base which had been closed and was now reopened to accommodate the Aeromedical Evacuation School. There were no other programs or units on the base.[453] The entire purpose of the base was as a site for training aeromedical evacuation personnel.

The number of students increased dramatically. Before the Korean War there were approximately 20 students per class.[454] In October, 1950 that number was increased to 60 students every seven weeks and in 1952 to 100 per class. By the middle of 1952 the Navy had fulfilled its quota for NNC flight nurses so classes were then decreased to 40 students.[455]

In order to provide for adequate training of the large numbers of students changes had to be made in the program structure. The flight nurse course was decreased in length from nine weeks to six weeks[456] and one of the major changes was that students no longer went out on actual aeromedical flights as part of their training.[457] Student participation in actual aeromedical flights had long been a staple of the flight nurse course and although a valuable experience for the students it was very time consuming. Colonel Kovach Scott, one of the faculty during the period, indicated that the students did still have "a couple of orientation flights" in an aircraft as part of their training but otherwise the course was all classroom and simulation experiences. [458] The flights were simply to orient the students to inflight since many had never actually flown. The class members simply climbed on board and the aircraft, in AF terminology, simply flew around the flagpole for a short period. In reality the flights were considered training missions and usually lasted 2-3 hours. From a practical standpoint it also gave the students the opportunity to determine if they were comfortable with flying. For those who discovered a fear of flying or had difficulty with motion sickness it was beneficial to recognize the problem before they graduated and faced assigment to an aeromedical

squadron.

The result of this educational effort was an increase in designated flight nurse numbers to 256 at the end of fiscal year 1950; 463 at the end of fiscal year 1951; and 656 at the end of fiscal year 1952.[459] In the space of two years the numbers of trained flight nurses had more than tripled providing ample personnel to meet the aeromedical needs of the AF. The importance of having sufficient trained flight nurses available for sudden emergencies had been clearly demonstrated.

Demands on the Aeromedical Personnel of the 801st MAES

The workload placed on the aeromedical crew members of 801st MAES provided an example of the need to have sufficient trained crew members available in the event of a sudden increased demand. In the early critical days of the Korean War the squadron flight nurses and aeromedical technicians often flew as many as three round trips a day between Korea and Japan and literally worked themselves to exhaustion.[460] The squadron Chief Nurse, Captain Bainbridge, described the first three to five days as flying around the clock until help arrived. The medical crews would catch some sleep under an aircraft wing or while deadheading back to Korea to pick up another load.[461] On maximum aeromedical days the 801st simply did not have enough

aeromedical crews to accompany all aircraft and in those instances the flight crews would have to care for the sick and wounded.[462] Since the aircraft crews only had basic first aid training the care they were able to provide was minimal. The average strength of the 801st during the Korean War, even after the unit received additional personnel, averaged only 30 nurses and 50 medical technicians.[463] During the first year of the war it was not uncommon for nurses assigned to the 801st to fly over 100 hours a month often under adverse conditions.[464] Although this does not seem like a large number of hours over the course of a month it is necessary to recognize that it only represents the number of actual hours in the air. On the type of missions being flown the majority of the time the crew is working is taken up by pre-flight preparation, post-flight duties, ground time at each stop when patients are being onloaded and offloaded, and deadhead time when the crew is getting into the theater of operations. Although crewmembers try to rest during the deadhead time it is not the most conducive of environments for rest.

A typical Korean War aeromedical evacuation mission as described by one of the flight nurses, then Captain Janice Albert, gives a good picture of the demands placed on the aeromedical evacuation crew.[465]

The crew would be picked up at 0130 (1:30 a.m.) for a 0300 (3:00 a.m.) takeoff and spend the pre-flight time checking supplies and equipment. The aircraft would then be loaded with cargo of varying types from mail to ammunition to jeeps to food or to personnel going to the fighting zone.[466] After loading supplies and checking emergency equipment the flight nurse goes to base operations to receive a briefing from the pilot on the weather and the flight plan for the day.[467] After grabbing a cup of coffee the nurse goes back out to the aircraft and rejoins the rest of her crew. They get as comfortable as possible for the trip and then it is take-off and time for a little sleep. After landing at the destination cargo is off-loaded and the crew is then busied getting the aircraft swept out and litter straps unrolled in preparation for the patients arriving from the MASH.[468]

The flight nurse determines where to position the patients in the aircraft and when the loading ramp, a converted jeep, pulls up so loading can commence she directs the positioning of patients. She then checks all the patients, makes sure litter straps are secure, gives pain medication if needed, briefs the patients and then it is time for take-off and the flight back to Japan.[469] The flight nurse and medical technicians give whatever care is needed inflight, oxygen, dressing

changes, medication, and after an almost 16 hour day see to the patients off-loading at the destination.[470] The next day may well bring a repeat if necessary and it often was, especially in the first days of the war. In 1954 then Captain Albert was awarded the air medal for her outstanding work as a flight nurse in Korea from 6 September 1950 through 2 June 1951.[471]

Aeromedical Crew Casualties

Aeromedical crew members faced the same risks as did other flight crew. Although few flight nurses were killed on missions the possibility existed. One of those occurred on 26 September 1950 when a C-54 transport took off from Ashiya Air Base, Japan enroute to Kimpo, Korea carrying ground troops to Korea as well as an 801st MAES aeromedical crew who would be bringing patients back to Japan on the return flight.[472] Shortly after take-off the aircraft crashed into the Sea of Japan not far from shore resulting in the death of one flight nurse, Captain Vera M. Brown, and one aeromedical technician.[473] The other flight nurse, Lieutenant Jonita Bonham, although injured, was able to assist the other survivors by directing them as to how to inflate the life rafts which kept them afloat until rescued three hours later. For her effort Lieutenant Bonham was awarded the Distinguished Flying Cross.[474] Captain Brown was posthumously also awarded the

Distinguished Flying Cross.[475]

The 1453rd MAES also lost one of its nurses although not because of an inflight incident. On September 3, 1951 one of the squadron flight nurses was in Japan on temporary duty status (TDY). She was killed in an automobile accident when the vehicle in which she was riding went through a bridge rail into a river.[476] This was the only 1453 MAES squadron flight nurse reported killed during the Korean War period in the monthly historical reports located.

The 1453rd MAES, however, was fortunate not to lose any other crew members or patients when on March 6, 1952 it experienced its first major aeromedical accident.[477] Taking off from Haneda AB, Japan an aircraft with 58 patients (35 litter and 23 ambulatory), three flight nurses, and four medical technicians had reached a take-off speed of 70 miles per hour when the right landing gear retracted, and the plane veered to the right off the runway where it stopped short of the sea wall.[478]

The flight nurses onboard were Major Lillie Crow, the squadron chief nurse who was sitting, along with a medical technician, in the front of the cabin next to the forward emergency exit, Captain Madeline Sebasky and Pilot Officer (P.O.) E.G. McCabe, RCAF, who were both sitting in the rear along with two medical

technicians.[479] The fourth medical technician was sitting up front near Major Crow with a stryker frame patient between them.[480] In her report Major Crow stated that she opened the left forward escape hatch, determined that everyone in the rear was allright and then started to assist with an injured patient. Another patient was asking for a nurse so Major Crow called one of the other nurses (P.O. McCabe) forward and she dressed a patients hand wound, which occurred when a propeller came through the fuselage, and then helped him out of the aircraft.[481] Captain Sebasky stated she and P.O. McCabe remained aft for offloading of patients and Major Crow directed offloading forward.[482] No litter straps or brackets were broken and the litters had remained secure during the crash. Litter patients were off-loaded through the rear emergency exit on the right side.[483] The top of the stryker frame was put on the stryker patient and secured with litter straps, and then the frame and patient were offloaded through the same exit as the other litter patients.[484] Ambulatory patients were evacuated through the two floor hatches. The whole off-loading was timed at 14.5 minutes.[485]

Major Crow recalled that after everything was all over the nurses assumed they were through for the day so they went to the Officers Club to relax and have some refreshments.[486] Certainly it was a well deserved

break after a harrowing day. However, shortly after arriving at the club word was sent that another aircraft had been located so they went back to the field and two hours later the new plane had been loaded and the mission took off-this time successfully.[487] There is no record of what the patients thought of this turn of events. Perhaps they simply considered it the AF version of "getting right back on the horse after falling off!"

Experiences with Returning Korean War POWs

After the former prisoners had been returned to the United States they continued on to their respective destinations via the Continental Division aeromedical flights.

One of the Continental Division flight nurses commented that she had noted a differance in the way patients had been treated while prisoners depending on whether they had been held by the North Koreans or by the Chinese.[488] She said that the prisoners of the Koreans indicated they had been treated vindictively but the prisoners of the Chinese reported that they had been the subjects of medical experiments.[489] Many of the returning POWs had contracted tuberculosis. In the United States at the time one of the treatments was to collapse the affected lung. Colonel Thomas stated that one of her patients who had been held by the Chinese

had that treatment but reportedly the Chinese had used raw chicken livers as an implant apparently in an attempt to find things that wouldn't react with the body.[490] No official documentation of that type of treatment was located. Colonel Thomas had no knowledge of how the patient eventually did, of course, since the flight nurses had no contact with the patients after they were transported to their destinations. However, she did remember that the patients were well met at their destinations although there were no big welcoming groups because the patients were scattered in small numbers to many final destinations.[491]

Temporary Upsurge in Fighting

Although the fighting had decreased and everyone was hopeful that the war would soon end it still persisted. Suddenly while the peace talks were progressing in May 1953 the Chinese began a series of major offensives primarily effecting the ROK troops holding most of the front line with a resultant large increase in casualties. The air evacuation patient load correspondingly leaped upward reaching a total of over 1800 in one day and 8996 during the month of June 1953.[492] It was the highest number of patients transported since the difficult days in December, 1950. Reminiscent of those difficult months aeromedical crews worked around the clock for days getting their only

rest during the cargo carrying legs of the the missions (deadheading in air crew terminology). Sometimes the nurses found themselves sleeping enroute lying on top of crates of different kinds of ammunition.[493] When one is exhausted any kind of flat surface to spread blankets for a bed is welcome.

Finally, however, a truce was declared and the war for all practical purposes was over. However, a state of war technically exists to this day although there is no ongoing armed conflict.

During the Korean War flight nurses accepted the same risks as other air crew members inflight especially when flying in treacherous conditions and in hostile country. No nurse in the Korean conflict refused to fly her mission[494] and many flew themselves into exhaustion when the situation demanded the effort.

During the Korean War no AF nurse died in what is considered "battle" under reporting conditions. Between 30 June 1950 and 27 July 1953 there were, however, 19 non-battle deaths of AF nurses. Two of these occurred in Korea as a result of aircraft accident and two happened in Japan-one from aircraft accident and one from drowning. Of the remainder two occurred in other overseas areas and 13 in the Continental United States from a combination of accidents and illnesses.[495] There was no report on

injuries sustained by nurses during this period.

The AFNC nurses had worked through a challenging and difficult time. Their corps had just passed its fourth birthday and during that period they had not only created an effectively functioning nurses corps but they had also met the difficulties of a major war. The nurses' experiences reflected the challenges they faced and their ability to meet those challenges. Their success was a positive harbinger for the AFNC future.

Chapter IV Notes

[390]Colonel Vivian Gersema, Colonel, USAF, Ret., Telephone conversation with Sharon A. Vairo, 14 April, 1991.

[391]Ibid.

[392]Crow

[393]Lieutenant Colonel Dorothy Menge, Personal Interview by Sharon A. Vairo, 11 April, 1991.

[394]Colonel Ethel Kovach Scott, Interview by Sharon Vairo, December 21, 1991, Transcript, United States Air Force Oral History Program, Bolling AFB, D.C., 1.

[395]Ibid., 2.

[396]Ibid., 3.

[397]Colonel Verena Zeller Seberg, Interview by Sharon Vairo, October 4, 1991, Transcript, United States Air Force Oral History Program, Bolling AFB, D.C., 8.

[398]Ibid., 9,12.

[399]"Air Force Nurse Corps," USAF Medical Service Digest, Vol. V, (September, 1954) 2.

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[401]Zeller Seberg, 1.

[402]Ibid., 4.

[403]Ibid.

[404]Ibid.

[405]Ibid., 5.

[406]Ibid.

[407]Kovach Scott, 8-9.

[408]Zeller Seberg, 3.

[409]First Report, 116.

[410]Zeller Seberg, 3.

[411]Colonel Verena Zeller Pettoruto, Interview by Colonel Dolores J. Haritos, 30 November 1982, Transcript, Office of Air Force History, Headquarters USAF, Washington, D.C., 56-57.

[412]Kovach Scott, 3.

[413]Ibid., 15.

[414]Colonel Frances Lay Wilson, Interview by Colonel Dolores J. Haritos, 13 December, 1982, Transcript, United States Air Force Historical Research Center, 37.

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[421]Air Force Regulation 35-14, Military Personnel, "Service and Dress Uniforms for Air Force Personnel," Department of the Air Force, Washington, D.C., 15 November, 1950, 1-19.

[422]Garrecht, 25.

[423]Ibid.

[424]Ibid., 26.

[425]Zeller Seberg, 33.

[426]Ibid.

[427]Ibid.

[428]Ibid., 34.

[429]Ibid.

[430]Message CG AU Maxwell AFB, Alabama to Commandants, Commanding Officers, and Directors, all AU Activities, Clarification of AFR 35-14 by HQ USAF.

[431]Colonel Jack R. Walker, Chairman, Department of Aerospace Nursing, Brooks AFB, Texas, "50th Anniversary of Flight Nursing," Banquet Narrative, given at Symposium "Flight Nursing Past, Present, and Future," 12 November 1992 ata the Marriott Rivercenter, San Antonio, Texas.

[432]Ibid.

[433]Air Force Regulation 35-80, Department of the Air Force, 1956.

[434]Kovach Scott, 26.

[435]Ibid.

[436]Ibid.

[437]Ibid., 26-27.

[438]Zeller Seberg, 16.

[439]Ibid.

[440]Ibid.

[441]Ibid.

[442]Lawton.

[443]Menge.

[444]Crow.

[445]Ibid.

[446]Menge.

[447]Ibid.

[448]Crow.

[449]Ibid.

[450]Futrell, "Aeromedical Evacuation," 534.

[451]Zeller Seberg, 16.

[452]Lieutenant Colonel Mary Hoadley, Telephone interview by Sharon Vairo, 17 April 1992.

[453]Zeller Seberg, 17-18.

[454]Kovach Scott (1991), 10.

[455]Futrell, "Aeromedical Evacuation," 572-573.

[456]Ibid.

[457]Kovach Scott (1991), 11.

[458]Ibid.

[459]First Report USAF Medical Service, 118.

[460]Futrell, Korea, 592.

[461]Bainbridge Lawton.

[462]Futrell, Korea, 592.

[463]Colonel Allen D. Smith, "Medical Air Evacuation in Korea and its influence on the Future," 9.

[464]Mary E. Hoadley, "Air Force Nursing in the Far East," Presented at the Fifth Annual Military-Medical-Dental Symposium, Held at the U.S. Naval Hospital, Philadelphia, Pa, 18-23 October, 1954, 6.

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[467]Ibid.

[468]Ibid.

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[472]Captain Annis G. Thompson, The Greatest Airlift-The Story of Combat Cargo, 1st ed. (Tokyo,

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[473]Ibid.

[474]The New York World-Telegram and Sun, June 26, 1951. Quoted in Rumianek, 36.

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[476]Ibid.

[477]Squadron Historical Report for Period 1 through 31 March 1952, 1453rd MAES, 9 April 1952. File K-MED-1453-HI, USAF Historical Research Center, Maxwell AFB, Al.

[478]Squadron Historical Report for Period 1 through 31 March, 1952, 1453rd MAES, with attached statement from Major Lillie U. Crow, Captain Madeline P. Sebasky, and P.O. E.G. McCabe RCAF.

[479]Ibid.

[480]Ibid.

[481]Ibid.

[482]Ibid.

[483]Ibid.

[484]Ibid.

[485]Ibid.

[486]Crow.

[487]Ibid.

[488]Thomas, 2.

[489]Ibid.

[490]Ibid.

[491]Ibid.

[492]History 315th Air Division, 1 July 1953 to 31 December 1953, 36.

[493]Thompson, 242.

[494]Hoadley, "Air Force Nursing, 8.

[495]The U.S. Air Force Personnel Report, Casualties, April-June 1955, 1. File K-134.58-1E, USAF Historical Research Center, Maxwell AFB, Al.

Chapter V

Summary, Conclusions, Recommendations

With the transfer of 1199 Army nurses on 1 July 1949 to the AF the newest of the military nursing services, the AFNC, came into being. These nurses brought with them the traditions, knowledge, and experience from their Army service. Most of the nurses who transferred to the AFNC had served on Army Air Corps installations and had already formed an identification with the air arm of the military service. Consequently, when they transferred to the new AFNC they, in essence, had already identified with the AF and thought of themselves as AF nurses.

The first year of the AFNC was primarily devoted to both developing an organizational structure to meet the needs of the AF and to provide training for nurses in the clinical specialty areas including administration. This training was important because many of the nurses transferring to the AF were relatively junior in rank and experience and had not had previous opportunity for specialty or administrative education.

At the age of 11 months the AFNC was abruptly thrust into meeting the demands generated by the onset

of the Korean War. Although the increased patient care load affected all of the AFMS the primary impact on the AFNC was aeromedical evacuation. There was a sudden demand for flight nurses. Unfortunately, the AFNC did not have sufficient qualified flight nurses to meet that demand and had to use the temporary expedient of sending nurses, who had not yet been to flight nurse school, to the Pacific to assist qualified flight nurses on the missions. It was essentially an on the job apprentice type system but did serve to meet the patient care needs until sufficient flight nurses could be trained.

The aeromedical evacuation system which had been in place before the war functioned with some scheduled flights plus an "as the need arose" basis. When not flying the nurses were expected to work in the local medical care facility. The tremendously increased patient load forced the development and expansion of the aeromedical evacuation system into a highly organized, yet adaptable system, which depended on highly skilled and motivated flight nurses who were excellent problem solvers and independent and creative thinkers. The measure of their success was the successful air evacuation of thousands of wounded and sick patients, not only from Korea, but throughout the worldwide areas of AF responsibility.

The AFNC proved able to rise to the challenges precipitated by the Korean War as well as continuing with the more mundane organizational tasks of developing policies and procedures and creating a new AF uniform. The uniform development created much interest among the nurses, probably much more than did the policies and procedures.

One of the lessons learned from the Korean War experience was the necessity of having sufficient qualified flight nurses available who could be called upon in the event of war or other crisis requiring large numbers of patients to be evacuated by air. The military calls this a surge capability. This lesson would be reinforced again in the next decade with the onset of another war in Southeast Asia. This recurrent need would lead to the decision to maintain a large number of fully qualified flight nurses in the Air Force Reserve (AFR) although it would take close to a quarter of a century before this occurred.

Recurrent Themes in Military Nursing

The themes consistently found in military nursing from the earliest beginnings of the United States remained present in the early years of the AFNC.

The theme of dedication to serve, protect, and care for the soldier patients was the theme most strongly defined in the early years of the AFNC. The

work of the AFNC flight nurses during the Korean War when they flew multiple aeromedical evacuation missions, often under hazardous conditions, around the clock if necessary in order to provide needed patient care is an example of the dedication of the nurses. The AFNC nurses once again demonstrated the commitment, devotion to duty, patriotism, heroism and self sacrifice that has been a hallmark of all the American women who chose to serve their country.

The theme of slow advance in status is one that is not obvious in the first five years of the AFNC. By the time the AFNC was created the difficult battle for official status in the military as well as permanent commissioned status had been won. That fight had been waged by military and civilian nurses for over fifty years and the AFNC was a recipient of the successful efforts that had been carried on by so many nurses.

It is unfortunate that the battle to achieve full commissioned took so long. Societal beliefs about the status of women undoubtedly contributed to the many difficulties that nurses had to overcome in finally achieving official military status. The efforts of all those who worked so long and sacrificed so much deserve the admiration and thanks of those who received full military status because of the efforts of their predecessors.

From the beginning of the corps AFNC members were aware of the need for improvement in increased rank and assignment opportunities. The first AF Surgeon General, Major General Malcomb Grow, set the tone when he said he wanted the AFNC Chief Nurse to be a Brigadier General, a rank commensurate with the responsibilities of a corps chief. However, the effort to achieve higher rank within the AFNC had to wait while the corps concentrated on development of an organizational structure followed by the need to meet the challenges of the Korean War. It was not until after the Korean War period that the AFNC could begin to devote more effort to the goal of improved rank and assignment opportunities for nurses.

The third theme of recognition of the need for adequate preparation of nurses is one that was clearly demonstrated in the first years of the AFNC. The first AFNC nurses, who had all transferred to the AF from the Army, were aware that experiences during World War II had demonstrated that nurses had not been prepared for wartime needs. An early goal was to train nurses in the skills which would be critical during war and nurses were assigned to schools for that training. Specialties such as anesthesia, operating room, and flight nursing were among those considered essential. Unfortunately the Korean War intervened before

sufficient flight nurses could be trained and the result was a major problem in staffing the aeromedical squadrons. Baccalaureate nursing education was not an early goal but rather took a back seat to the need to train nurses in critical wartime skills. Eventually the goal of an all-baccalaureate goal would be established but that would not be until well after the Korean War years. Even so, the establishment of the goal of baccalaureate preparation for all military nurses far exceeds the goal set by civilian nurses. The efforts of military nursing in the area of professional education requirements for practice stand as a model for their civilian colleagues.

The fourth goal, the development of political astuteness in achieving goals, was demonstrated as AFNC nurses dealt with the difficulties and challenges encountered during the first years of the corps. The AFNC was a component of the AFMS and, as such, had to work within that structure. That required a chief nurse who was able to effectively work with the Surgeon General and the rest of the command structure. The AFNC was fortunate in that their Chief Nurse, Colonel Verena Zeller was such a person. She also had the assistance of several senior nurses and they were able to develop creative ways of managing difficulties. An example of this was their development of a flight nurse

apprentice system to temporarily meet the need for increased numbers of professional nurses to give inflight care until sufficient flight nurses could be trained. Other nurses worked within the system to solve problems ranging from how to speed up the training of flight nurses to convincing higher headquarters to remove an aircraft the nurses had determined was unsafe for aeromedical evacuation from that assignment. Their success reflects their creativity, ingenuity, endurance, and persistence in meeting day to day challenges as they established a military nursing service dedicated to the health care of all AF members.

Lack of Documentation

A major problem in writing the first five years of the AFNC history was the absence of documentation about the AFNC and the decisions, rationales for actions, and activities of the nurses. There was information available concerning the AF, the AFMS, and a variety of squadron and higher headquarters information sources. These sources were particularly good at reporting logistical information, numbers of patients seen, categories of injury or illness, equipment available or needed, etc., but said very little about nurse corps activities. Some reports included names of the nurses, most did not. As a result the activities of the nurses

often had to be inferred from the information about patient population, type of facility, missions flown in the case of aeromedical units, types of aircraft utilized and their limitations, and any other facts provided which could conceivably impact nurses in whatever circumstances they were assigned.

Interviews of nurses who served during the first years of the AFNC helped to provide a more accurate picture of AF nursing during those early days. Major events such, as the events during the first days of the Korean War or being in an airplane crash, were remembered clearly and in detail. However, specific details of such things as assignments, remembrance of who was where or when, who was the chief nurse at a particular location, and why certain decisions were made were often lost to memory by the passage of time. A hiatus of 40 plus years takes its toll on the accuracy of detail recollection. Nevertheless the remembrances of the nurses did broaden the picture of the early years of the corps.

Recommendations

In light of the lack of documentation of AFNC activities in the early years one recommendation is for the corps to develop a system to record significant activities and nursing actions on a regular basis. This would allow for details to be recorded which might

be omitted when done in retrospect. Data such as rationales for decisions and activities, personal experiences of the nurses, and identification of the nurses involved in various actions would be valuable. Assigning AFNC officers the additional duty of historical officer, depending on the unit situation, would be helpful in increasing the amount of nursing related information included in squadron histories.

A second recommendation is that the history of the AFNC during the war in Vietnam be written as soon as possible. The memories of nurses who served during that conflict 25 to 35 years ago may well not recall details of occurrances over that span of time. Many of the women and men who served are now in their fifties and sixties and the recollection of details of their experiences will decrease as the years increase. Vietnam had a major impact on the AFNC as well as all the other members of the military and society. AFNC actions during that conflict deserve to be documented as clearly as possible.

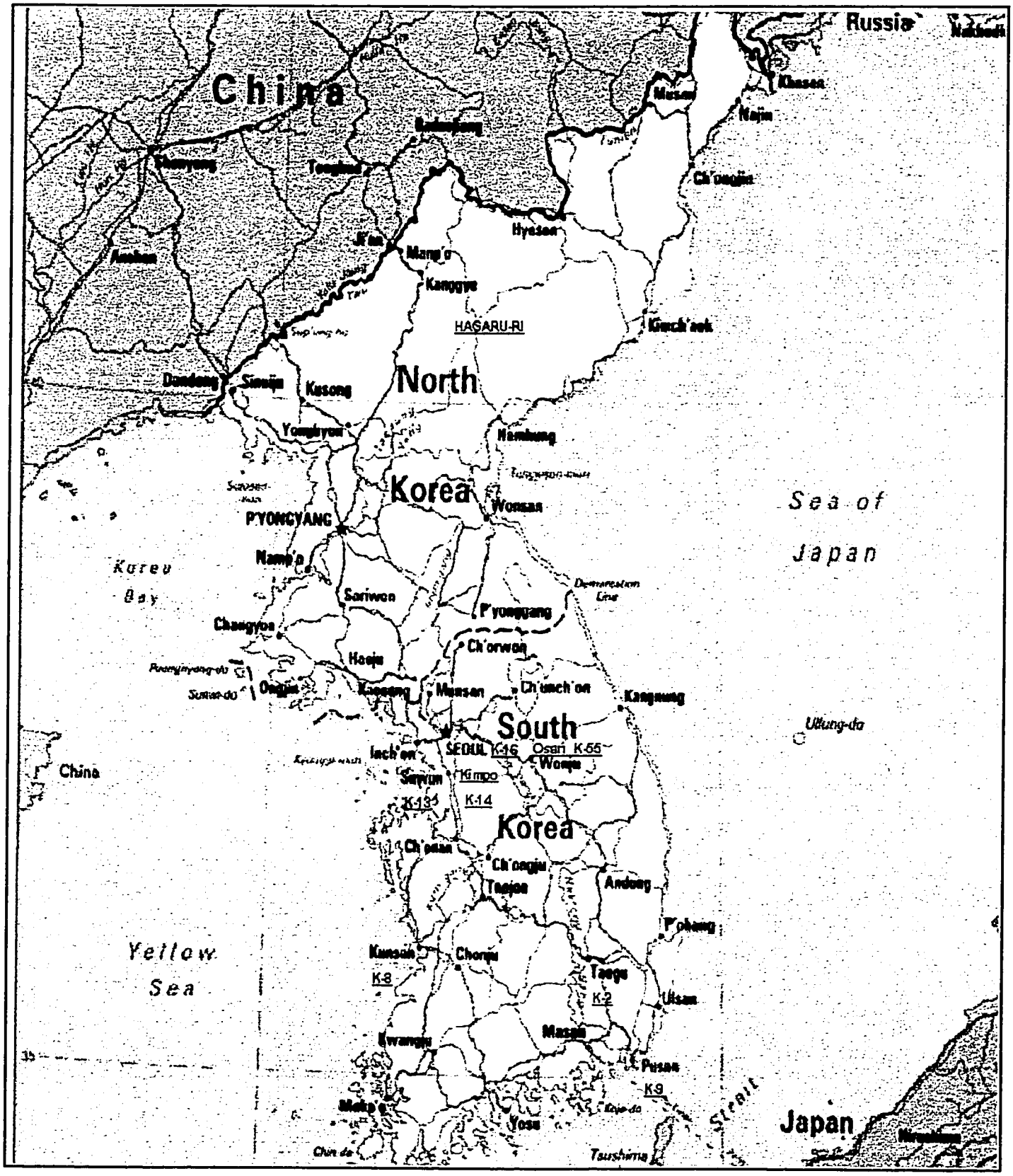
Since Vietnam the AFNC has been involved in a number of various humanitarian missions as well as the Gulf War. The efforts of the AFNC in those missions also deserve as accurate a documentation as possible. Interviews, as soon as possible after the event, of personnel involved in the various missions would be one

way of preserving much of the thoughts, emotions, rationales for activities, and other details of the AFNC actions during significant times in the corps history. It is hoped that a 50th anniversary history can be completed by the time that milestone is reached.

The AFNC will reach its 50th birthday in 1999. During the relatively short period of its existence the corps has met many challenges while serving during three wars and many humanitarian missions, been instrumental in the development of a worldwide aeromedical evacuation system, and been an integral part of the AF and the AFMS. It is hoped that this history of the first five years of its service will be of interest to corps members and accurately reflect the accomplishments of those who served.

Appendix A

Aeromedical Locations Cited



Appendix B

lIST OF MILITARY ABBREVIATIONS

AAF	Army Air Force
AB	Air Base
AF	Air Force
AFB	Air Force Base
AFMS	Air Force Medical Service
AFNC	Air Force Nurse Corps
ANC	Army Nurse Corps
DA	Department of the Army
DAF	Department of the Air Force
DOD	Department of Defense
FEAF	Far East Air Forces
FEC	Far East Command
KMAG	Korean Military Advisory Group
MAES	Medical Air Evacuation Squadron
MASH	Mobile Army Surgical Hospital
MATS	Military Air Transport Service
MOS	Military Occupational Specialty
MSC	Medical Service Corps
NNC	Navy Nurse Corps
ROK	Republic of Korea
SG	Surgeon General

USAF United States Air Force

USAFE United States Air Force Europe

ZI Zone of the Interior-Refers to Continental U.S.

Appendix C

LIST OF NAMES CITED AND PAGE LOCATIONS