

✓ THE ROLE OF THE ARMY MEDICAL SERVICE

IN THE

DOMINICAN REPUBLIC CRISIS OF 1965

U.S. ARMY MILITARY HISTORY INSTITUTE

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FOREWORD

The ability of the Army Medical Service to react quickly in cases of extreme international emergencies was graphically illustrated during the Dominican Republic crisis of 1965. The sudden commitment of a large force to counter a threatened Communist takeover brought with it a number of medical problems. The solutions to these problems again demonstrated the need for continued emphasis on sound planning and constant readiness, in order that the Army Medical Service mission of conserving the fighting strength can be accomplished with a minimum of difficulty.

The medical situation in the Dominican Republic was noteworthy in many respects, especially in the extensive and highly successful phase of civilian care, which offered immediate and effective treatment to more than 50,000 Dominicans in dire need of expert medical care. Medical personnel, too, gained significantly from the realistic training opportunities created during this critical operation.

The success of our medical mission must be measured by more than the lives saved and the treatment provided. The lessons learned from this experience will be beneficial in future planning when similar contingencies are encountered.

LEONARD D. HEATON,
Lieutenant General,
The Surgeon General.



PREFACE

The most valuable contributions to the preparation of this monograph were made by the actual participants in the Dominican Republic operation. Before and after writing got underway, frank discussions about the medical activities of the operation were held with many of the officers and men of the Surgeon's Office, XVIII Airborne Corps; the 307th Medical Battalion and the Surgeon's Office, 82d Airborne Division; the 55th Medical Group and affiliated units; the Surgeon's Office, USCONARC; and the Office of The Surgeon General.

Special thanks are due for the valuable assistance provided by LTC Foster C. McCaleb, Jr., MC, Surgeon, XVIII Airborne Corps; MAJ Howard D. Smith, MSC, Medical Operations Officer, XVIII Airborne Corps; MAJ Quitman W. Jones, MC, Surgeon, 82d Airborne Division; CPT Robert E. Steward, MC, Acting Surgeon, 82d Division; 2LT John T. Lane, MSC, of the Surgeon's Office, 82d Division; LTC Charles Anistranski, MSC, Commanding Officer, 307th Medical Battalion; CPT Robert F. Elliott, Commanding Officer, of Company D, 307th Medical Battalion; 2LT Joseph Palumbo, MSC, of Company C, 307th Medical Battalion; COL Peter S. Scoles, MC, Commanding Officer, 55th Medical Group; LTC Richard F. Barquist, MC, who succeeded COL Scoles; LTC William L. Richardson, MC, Commanding Officer, 15th Field Hospital; LTC Donald G. McLeod, MC, another Commanding Officer, 15th Field Hospital; MAJ Kent E. Gandy, MSC, Commanding Officer, 54th Medical Detachment (Helicopter Ambulance); CPT Francis A. Sunseri, MC, of the 42d Civil Affairs Company; Mr. Morris Bradley O'Bryant, entomologist with the Pan American Health Organization; COL L. E. Sharpe, MSC, and LTC James D. Davenport, Jr., MSC, of the Surgeon's Office, USCONARC; Dr. Brooks E. Kleber, Chief Historian, USCONARC; and Arthur R. Turner, M.D., Chief Medical Intelligence Coordination Officer, Office of The Surgeon General.

Others who furnished information by mail or in person during trips by Historical Unit personnel to the Dominican Republic, Fort Bragg, Fort Monroe, Fort Meade, Office of The Surgeon General, and elsewhere are too numerous to mention, but the courtesy and helpfulness of all was much appreciated.

A history of the operation prepared by LTC McCaleb was a primary source for this monograph and for much of the factual material, the flavor, and the historical evaluations. Other information contained in this monograph, not derived from interviews or from the documents cited in footnotes, came from general sources, such as newspapers and reference books.

A special note of appreciation is due the author, CPT Darrell G. McPherson, MSC, who not only gathered all the reference material and evaluated it, interviewed key personnel, both in the continental United States and in the Dominican Republic, but also organized and carried through to

completion the overall preparation and writing of this monograph. During a very successful and productive tour of duty with the Historical Unit, CPT McPherson's additional achievements included co-authorship of the History of Physical Standards in World War II and the completion of a chapter in volume VIII of the History of Preventive Medicine in World War II. He departed this unit on 11 May 1966 to activate and assume command of the 27th Military History Detachment.

ROBERT S. ANDERSON,
Colonel, Medical Corps,
Director, The Historical Unit.

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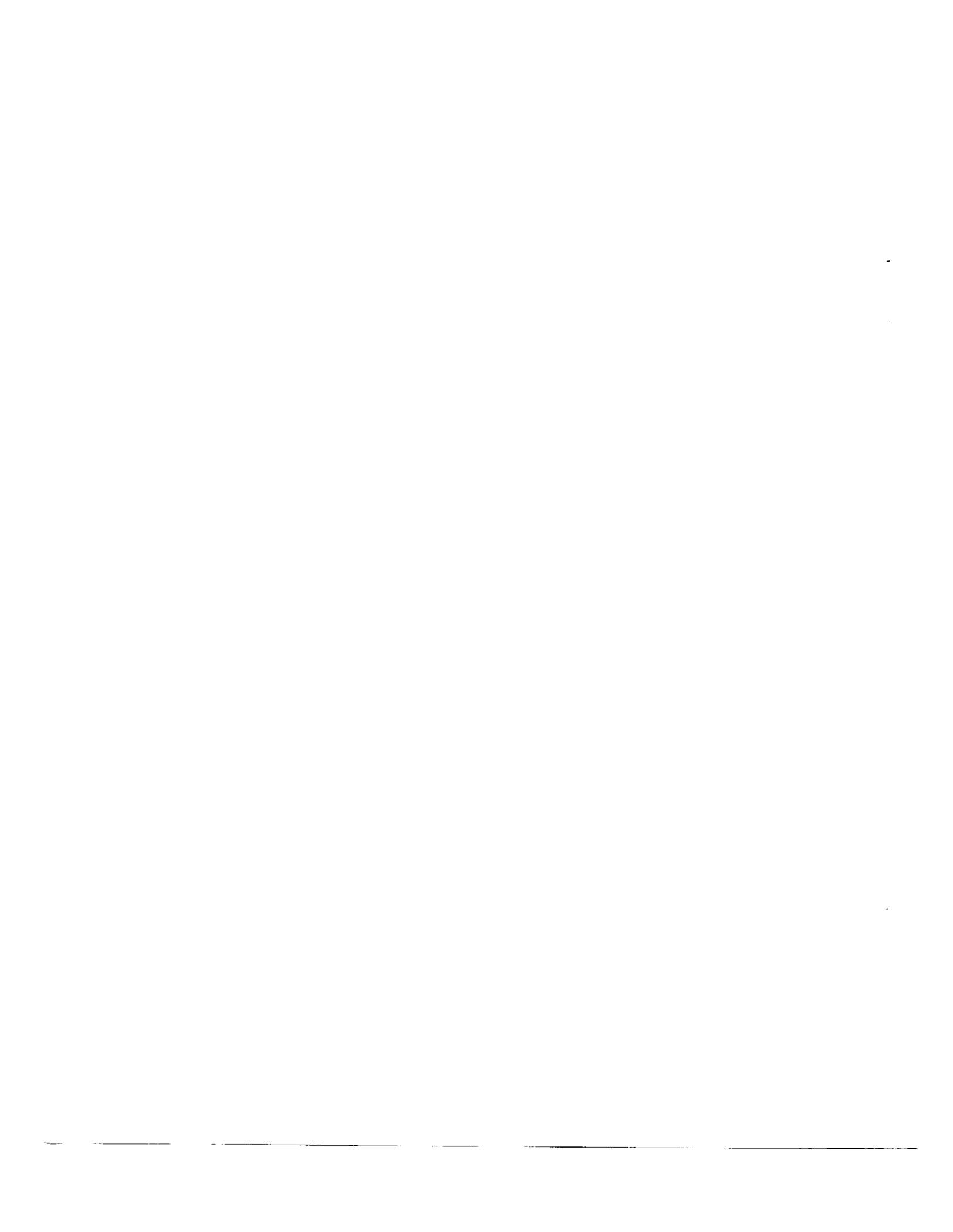
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THE ROLE OF THE ARMY MEDICAL SERVICE
IN THE DOMINICAN REPUBLIC CRISIS OF 1965

INTRODUCTION

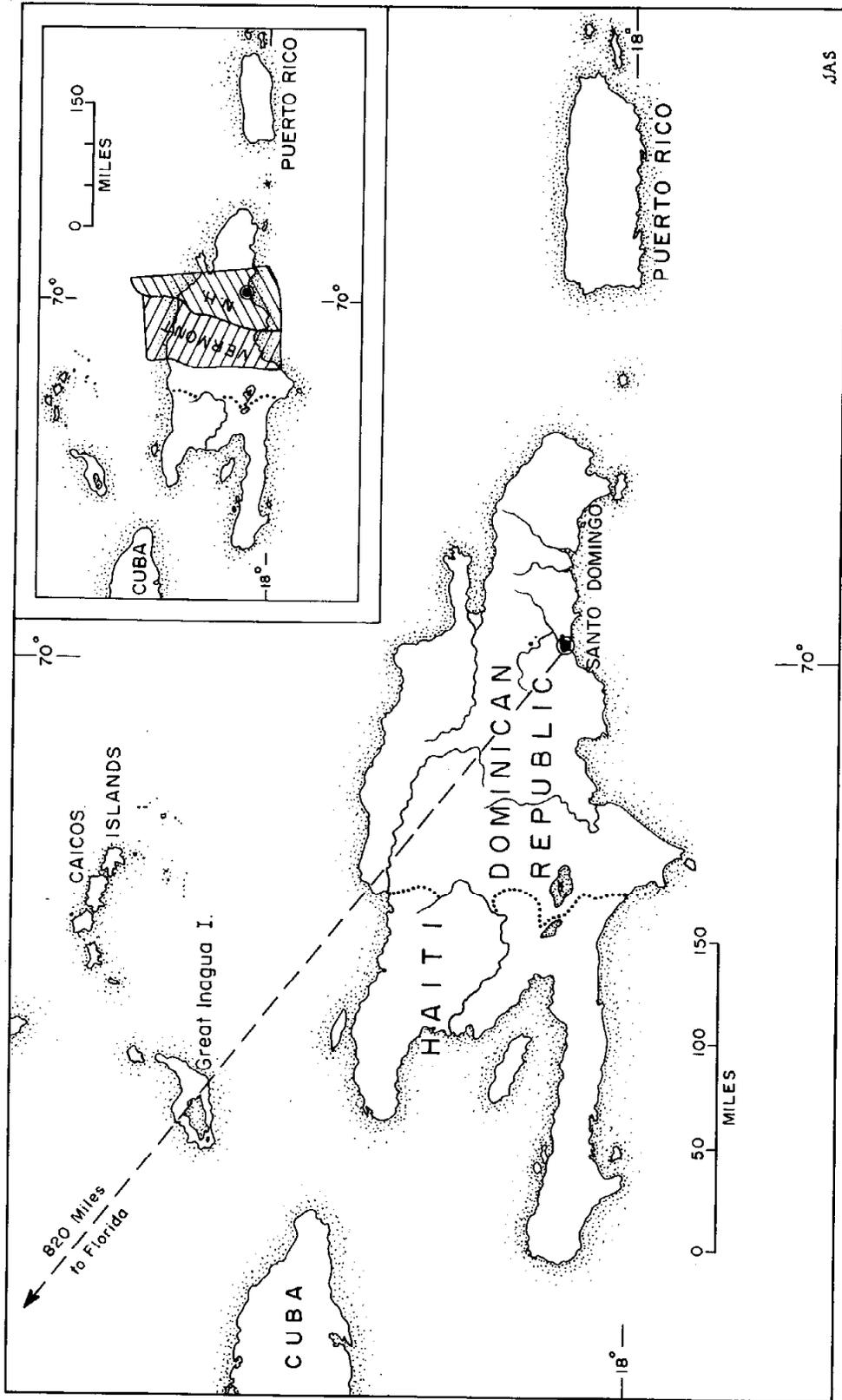
Army Operations

After the 82d Airborne Division headquarters at Fort Bragg, N.C., was alerted on 26 April 1965 that a combat force might be deployed to the Dominican Republic (map 1), a brigade combat team consisting of two battalions and support units began to prepare for an airdrop near the eastern approach to Santo Domingo.¹ Preparations proceeded rapidly until word came on 29 April that the force was to move out. That evening some 1,750 troops were airborne and preparing to jump when word came that the aircraft could be landed at San Isidro (Dominican Air Force Base) instead (map 2). The first planes landed at 0200 on 30 April and began to disgorge the brigade combat team and tons of cargo which had been rigged for airdrop.

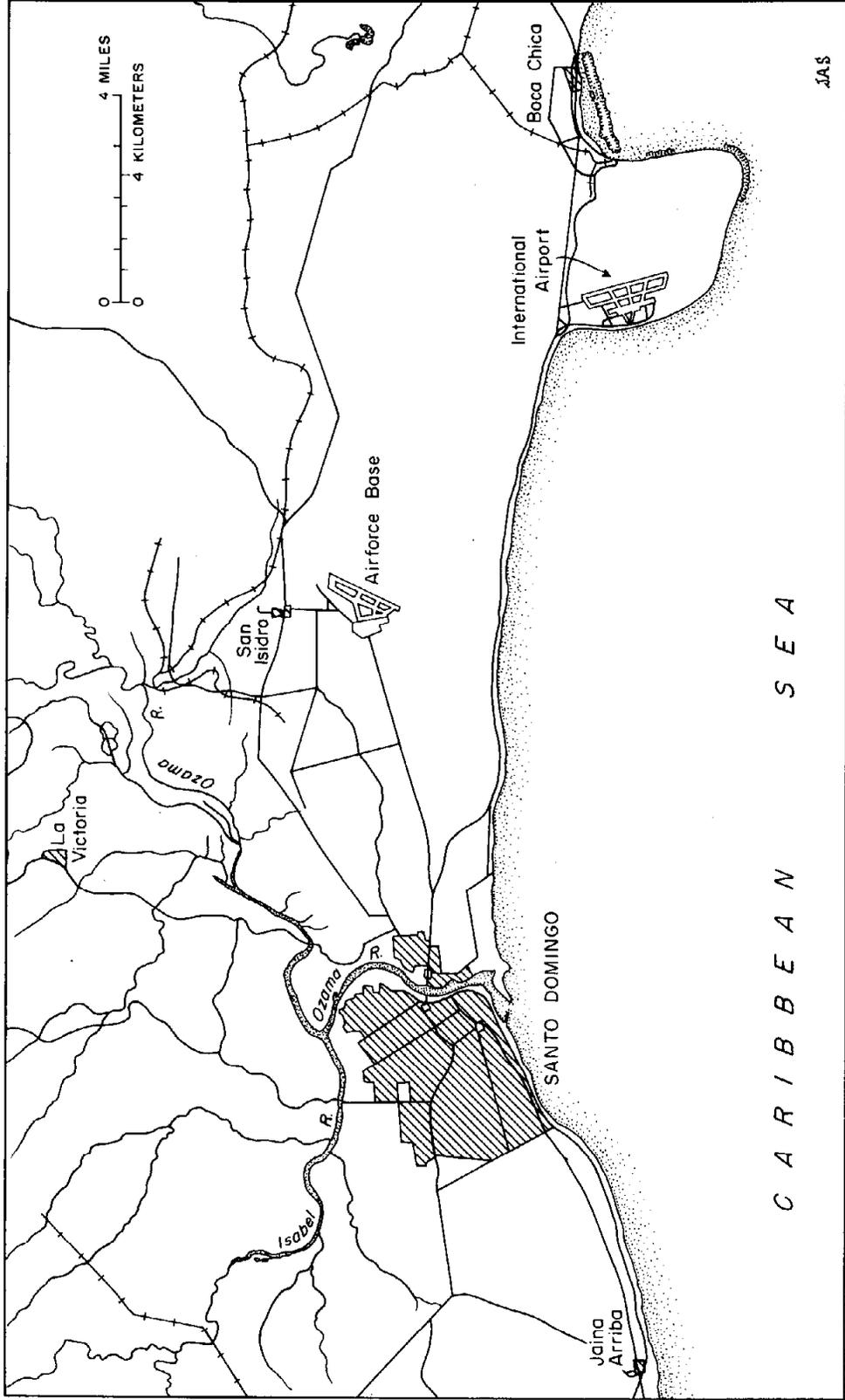
Although there were few lights on the airfield and the cargo had to be unloaded with muscle power, the operation went smoothly. The combat team was on the ground within an hour, and support craft landed thereafter either at San Isidro or were re-diverted to Ramey Air Force Base in Puerto Rico.² The last aircraft landed at San Isidro with equipment for combat troops approximately 14 hours after the initial landing.

¹ Palmer, LTG Bruce, Jr., "The Army in the Dominican Republic," in Army Magazine, vol. 15, No. 16, November, 1965.

² Ibid.



Map 1.--The Dominican Republic.



Map 2.--Santo Domingo area.

After landing at San Isidro, the Army troops struck westward toward Santo Domingo and the Duarte bridge, the entrance into the principal city area. The main highway and bridge were taken and the troops were in a defensive position after the first day.

Meanwhile, the Marines who had landed earlier had entered the city from the other direction and secured real estate in a western portion of the city. Their sector included the Hotel Embajador, which was used as an assembly point in the evacuation of foreign nationals.

On 1 May an Army patrol³ moved through the city to establish contact with the Marines. They met some resistance, lost two killed and five wounded. During the early hours of 3 May, three infantry battalions⁴ had little trouble in securing a path through the city and linking up with the Marines (map 3). The operation took a little more than an hour. Next day the 82d troopers began widening this zone. Then for the next several days, the Army generally maintained its position, suffering casualties from snipers.

Meanwhile, President Johnson had ordered substantial increases in the U.S. troop commitment, and by the end of the first week of May much of the 82d Airborne Division and support elements were on the island. Army involvement in fighting was almost totally confined to Santo Domingo.

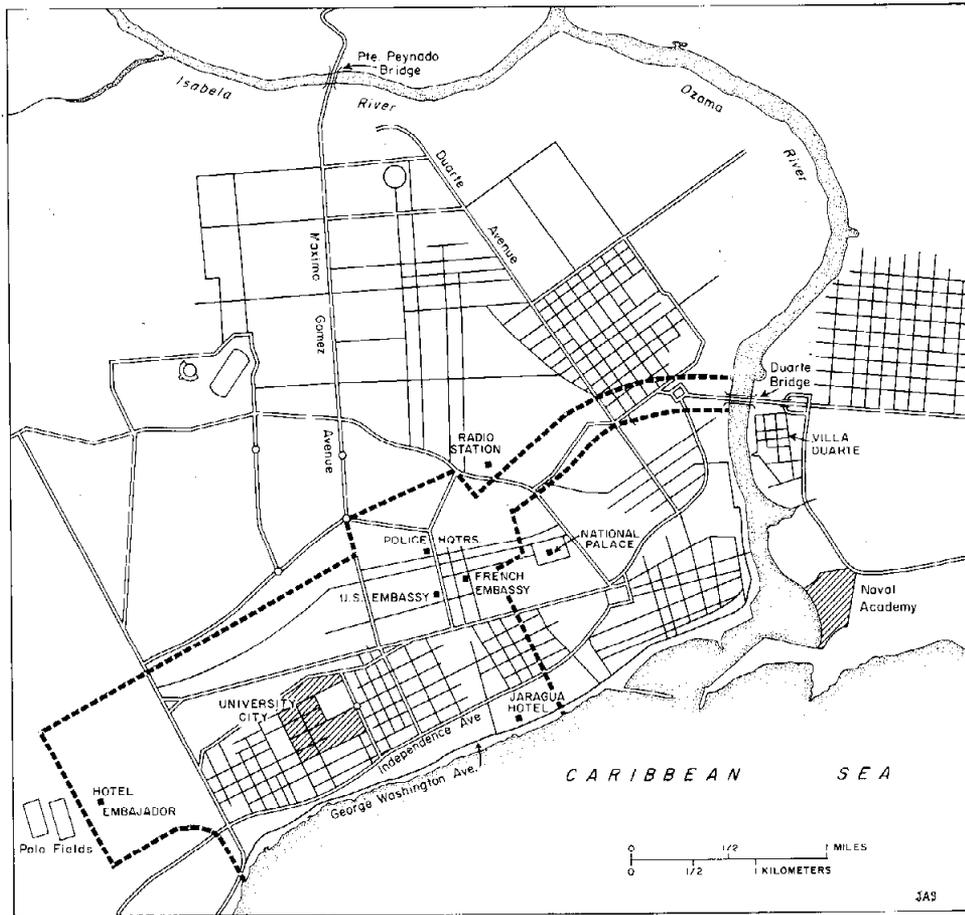
The brigade-size force of Marines was withdrawn early in June and replaced by troops supplied by other members of the Organization of American States. In July, the total number of outside troops in the Dominican Republic was reduced to about twelve thousand but of these more than ten thousand were from the United States. At the end of the year, U.S. troops on the island numbered fewer than six thousand.

Organization

The Commander in Chief, Atlantic, was responsible for all U.S. military operations in the Dominican Republic and initially exercised operational command through the Commander, Joint Task Force 122 (who normally commanded the Second Fleet). Within a few days--on 1 May--LTG Bruce

³ Troop A, 1st Squadron, 17th Cavalry, 82d Airborne Division.

⁴ 2d Battalion, 325th Infantry; 1st and 2d Battalions, 505th Infantry.



Map 3.--The Santo Domingo corridor.

Palmer, Jr., Commanding General, XVIII Airborne Corps, arrived in Santo Domingo and assumed command of U.S. forces ashore, although remaining under CJTF 122's operational command. Less than a week later he became joint commander of all U.S. military components in the area and was placed directly under Commander in Chief, Atlantic.

The command, USFORDOMREP (U.S. Forces, Dominican Republic), was established on 7 May with LTG Palmer in command, and JTF 122 was disestablished.⁵ MG Robert H. York commanded the 82d Airborne Division in DOMREP until August when BG John R. Deane, Jr., took over the reduced force there.

On 23 May the U.S. peacekeeping mission on the island became subordinate to the Organization of American States when the Inter-American Peace Force was created. General of the Army Hugo Panasco Alvim of Brazil took command and LTG Palmer became his deputy.

ARMY MEDICAL SERVICE IN THE DOMINICAN REPUBLIC

The types and numbers of medical units of the U.S. Armed Forces sent to the Dominican Republic to participate in the Inter-American Peace Forces restoration of peaceful order there in 1965 and their assignments after arrival were determined as much by humanitarian and public relations considerations as by the basic mission of the Medical Service--to maintain the fighting strength.

Mass-scale medical aid to the civilian populace was not called for in standing contingency plans for the Dominican Republic before the government of that country was overturned on 24 April 1965. At the time of the uprising, however, the American Embassy reported heavy civilian casualties and requested above-normal Army medical support. The Army responded immediately by sending heavy support for the 82d Airborne Division from outside the Division, but as things worked out, the Division's own medical units were the ones which provided most aid to Dominican civilians.

⁵ USFORDOMREP General Orders Nos. 1, 2 and 4, 7 May 1965.

Plans

Normal medical support within the 82d Airborne Division, in addition to battalion aid stations, and so forth, called for a company from the 307th Medical Battalion (of the Division) to accompany each combat brigade as it was committed to operations. To add flexibility, enhance the medical support, and make it self-sufficient, the field hospital was to be augmented by surgical teams and transportation and other paramedical units.

Planners from the Office of The Surgeon General, the Continental Army Command, and the XVIII Airborne Corps, when faced with the Dominican operation, put the following medical and paramedical units on the troop list to support the Division:

15th Field Hospital	Fort Bragg, N.C.
584th Ambulance Company	Do.
545th Medical Detachment (Supply)	Do.
69th Medical Detachment (Veterinary Food Inspection)	Do.
714th Preventive Medicine Detachment	Do.
54th Medical Detachment (Helicopter Ambulance)	Fort Benning, Ga.
53d Medical Detachment (KA) (General Surgical)	William Beaumont General Hospital, Tex.
139th Medical Detachment (KB) (Ortho- pedic Surgical)	Valley Forge General Hospital, Pa.
232d Medical Detachment (KA) (General Surgical)	Fort Sam Houston, Tex.

The 2d Surgical Hospital of Fort Bragg and the 50th Clearing Company of Fort Benning were listed in follow-on status. The Fort Bragg units other than those from the Division were part of the 55th Medical Group, 5th Logistical Command (later the 12th Support Brigade), Third U.S. Army. Professional personnel to staff the units on the troop list were designated by the Office of The Surgeon General and came from points throughout the United States.

Commitment to Operations

According to plan, the 82d Division's own medical units accompanied the combat brigades. First medical units on the scene from the Division, beginning on 29 April, were battalion aid stations of the 1st Battalion, 505th Infantry and 1st Battalion, 508th Infantry, as well as Company D of the 307th Medical Battalion. Also among the first medical units to arrive in the Dominican Republic was an orthopedic surgical team (139th Medical Detachment (KB) of Valley Forge General Hospital) which was slated to be attached to the 15th Field Hospital. As the

combat commitment was escalated to division size by increments, the rest of the medical support organic to the Division was flown to the island.⁶

Reports by the U.S. Embassy and other sources at the scene when the revolt began painted a picture of bloody fighting and many wounded civilians in the streets of Santo Domingo. It was not known at that time that the civilian casualty rate had been greatly exaggerated, so the Washington administration directed Fort Bragg, through the Commander in Chief, U.S. Army Forces, Atlantic, to speed the entire 15th Field Hospital (400-bed) and two platoons of the 584th Ambulance Company from Fort Bragg to the Dominican Republic to perform civil aid. The medical units were injected into the airstream between combat units, and the first increments began arriving at San Isidro during the early morning darkness of 1 May. This resulted in "some chagrin on the part of the [82d] Division commander who had not requested any change in the [original] plan and who was less than pleased as aircraft after aircraft⁷ arrived and discharged a steady stream of red crosses instead of the combat troops expected."⁸ LTG Palmer, however, was well aware of the situation, since his headquarters was arriving in the same priority as the medical units.

This priority notwithstanding, it was several days before the hospital medics could find many Dominican casualties to treat.

Accompanying the field hospital and the ambulances was a general surgical team, the 53d from William Beaumont General Hospital. Also on 1 May, the Air Force set up a casualty staging detachment at San Isidro which subsequently administered the evacuation of all casualties from the island except for some Navy and Marine personnel who were processed through their own medical facilities and sent out to ships.

The XVIII Airborne Corps Surgeon, MAJ Foster C. McCaleb, Jr., MC (later promoted to LTC during the operation) and his small staff also landed at San Isidro on 2 May. Three days later the 345th Medical Detachment (Supply) and the first shipment (62,000 pounds) of many shipments of civil relief supplies arrived by air. The following day, 6 May, the 54th Medical

⁶ (1) Report, Commanding Officer, Company D, 307th Medical Battalion, to Commanding Officer, 307th Medical Battalion, 82d Airborne Division, 2 June 1965, subject: Interim Report, Dominican Republic Stabilization Operation. (2) Brief History of 82d Airborne Division Civil Aid Program in Dominican Republic (29 Apr. - 31 July). [Official record.]

⁷ 36 aircraft for the hospital alone.

⁸ McCaleb, LTC Foster C., Jr.: Historical Activities Report, Medical Operations in the Dominican Republic. [Official record.]

Detachment (Helicopter Ambulance) from Fort Benning moved five UH-1B air ambulances (fig. 1) ashore from the aircraft carrier USS Boxer. During the same time the 714th Preventive Medicine Detachment of Fort Bragg (two control sections, one sanitary engineer, and one entomologist of the 714th Preventive Medicine Unit) and the 69th Veterinary Food Inspection Detachment of Fort Bragg also came to the island. By that time the medical situation in Santo Domingo had been reevaluated, and the shipment of the 2d Surgical Hospital (Fort Bragg), the 232d Medical Detachment (KA) (Fort Sam Houston), and the 50th Clearing Company (Fort Benning) was canceled.

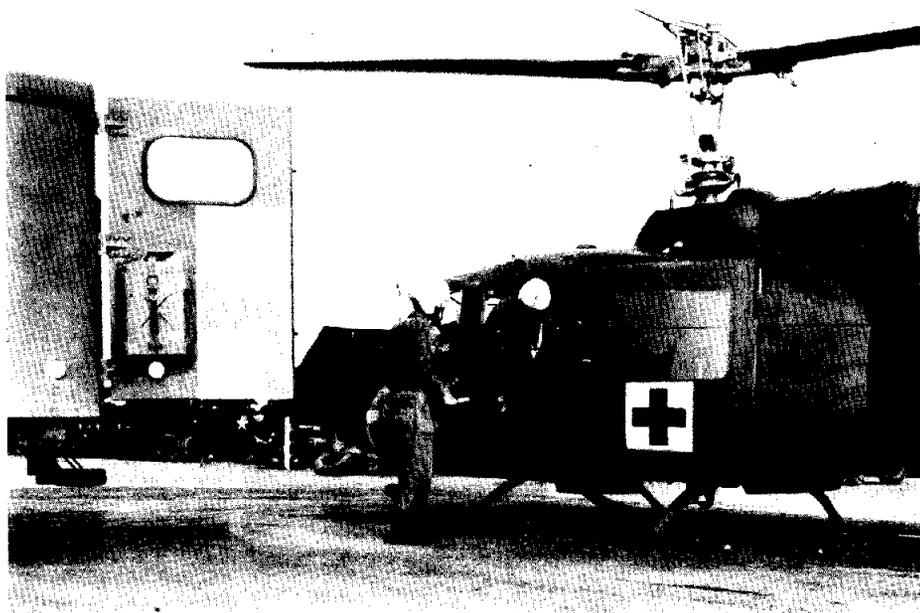


Figure 1.--UH-1B type helicopter used by the Army Medical Service in the Dominican Republic.

Organization

On 30 April, when the first Army troops landed, there were few organizational problems among Medical Service personnel. Technically, a naval officer was Task Force Surgeon, but the 82d Airborne Division, being the only Army unit on the ground, and MAJ Quitman W. Jones, MC, Division Surgeon and Commanding Officer, 307th Medical Battalion, were really more or less left in charge of the immediate situation, while still complying with orders from higher authority. The only non-division medical unit on the island was the surgical team from Valley Forge General Hospital which had arrived before its parent, the 15th Field Hospital. The surgical team was attached to Company D, 307th Medical Battalion, for operations until the 15th Field Hospital reached the Dominican Republic.

The next day, 1 May, the 15th Field Hospital, with LTC William L. Richardson, MC, in command, began to arrive by increments and to set up for business (fig. 2). The field hospital was then attached to the 82d Airborne Division. The 15th and its attached support units were part of the 55th Medical Group at Fort Bragg but the group headquarters was not assigned to the operation. The Group commanding officer, COL Peter S. Scoles, MC, did visit his medical units in the Dominican Republic in an advisory capacity, however.



Figure 2.--Medical Service officers conferring near Santo Domingo in early May. Facing the camera are LTC William L. Richardson, MC, Commanding Officer, 15th Field Hospital, and MAJ Quitman W. Jones, MC, Surgeon, 82d Airborne Division.

On 3 May, the day after the XVIII Airborne Corps Surgeon, MAJ McCaleb, arrived in Santo Domingo, he assumed control of the 15th Field Hospital, and its allied units from the 82d Airborne Division. On 4 May, the 5th Logistical Command became operational on the island and took operational control of the 15th Field Hospital. The Logistical Command, in turn, was under the Corps for tactical command. Within a few more days USFORDOMREP was established, and MAJ McCaleb became the USFORDOMREP Surgeon as well as Surgeon of U.S. Army Forces, DOMREP.

Meanwhile, the individual companies of the 307th Medical Battalion were attached to the combat brigades they supported until 5 May, when they reverted to Medical Battalion control.

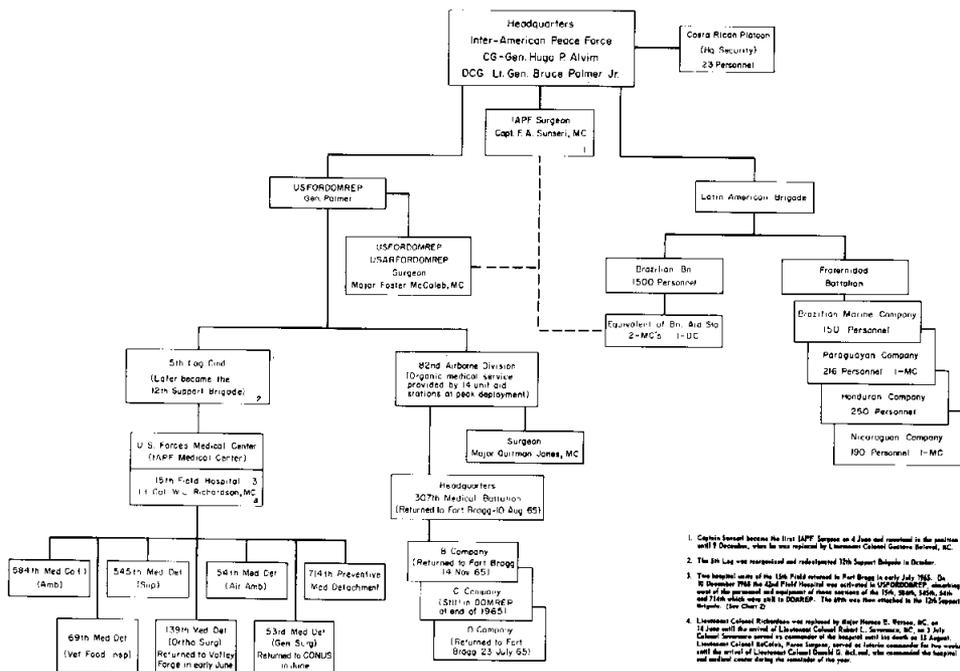
Thus, during the first few days of the operation, command and technical supervision lines were repeatedly shifting, but as the work at hand was more important than the lines on an organization chart, this was of little consequence. After USFORDOMREP was established, parallel command and technical lines ran down from Force Headquarters (staffed by Corps personnel) through the Division on one side and the Logistical Command on the other, and things were less confused. Organizational problems tended to be magnified only later when there was little work to be done.

On 11 June, the 15th Field Hospital and the other medical and paramedical units under the 5th Logistical Command were redesignated as U.S. Forces Medical Center, COMDOMREP (appendix A) and later became known as the Inter-American Peace Force (IAPF) Medical Center (fig.3). Even with the IAPF title, however, the medical complex owed its basic allegiance to the U.S. headquarters, although the latter was theoretically below the IAPF level (chart 1).



Figure 3.--COL Peter S. Scoles, MC, Commanding Officer, 55th Medical Group (second from right) with his replacement, LTC Richard F. Barquist, MC; LTC Robert L. Severance, MC, Commanding Officer, 15th Field Hospital, from 3 July until his death on 13 August; and two 15th Field Hospital nurses, 2LT Barbara Gouldthrope, ANC, and MAJ Marlys E. Dullum, ANC.

Chart 1.--Organization of the Medical Service in the Dominican Republic after 10 June 1965



On 4 June, CPT Francis A. Sunseri, MC, a Special Forces officer who had been serving with the 42d Civil Affairs Company, became the first Inter-American Peace Force Surgeon and served in that position until December. The IAPF Surgeon acted as liaison between the Latin American and U.S. Army medical services. CPT Sunseri, a preventive medicine specialist, also devoted much time to advising the Latin American Brigade on sanitation and preventive medicine.

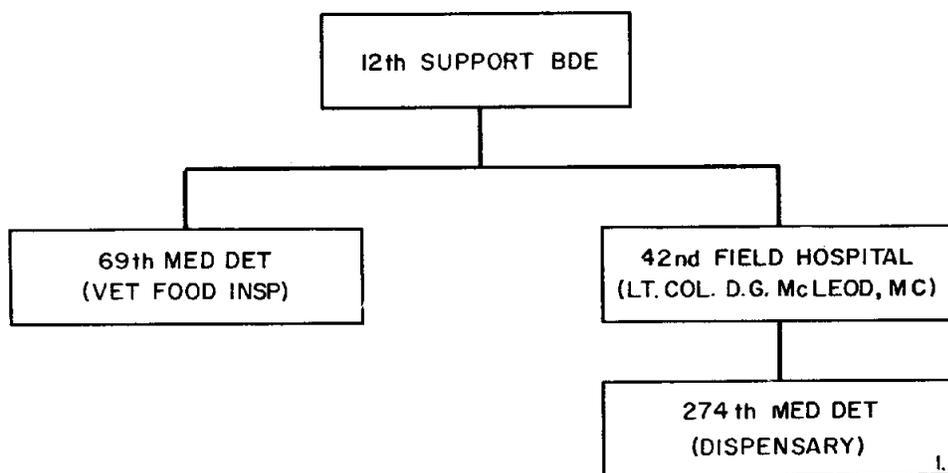
As the months passed, redeployments to the continental United States affected the medical organization in DOMREP somewhat. Even before the end of May, some personnel of the 15th Field Hospital were being redeployed, and by the first week in July, two of the three hospital units of the 15th were back at Fort Bragg. The small 139th Medical Detachment (Orthopedic Surgical) was sent back to Valley Forge piecemeal during the first two weeks of June, except for MAJ Horace E. Watson, MC, who stayed on as commanding officer of the 15th Field Hospital from 14 June until 3 July. The individual members of the 53d Medical Detachment (General Surgical) also returned to the States during the first two weeks of June. The ambulance unit's contingent in

DOMREP was reduced to one platoon by 28 June, and the air ambulance detachment's commitment in DOMREP was reduced considerably before the end of the year.

In the 82d Airborne Division, the organic aid stations were re-deployed with their parent units as the overall commitment in DOMREP was reduced. Company D of the 307th Medical Battalion returned to Fort Bragg on 23 July and Company B on 14 November. At the end of the year, the Division's medical service in DOMREP consisted of five aid stations and Company C of the Medical Battalion.

A major organizational change for medical support units took place on 10 December with the establishment of USFORDOMREP as a separate command. The one hospital unit of the 15th Field Hospital, the ambulance platoon, supply detachment, air ambulance detachment, and preventive medicine detachment in DOMREP were all officially returned to CONUS, but most of their personnel and equipment stayed in the Dominican Republic and became part of the newly activated 42d Field Hospital⁹ (chart 2). At the same time, the 69th Medical Detachment (Veterinary Food Inspection) was attached to the 12th Support Brigade. The 274th Medical Detachment (Dispensary), newly arrived from Fort Knox, Ky., was attached to the 42d Field Hospital and had the responsibility of providing primary support to IAPF Headquarters, USFORDOMREP Headquarters, and related units.

Chart 2.--Medical support organization under the 12th Support Brigade, 31 December 1965



¹ The 274th arrived in DOMREP in December, was attached to the Support Brigade, and further attached to the hospital.

⁹ USFORDOMREP General Orders No. 7, 10 Dec. 1965.

EXTENT OF MEDICO-MILITARY OPERATIONS

Army Battle Casualties

It developed that Army hospital and medical facilities for the Dominican stabilization operation were far in excess of what was needed to care for military casualties alone. During the period from April 1965 to September 1966, 14 U.S. Army personnel were killed in action and 148 were wounded, three of whom later died as a result of their wounds. Of the 68 combat casualties who required hospitalization, most had received wounds from small-arms fire and only a few from fragmentation devices. Based on hospitalized wounded for which data are available, 21 percent were wounded in the head or neck, 29 percent in the trunk, and 50 percent in the extremities.

The problem soon became one of having people on hand who had too little to do. It was generally agreed, however, that it was far better to have too much too soon than too little too late. The problem of having too many people on hand was eventually solved by redeployment.

Aid stations were located in the center of the city, and the medical companies of the 307th Medical Battalion rotated in and out of the area of greatest activity, providing medical service on an area basis. Casualties could be in battalion aid stations within a few minutes after they were hit, in clearing stations, if indicated, a short time later, or instead--as often developed--in the field hospital in less than a half hour.¹⁰ During the June flareup, most casualties were taken directly to

¹⁰ The 82d Airborne Division reported in its 1965 Medical Service Activities Report, 28 Feb. 1966, that patient care for division personnel in the Dominican Republic "was provided by fourteen unit aid stations and three clearing companies of the 307th Med. Bn. One of the clearing companies established a 25-bed capacity holding facility and cared for 82d Abn. Div. troopers who required short term hospitalization. Basic laboratory procedures such as gram stains, blood counts and urinalyses, were performed by the medical officers and enlisted men at these Division level installations. The evacuation support was provided by the 15th Field Hospital and an Air Force Casualty Staging Facility at San Isidro Airfield. However, because of the unconventional combat situation, the normal chain of evacuation--aid station to clearing company to hospital and etc.--often was not exactly adhered to. This often was generated by the tactical situation requiring clearing companies to be located further from the combat area than the Field Hospital and when civilian aid stations (operated by the clearing companies) were located within the city of Santo Domingo."

the field hospital and admitted in less than a half hour (appendix B).¹¹

Evacuation Policies and Procedures

A 15-day evacuation policy (changed later to 30 days)¹² was instituted in the Dominican Republic, but this was very flexible, especially during the early days of the operation. At the outset there was some difference of opinion in the command about where patients who had to be evacuated should be sent for care. This problem was completely solved, however, when the Air Force was given evacuation responsibility and its Casualty Staging Facility at San Isidro became the Medical Regulating Authority for the area.

In the first few days of fighting there was some confusion at lower levels, and a few Army patients even bypassed Army medical channels and were mistakenly evacuated by the Air Force Casualty Staging Facility. The ailments of the soldiers in some of these cases were minor--sometimes little more than severe colds. But the Air Force handling of air evacuation as a rule was highly efficient and speedy, and won high praise from the XVIII Airborne Corps Surgeon, the 82d Airborne Division Surgeon, and other Army Medical Service officers who had contact with the facility. Air Force liaison personnel who worked directly with the Army could, by using radios, have aircraft available for emergency medical evacuations within minutes.

Most casualties requiring extensive treatment were flown to Pope Air Force Base and then transported by ambulance in a matter of minutes to Womack Army Hospital, Fort Bragg, for hospitalization. Patients with fractures were air evacuated immediately after the affected bone was stabilized. When indicated, patients were flown to specialized care facilities, such as the burn facility at Brooke Army Medical Center, Fort Sam Houston. Casualties requiring immediate surgery beyond the capability of the 15th Field Hospital were evacuated either to Ramey Air Force Base or Rodriguez Army Hospital in San Juan, Puerto Rico.

¹¹ On 15 June, physicians of the Brazilian Forces voluntarily augmented the professional staff of the 15th Field Hospital. The South American physicians performed some operations, including one neurosurgical procedure on a head wound.

¹² (1) Appendix I (Medical) to Annex M (Logistics) to USCOMDOMREP, OPOD 2-65, 081500R June 1965. (2) Appendix I (Medical) to Annex M (Logistics) to USFORDOMREP, OPOD 4-65 (U), 071200R October 1965.

A special evacuation policy on individuals bitten by animals had to be promulgated early in the operation. There had been no rabies control programs in the Dominican Republic for more than five years, and since the Army lacked impounding facilities and adequate laboratory capability, rabies vaccine and antitoxin was indicated for all persons bitten. Therefore, for some weeks, individuals who had been bitten were evacuated to their home stations for completion of treatment. Later, a pound was constructed for the confinement of animals, and personnel who had been bitten were retained in the area for treatment. This concern for animal bites proved largely precautionary, however, since the only animal shown to have rabies by laboratory examination was a mongoose which had been impounded for biting an airman at San Isidro.

The Army's lack of denture repair and spectacle replacement facilities in the Dominican area increased evacuation loads. The 15th Field Hospital lacked optical and denture repair facilities. The Force Surgeon, LTC McCaleb, pointed out that such teams are needed even in small short term operations because personnel "can be relied on either by accident or by design to break or lose dentures or spectacles, particularly if repair facilities are not readily available, and replacement necessitates evacuation from the objective area."¹³

Many individuals arrived in the Dominican Republic without two pairs of spectacles as required. Few of those who subsequently lost or broke their glasses could produce a copy of their spectacle prescription, so it was necessary in many cases to send people to Puerto Rico for refraction or to write to home stations and have health records searched for prescriptions before replacement spectacles could be ordered.¹⁴

Men who lost or broke their dentures had to be returned to Fort Bragg where repair and replacement facilities were available.¹⁵ Some hanky-panky was proved or suspected in a few cases involving the loss of glasses or dentures, such as in the case of a sergeant who accidentally ran over his dental plate with a truck.

¹³ See footnote 8, p. 8.

¹⁴ Unclassified Routine Message (AJDSU 5600DR), Commanding General, 82d Airborne Division, to Distribution A, 30 July 1965.

¹⁵ Unclassified Routine Message (AJDSU 6963DR), Commanding General, 82d Airborne Division, to Distribution A, 15 Sep. 1965.

Nonbattle Medical Problems

Nonbattle military casualties developed in a predictable manner. The XVIII Corps Surgeon reported that shots had hardly stopped ringing from the first fire-fight engaged in by U.S. troopers when a soldier reported on sick call for treatment of fingers he had mashed moving an air conditioner. Gastrointestinal problems and even a case of gout showed up in a relatively short time. But the medical problem taking the greatest toll was venereal disease.

Injuries.--Medical personnel in the Dominican Republic treated the same types of injuries common at any military post in the United States. After the fighting had settled down, soldiers could rent cars or motorbikes in Santo Domingo, and this led to a rash of vehicle accidents.

The sea presented a more unusual hazard. Most of the shoreline in the Santo Domingo area is an undercut volcanic cliff with a drop of 10 to 20 feet to the sea. Individuals who fell into the sea found it difficult to climb out and more than one soldier drowned as a result. Also, the surf is often quite rough and there is a significant undertow. This was also thought to have contributed to the drowning of one or two individuals who swam in unsupervised beach areas.

Hepatitis.--By June a number of soldiers had come down with hepatitis, and as incidence began to follow a rising curve¹⁶ the Medical Service became concerned. Almost all the individuals affected by the disease were stationed in the American corridor through Santo Domingo. In that area the temptation to use water from other than approved sources and to buy food and drink from street vendors was great. Since it was impossible to relate the outbreak epidemiologically to any particular military facility or messhall, it was assumed that the occurrence of the disease resulted from the general exposure of the troops to the city's environment. The use of gamma globulin immunization seemed indicated, was tried,¹⁷ and proved successful, for only an occasional rare case was found following immunization.

¹⁶ (1) Seven cases in May, one in June, and 12 in July before the number began to decline. (2) Statistics based on U.S. Army Dominican Republic Morbidity Reports for July, August, September, and October. (3) Routine Unclassified Message (AJDSU 5317DR), Commanding General, 82d Airborne Division, to Distribution A, 22 July 1965.

¹⁷ Disposition Form, Surgeon, USCONARC, to Chief of Staff, USCONARC, 27 July 1965, subject: Immunization of Troops.

Gastrointestinal diseases.--Environmental impediments and pressing operational activities of the first few weeks of Army involvement in Santo Domingo contributed to a poor state of sanitation within the military establishment. Negligence, ignorance, and resentment over harangues on the dangers of disease-breeding filth were evident in many units, but the city itself was the worst enemy. Rock-hard volcanic subsoil drastically slowed the digging of adequate latrines and garbage sumps. In addition, the presence of myriads of flies, the accumulation of garbage everywhere during the fighting, and an existing diarrhea epidemic among the infants in the city made a serious outbreak of gastrointestinal disease almost inevitable.

But contrary to experience of the past, good fortune in the form of accurate daily medical reports prevailed, and no serious outbreak occurred among the troops.

The slack produced by the failure of most units to provide required field sanitation teams was largely taken up by the 714th Preventive Medicine Detachment. During the first 2 months of the operation, the unit was swamped by requests to do the actual spadework in providing sanitation for individual units, while continuing to perform its many legitimate functions. Then from 28 June to 2 August, personnel of the 714th conducted a series of 6-hour field sanitation courses three times a week for representatives of individual units. All units of company or battery size were requested to place two men on orders to function as a field sanitation team and to attend the 714th's course of instruction. In all, 114 personnel successfully completed the course, which outlined the responsibilities of a unit sanitation team, taught the team how to procure and use authorized equipment, and familiarized them with the capabilities of the 714th.¹⁸ The field sanitation problem grew smaller with each passing week, partly because of enlightened unit effort, partly because of planned deployment.

All 82d Airborne Division medical units, including battalion aid stations, were required to report daily on all cases of gastrointestinal disease or complaints, including suspected cases of infectious hepatitis. The Division Surgeon's Office conducted inspections in areas where a potential outbreak was suspected. In addition, several medical bulletins outlining health hazards were published by the Division early in the operation.

During the Dominican operation there were a number of mild diarrheas scattered throughout the command, but these could usually be traced to poor mess sanitation. Messkit washing facilities were inadequate, water was

¹⁸ (1) Hostetter, 1LT Donald L.: Operations of the 714th Preventive Medicine Detachment During the Dominican Crisis. [Official record.] (2) Report, Surgeon, 5th Logistical Command, to Commanding Officer, 5th Logistical Command (-), 7 June 1965, subject: 714th Preventive Medicine Unit Operations.

not hot enough, or troops were not careful in washing utensils. Diarrhea outbreaks were halted when command interest in mess sanitation was stimulated. Such measures, plus cleanup programs in the city and vector control activities, kept gastrointestinal disease to a minimum.

Venereal diseases.--Prophylactics were not available during the first weeks. Troops were briefed on the high incidence of venereal disease, its lasting nature, the dangers in "no sweat" pills, and the importance of reporting on sick call if venereal disease were contracted. All houses of prostitution, when they became known, were put off-limits, and troops were generally restricted in their movements. The movements of female Dominicans could not be so easily restricted, however. Incidence of venereal diseases among U.S. troops in the Dominican Republic jumped in May to a point far higher than normal stateside levels.¹⁹ Lectures by surgeons, chaplains, and commanders seemed to be totally ineffective, and the situation was aggravated in time, by an increase in spare time. The U.S. Army, Dominican Republic, reported an initial rate for venereal disease of 369 per thousand per annum for May 1965. Rates for the following three months were lower: on the order of 211, 190, and 234. The rate for September rose to 380 per thousand and was the peak for 1965. Thereafter the rate declined steadily for the remainder of the year. In January 1966, the rate rose precipitously to 593 per thousand per annum, the highest rate for the entire operation. The rate was 567 in February, 410 in March, and declined steadily to its lowest point for the entire operation at 123 in August 1966. The annual rate for the 18 days in September was 232 per thousand, the next lowest for the year and the fifth lowest for the operation. These were mostly cases of gonorrhea, but there were 118 cases of syphilis in 1965 and 81 cases in 1966, totaling 199 for the entire operation.²⁰

Commanders were directed that men were not to be punished for having venereal disease, and unit surgeons were reminded that personnel treated for venereal disease were not to be reported. The reasoning for this policy was disseminated to commanders on 22 May (appendix C). Unit surgeons were to maintain lists of treated personnel for followup studies after the personnel returned to CONUS. (For overall redeployment physical evaluation policies, see appendix D.)

¹⁹ The consolidated Morbidity Reports for U.S. Army, Dominican Republic, show 127 cases of skin infections in 1965 and 97 in 1966. There were also a total of 2,139 cases of venereal disease in 1965 and 1,228 cases in 1966. Together there were 3,464 cases of skin infections and venereal diseases among U.S. Army personnel during the entire period from 30 April 1965 to 18 September 1966.

²⁰ Command Health Reports.

Before the end of the year, the IAPF Surgeon, CPT Francis A. Sunseri, MC, and CPT Joseph D. Goldstrich, MC, a preventive medicine officer in the USFORDOMREP Surgeon's office, worked out a reporting procedure for tracing the sources of venereal disease, which involved the cooperation of the civilian health services of North Carolina and the Dominican Republic, as well as the Army Medical Service. Some infected women were traced through this program, but no reduction in venereal disease rates among soldiers in the Dominican Republic was noted. To the contrary, rates which were declining at the end of the year rose precipitously in January and February 1966.

Psychiatric Problems

A total of 33 cases of psychotic and psychoneurotic conditions occurred among U.S. Army troops in the Dominican Republic. However, most of these did not occur under conditions of fire, but when there were heavy restrictions on activities and a "great deal of uncertainty as to who and where the enemy was."²¹ The 82d Airborne Division psychiatrist, CPT William H. Goodson, Jr., MC, reported that he saw only one patient with combat exhaustion. Life-threatening situations and physical deprivation in the Dominican Republic operation "were never sustained enough to give rise to the conditions known to precipitate classical cases of combat exhaustion."²² (The psychiatrist's complete report appears in appendix E.)

PREVENTIVE MEDICINE-CIVIL PUBLIC HEALTH ACTIVITIES

Military preventive medicine activities and civil public health activities are always difficult to separate because, in practice, any sanitation and health measures which are carried out benefit everyone in a given area, not just those persons for whom the measures are taken. And in the Dominican Republic the medical mission was usually aimed at both the civil populace and the military at the same time.

Medical intelligence for the operation was outdated and not available to the medical personnel when they first went into the Dominican Republic. The whole operation was a rush job and most personnel reported to the area with some preconceived ideas, but with little briefing and no experience in any combat area. It was only after arriving in Santo Domingo

²¹ Appendix I, After Action Report, Division Psychiatric Activities, Dominican Republic, in Annual Medical Service Activities Report, 82d Airborne Division, 1965.

²² Ibid.

that a reliable picture of the city's public health was obtained. Valuable medical intelligence was rendered by the Dominican military, city health officials, and especially by the Pan American Health Organization, affiliated with the World Health Organization. Only then was the Army Medical Service able to provide meaningful medical assistance to the civil populace as well as to protect the health of U.S. troops.

The Force Surgeon's Office maintained liaison with health organizations in the country, while the 714th Preventive Medicine Detachment carried out most of the Army's preventive medicine-civil public health practices. The detachment consisted of two control sections with one sanitary engineer and one entomologist. The 69th Veterinary Food Inspection Detachment also made a significant contribution, and there was cooperation from the three Medical Corps officers and a sanitary engineer of the 42d Civil Affairs Company during its one-month stay on the island, as well as from decontamination sections of a Chemical Corps unit. After the Civil Affairs Company was redeployed, a preventive medicine officer was assigned as IAPF Surgeon, and the sanitary engineer went with the 714th Preventive Medicine Detachment.

Public Service Functions

For all practical purposes, public services ceased entirely during the fighting. Public health officials in the Dominican Republic and Santo Domingo were political appointees, making their services even more subject to disruption during political disturbances. Many private physicians fled the city. Even the health services of the Dominican Red Cross and the Pan American Health Organization were disrupted by loss or destruction of equipment and by shortages of personnel. The Pan American Health Organization lost \$30,000 in equipment, and the Army spent many man hours, but no money, in helping them obtain new equipment. The Army also loaned equipment to the Pan American Health Organization, the Dominican Red Cross authorities, and the Ministry of Health, and issued thousands of dollars in medical supplies to help the organizations function effectively.

Water Supply

All Dominican water sources inspected during the operation were considered nonpotable by U.S. military standards; inadequate sewage disposal facilities and subsequent runoff of human and animal wastes into ground water supplies were the primary sources of contamination.

Santo Domingo obtained its water from a surface supply located some 35 miles northwest of the city. The reservoirs, which used a slow sand filter system, were constructed by the U.S. Marines in 1924.

The first weeks of the 1965 operation were during the dry season and the river level was so low that no intake was possible. The city was dependent on water stored in tanks. A number of city water mains were broken during the revolt and there was a serious water shortage. Fortunately the rainy season began, but the rains damaged the sand filters at the reservoirs, and repairs and cleaning were not possible because of the disruption of public services. Thus, during much of the military operation, the city's water was unfiltered.

The Army lent chlorination testing equipment to representatives of the Pan American Health Organization, which was attempting to restore some public services, and helped them requisition chlorine to be added to the water system at several points. Army medical personnel also helped repair chlorination equipment. Still, even late in the year, there were several breaks in the water system where contamination was introduced, and tests at various points revealed no significant chlorine residual. Cultures often produced coliform organisms.

With such deficiencies in the public water system, the Force Surgeon and the local medical authorities became concerned in May with the possibility of a typhoid epidemic in the city. The Army lent four jet injector guns to local Red Cross authorities and issued them 300,000 doses of typhoid vaccine to be used in inoculating Dominican civilians.

Although LTC McCaleb was shown several civilian patients in another province (Monte Cristi) who were said to have typhoid, no significant incidence of the disease developed in Santo Domingo.

The Army used water from several sources, including city water, which was distributed at several supply points after it had been filtered through Engineer equipment. A chlorine residual of 5 p.p.m. was maintained.

Garbage Collection and Disposal

Many of Santo Domingo's refuse trucks were damaged, destroyed, or stolen during the fighting. The stench, the great swarms of flies, and the unending piles of garbage which collected in all the streets during the fighting testified to the breakdown of the collection and disposal service in the city. Even after the Army furnished trucks and directed personnel to sweep the streets the problem continued. Stray dogs, rummaging children, and the continuing violence saw to it.

The city had two methods of garbage disposal--an incinerator near the Duarte bridge and a sea cliff dump. The incinerator was damaged in the fighting; the dump, where garbage was dropped to be ground to nothing against the volcanic sea floor by an active surf, was inadequate for the whole city.

Meanwhile, the military was having its own problems. Attempts to use burning pits did not work out because of the persistent failure of units to separate combustible and noncombustible garbage. Within weeks after the start of the operation, the entire pit area was choked with garbage, wet containers which would not burn, and flies. Even after the Army assisted in the construction of two additional sea cliff dumps, helped repair the city's incinerator, and began using the city's new facilities, the fly problem could not be controlled at its own officially closed burning pits for several weeks. Garbage also accumulated alongside the city's cliff dumps, but this problem was overcome after the U.S. Army loaned heavy equipment to Dominican Army engineers, who in turn cleaned up the areas.

Psychological warfare teams distributed leaflets in the city and conducted loudspeaker campaigns to arouse the citizens to clean up the streets. Fifty-five-gallon drums were placed throughout the city with "Keep the City Clean"-type slogans painted on the sides. Yet the garbage problem in Santo Domingo was far from being solved when the year ended.

Insect Control

Flies.--The fly problem described above was not only annoying but also a significant health hazard. Also as described above, few Army units in DOMREP had field sanitation teams, and even fewer had supplies or equipment for such teams until after the 714th Preventive Medicine Detachment conducted its sanitation courses.

Chemical Corps decontamination sections of the XVIII Airborne Corps and of the 82d Airborne Division were diverted from normal troop duty to join the 714th in conducting an insect control program. The 714th used a Malathion²³ mixture in mist sprayers while Chemical Corps personnel utilized smoke generators brought in from Fort Bragg. The Chemical Corps personnel mixed Malathion with chemical smoke to produce insecticide smoke. It was not long before the Malathion damaged the machines, however, and they had to be rotated with other machines from Fort Bragg to permit maintenance. Chemical Corps officers then devised a system by which the Malathion could be introduced into the hot fog as it left the generator rather than being put directly into the machine. This system, which utilized a venturi tube injection device, was equally effective without damaging the generators.

At first, only troop areas and billets were fogged or sprayed, but later several civilian areas, including the national prison area at La Victoria and the corridor through Santo Domingo, were added to the schedule.

²³ Flies and other insects in the Dominican Republic had become resistant to DDT. Malathion was one of the newer and safer organophosphates in the Army supply system and was especially effective against flies.

In civilian areas the fogging devices were preceded by psychological warfare loudspeaker trucks which broadcast an explanation of what was being done. Despite this precaution, cries of "chemical warfare" arose from some extremist groups along the western border of the zone considered held by the Constitutionalist forces. Civilians were warned that food should be covered and children brought in off the streets. But as LTC McCaleb recalled, "the latter advice was usually ignored, and the clouds contained more children than insects."²⁴

Malathion fogging was effective for 36 to 48 hours, then had to be repeated to keep flies at endurable levels.

Mosquitoes.--The Pan American Health Organization had been conducting a malaria eradication program in the Dominican Republic for several years before April 1965. The program, directed by entomologist Morris Bradley O'Bryant, the only American on the staff of the Pan American Health Organization in the country, had made significant progress. By 1965 only three isolated pockets of malaria were known to exist, these in the western part of the country.²⁵ But the primary vector, Anopheles albimanus, was prevalent in Santo Domingo and surrounding areas.

Dengue fever was prevalent among the younger indigenous personnel working for the Army, and the dengue vector, Aedes aegypti, was numerous in the area.

Filariasis was endemic throughout the country, where the vector, Culex pipiens quinquefasciatus (=C. fatigans), was found although the disease was more prevalent among the Negro population of coastal areas.

Two outbreaks of equine encephalomyelitis had been recorded in the country during the previous two decades, but the disease had not been typed because of a lack of local facilities for virus diagnosis.

Yellow fever had not been recorded in the Dominican Republic since the turn of the century.

Despite all the potential dangers, the U.S. military were not bothered by arthropodborne diseases in USFORDOMREP.²⁶ The Pan American Health Organization malaria eradication program had reduced the dangers

²⁴ See footnote 8, p. 8.

²⁵ Two areas were predominantly Plasmodium vivax and the other Plasmodium falciparum.

²⁶ Morbidity Reports for the U.S. Army, Dominican Republic, listed one case of malaria and five cases of dengue.

of the other diseases somewhat, and the preventive measures taken by the Army proved effective. The use of bed nets was enforced, aerosol insecticide bombs were issued for use in billeting areas, and all personnel were directed to take malaria suppressive medication.²⁷

The fogging with Malathion reduced danger to the civil populace as well as to the military.²⁸

In addition to insecticide treatment, the 714th Preventive Medicine Detachment also did larviciding, but this had to be limited to areas adjacent to military compounds. The terrain and the multitude of small breeding places throughout the Santo Domingo region were too much for the limited amount of equipment and personnel in the unit.

Rodent Control

There was a large rat population throughout most of the Dominican Republic, but no plague was reported. Personnel of the 714th Preventive Medicine Detachment examined more than 100 live trapped rats without finding a flea. In fact, no ectoparasites were found except for a few mites.

During the uprising, the rats in Santo Domingo thrived on the excess of garbage and found excellent harborage in the numerous old buildings. Several Army personnel were bitten. In fact, 82d Airborne Division medical personnel reported on 20 June that more than 20 troopers had been medically evacuated because of rat bites.²⁹ The 714th Preventive Medicine Detachment, an Engineer utility detachment, and unit sanitation teams conducted trapping and poisoning programs which met with some success, but they did not have the means to conduct programs outside of military confines. Personnel

²⁷ (1) Many individuals, after taking their weekly chloroquine-primaquine tablets, complained of headache, nausea, abdominal cramps, and diarrhea during the ensuing 24 hours. As usual, some of these men then stopped taking the drugs. Personnel who had a bona fide reaction to chloroquine-primaquine severe enough to warrant discontinuation of the drug were medically evacuated to the continental United States. (2) Routine Unclassified Message (2642DR), Commanding General, 82d Airborne Division, to Distribution A, 14 June 1965. (3) See footnote 18 (1), p. 18.

²⁸ Mosquitoes in the area had built up a resistance to DDT, as well as to some of the more toxic organophosphates such as dieldrin and Diazinon.

²⁹ Routine Unclassified Message (AJDSU 3039DR), Commanding General, 82d Airborne Division, to Distribution A, 20 June 1965.

of the 714th also provided technical assistance to all units with rodent problems and assumed complete responsibility for some of the larger compounds and hotels utilized by U.S. Forces. Anticoagulant poisons, Fumarin and Warfarin, were used.

Some of the individual soldiers devised their own rattraps. The Force Surgeon reported that one trooper ringed his position with an exposed wire elevated from the ground on short stakes and connected to the unit power generator. Approaching rats completed the circuit between wire and ground and were electrocuted.³⁰

Restaurant Inspection

A number of high-priced, apparently first-rate restaurants were located in the embassy section of Santo Domingo. These were off limits, but after things had quieted down the troops flocked to them for food and drink in such numbers that some of the restaurants added extensions to their serving areas. Recognizing that morale would suffer if the soldiers were denied access to these establishments, and that control would be difficult anyway, the Force Surgeon, personnel of the 714th Preventive Medicine Detachment, and the Acting Minister of Health developed a sanitation inspection system.

A letter rating was given (to be displayed prominently in the restaurants) based on a point system of inspection as outlined in USFOR-DOMREP Circular No. 40-4 (appendix F). The five most popular restaurants were inspected first. Most of them operated under deplorable sanitary conditions, but most of the restaurant managers were cooperative and conditions improved rapidly.

Before the end of the year, eight restaurants were on the list and were inspected weekly by 714th Preventive Medicine Detachment personnel. Most American patronage continued to be confined to three of these, however.

Concurrently, 714th personnel conducted inspections of wholesale businesses such as slaughterhouses, dairies, and poultry farms to evaluate the food being supplied to the various restaurants.

Beverages

Four major producers of soft drinks and one brewery were located in Santo Domingo. All five plants were outside the "occupied" area and

³⁰ See footnote 8, p. 8.

could not be inspected. Preventive medicine personnel tested the products at random, after obtaining them from retail sources, and identified one soft drink as being of variable quality. Its unacceptability was announced to military personnel. Personnel who tested the beer, Presidente, declared it an excellent pilsner and quite safe to drink. It was widely consumed.

Ice Procurement

Normally, the mission of a preventive medicine unit relative to ice procurement would be to inspect the ice-producing facility for sanitation and to check the water used and ice produced for bacterial organisms. In the Dominican situation, however, the complete responsibility for ice procurement was delegated to the 714th Preventive Medicine Detachment. One plant was selected to receive an Army contract, but then preventive medicine personnel spent 6 weeks trying to persuade the manager to have the place cleaned and to have the raw water filtered and chlorinated to 5 milligrams per liter. After many promises and little action, the 714th found another plant. After another week of wrangling the facility was approved and a contract for ice was let. Before the year's end, four plants were producing potable ice for U.S. troop consumption.

Street Vendors

Street vendors could be seen everywhere in Santo Domingo from dawn until dusk. Some of the more popular items they sold were soft drinks, meat pies, bakery items, frozen ice treats, and shaved ice snowballs. In spite of many official warnings (appendix G), U.S. personnel widely patronized the vendors. It was believed that such food sources accounted for most of the hepatitis among the military. The only control which could be imposed was the restriction of vendors from the immediate vicinity of billeting areas.

Extent of Medical Treatment Provided Dominican Civilians

The fact that military casualties were relatively low and that specialized units handled most of the preventive medicine activities did not mean that the rest of the Army medical personnel in the Dominican Republic were left with time on their hands. During the period of May through August, 82d Airborne Division medical personnel treated 55 Dominican civilian inpatients and had 50,792 outpatient visits. In the same period 104 civilian inpatients and 212 civilian outpatients were treated by 15th Field Hospital personnel.

In the first weeks of the operation most of these patients were either combat casualties or persons with significant illnesses, but in later weeks, to quote LTC McCaleb again, the disease spectrum "was no different than that of any stateside clinic where free care invites insignificant clientele."³¹

MEDICAL UNIT ACTIVITIES

Alert and Movement

The professional medical personnel who served in the Dominican Republic during the combat phase of the operation were generally inexperienced in combat and in the handling of battle casualties, but had gone through repeated alert and practice situations. When the Dominican alert came in late April, those in ready force status prepared men and equipment for airdrop or air-land operations in accordance with contingency operations planning.

For example, Company D (commanded by CPT Robert F. Elliott, MSC) of the 307th Medical Battalion had assumed normal division ready force posture in support of the 3d Brigade at noon on 23 April. This meant that 16 medical personnel and equipment were prepared for parachute operations, while 23 personnel, six ambulances, one 1/4-ton truck, one 3/4-ton truck, one 3/4-ton trailer, one 2 1/2-ton truck, and one 1 1/2-ton water trailer were prepared for air-land operations, as prescribed by standing operating procedures and policies dictated by higher echelons. Thus when the 3d Brigade alerted the company to a higher status of readiness at 0030 on 26 April, all personnel were assembled in short order. The next higher stage of alert before actual takeoff came at 1800 on 28 April, and all personnel and equipment were available within an hour. At 1430 the next day the parachute element was split, with an officer in charge of each element, and lodged with the 505th Airborne Infantry Battalion and with the 508th Airborne Infantry Battalion for outloading. At approximately 1730 the same day, the air-land element moved by convoy from Fort Bragg to Seymour-Johnson Air Force Base, N.C. Upon arrival they moved immediately to the marshaling area to await loading into C-124 transport aircraft. There, as planned, the Company D personnel took on an orthopedic surgical team, the 139th Medical Detachment (KB) from Valley Forge (commanded by MAJ John B. McGinty, MC), which had arrived at 1230 the same day.³²

³¹ See footnote 8, p. 8.

³² See footnote 6, p. 8.

The orthopedic surgical team, which was officially attached to Company D until it could join the 15th Field Hospital, was the first unit loaded out at Seymour-Johnson Air Force Base. After taking off at 0100 on 30 April and making a stop at Pope Air Force Base, it arrived at San Isidro at 0645. At San Isidro the team secured (with the cooperation of the Dominican Air Force) the use of a Technical Instruction Building near the south end of the runway. The building then served as Company D clearing station during the next 30 hours.

Throughout the night and morning of 29-30 April, the air-land and parachute elements of Company D (which also air-landed) assembled at the Technical Instruction Building. Equipment was de-rigged and hand-carried to the site by medical personnel, as was a large amount of automatic issue medical supplies which had been flown in from Puerto Rico for the operation.

CPT Leon R. Moore, ANC, began organizing the clearing station, and it was in full operational status before 1600 on 30 April. Only one Army battle casualty arrived before the clearing station was fully set up and he was evacuated to the USS Boxer after emergency treatment for a bullet wound.

While in the Technical Instruction Building the professional staff of Company D alternated duties with the staff of the orthopedic surgical team.

Company D frontline ambulances were dispatched to a battalion aid station, which had been set up at the Duarte bridge, and evacuated 18 battle casualties to the clearing station during the next 24-hour period. Ambulance drivers came under fire to perform their duties.

At about 1530 on 30 April, the Airborne medical personnel sent various medical supplies via Marine helicopter to the Marine aid station which was operating near the Embajador Hotel.

During the evening of 30 April and the following morning, the Division Surgeon, elements of the 584th Ambulance Company, and the 15th Field Hospital, as well as Company C of the 307th Medical Battalion, arrived at the Technical Instruction Building, which was the objective area. In the days immediately following, the rest of the 307th Medical Battalion and the various Battalion aid stations were flown in. The departure of Medical Battalion personnel from North Carolina occurred as follows:

Deployed 29 April

	<u>Officers</u>	<u>Enlisted men</u>
Headquarters and Company A	3	0
Company C	1	0
Company D	1	25

Deployed 30 April

Headquarters and Company A	5	0
Company B	1	0
Company C	2	47
Company D	1	27

Deployed 1 May

Headquarters and Company A	1	2
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Deployed 3 May

Headquarters and Company A	2	0
Company B	2	46

Deployed 4 May

Headquarters and Company A	5	17
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Deployed 5 May

Company B -- 3 STRAC Designee Medical Corps officers from outside the Division.

Deployed 6 May

Company C	1	0
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Company A was not actually deployed as the information above would indicate. The enlisted men listed as deploying with "Headquarters and Company A" were part of the Battalion Headquarters staff, while the officers listed after "Headquarters and Company A" actually were the medical professional staff of the Battalion, redistributed after reaching DOMREP. Part of the Battalion Headquarters and all of Company A remained at Fort Bragg. The total number of 307th Medical Battalion personnel deployed from North Carolina from 29 April to 6 May, was 28 officers and 164 enlisted men.

The alert and movement was not as smooth for all units as it was for Company D. Although the medical support for the DOMREP operation was adequate and effective throughout, confusion accompanied rushed operations. And in the Dominican crisis, information was not always disseminated to those with a need to know as fast as it should have been.

For example, Company C of the 307th Medical Battalion was not on ready force status when it was alerted at 2230 on 28 April.³³ Required equipment was on hand and personnel were assembled in an hour and a quarter, but they received no definitive briefing at that time and the possibility of quick deployment seemed remote.

The following day, officers of Company C were briefed at Battalion Headquarters and learned that Company D was being prepared for movement in support of the 3d Brigade. It was late afternoon before it was determined that Company C would be deployed to support the entire 2d Brigade rather than just part of it or as support for the Division as a whole. Later that night the company loaded all its equipment on trucks.

Then the next morning (30 April) at 0400 the unit was alerted for movement and its officers told that the company would be under Division rather than Brigade control. Later that morning personnel were paid, ate, and then loading began. The planes took off at 1330. During the flight it was found that not enough in-flight rations had been issued for the entire company, but the 4-hour flight had begun shortly after lunch and additional rations were not really needed. By 1845 Company C and almost all of its equipment were at San Isidro.

After they arrived in the Dominican Republic, Company C officers found that they had no specific instructions on whom they should report to or on what was to be done. So, after unloading the aircraft they held the unit in one location. When they heard that Company D was in a building near the end of the runway, they contacted them, left some needed equipment, and awaited further instructions.

The following day, 1 May, personnel were briefed on the tactical and medical situation, including their potential role in the medical support operation, and were told that there was a water shortage. Then, in the afternoon, the Company C commander accompanied the Division Surgeon in quest of a place to set up. It was decided that the company should move in near 3d Brigade Headquarters on the edge of Santo Domingo and provide support in order to conserve time and effort and to avoid further confusion,

³³ Report, Commanding Officer, Company C, 307th Medical Battalion, to Commanding Officer, 307th Medical Battalion, 82d Airborne Division, 2 June 1965, subject: Interim After Action Report.

even though Company D had originally been slated to provide such support. Therefore Company C moved and began to treat and evacuate patients.

Had the original plan been followed, Company D, already housed in the Technical Institute Building, would have had to move out and re-load their equipment, whereas Company C was still "on wheels" and more easily deployable. Movement of Company D would also have interrupted the only existing Army medical support available at that time.

Meanwhile, the 15th Field Hospital and other support units had been having their problems. After the 5th Logistical Command received a preliminary alert notification on 27 April, the 55th Medical Group was placed on a higher alert status on 29 April. A series of conferences and exchanges of information had begun and finally resulted in the listing of medical units actually to be used in the Dominican operation (p. 7). At 0510 on 30 April, the 55th Medical Group had been informed that one (100-bed) hospital unit of the 15th Field Hospital was to "move out immediately." Twenty minutes later it was learned the entire field hospital was to go to the Dominican Republic as quickly as feasible.³⁴

Hospital personnel began loading equipment and one hospital unit was ready to go before noon. Planes carrying the first hospital unit took off throughout the afternoon and into the night.³⁵

The next morning, 1 May, elements of the hospital unit (and the first platoon of the 584th Ambulance Company (-)) began arriving at San Isidro approximately 12 hours ahead of some necessary equipment. There had been a mixup in the loading line at Pope Air Force Base, and a detour to Puerto Rico with some of the personnel scheduled to go to Santo Domingo.³⁶ LTC William L. Richardson, MC, the hospital commander, reported to the 82d Division Headquarters at San Isidro, and although the Division had many activities in progress, the Division Surgeon, MAJ Quitman W. Jones, had Company D move out of the Technical Instruction Building at the airfield so that part of the hospital unit could begin setting up there. The orthopedic surgical detachment (139th of Valley Forge) was detached from Company D and attached to the hospital.

³⁴ Diary of Actions, 55th Medical Group, 27 Apr.-5 May 1965. [Official record.]

³⁵ Report, Commanding Officer, 15th Field Hospital, to Commanding Officer, 5th Logistical Command, 13 June 1965, subject: U.S. Stability Operations in the Dominican Republic.

³⁶ Report, Commanding Officer, 15th Field Hospital, to Commanding Officer, 5th Logistical Command, 24 May 1965, subject: Summary of the Initial Operation of the 15th Field Hospital.

Before the hospital unit was completely unpacked, however, personnel had to find a new place for two bodies which had been left in the operating room. Arrangements were finally made with the Air Force to keep the bodies in an appropriate place for handling by a small Graves Registration Unit which had just arrived.

The 15th Field Hospital then set up a 20-bed ward, operating room, central materiel section, pre-operative and receiving sections, laboratory, X-ray, and pharmacy. Several casualties with gunshot wounds were treated and evacuated almost immediately. The patient load on 1 May was 16 and this number increased daily for the next several days.

Back at Fort Bragg the remaining hospital units and headquarters element of the 15th Field Hospital encountered numerous packing and transportation problems. However, they and the 53d Medical Detachment (General Surgical) and another platoon of the 584th Ambulance Company were able to join the first hospital unit of the 15th at San Isidro over the next 2-day period.

Buildup and Operations

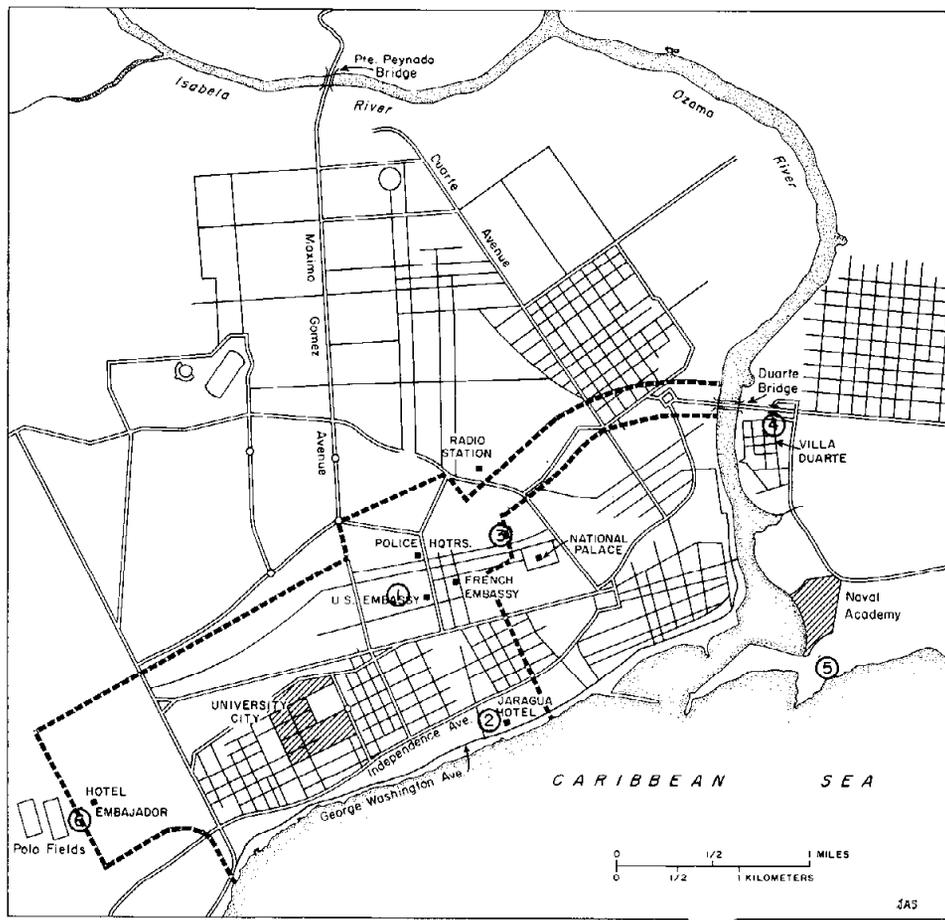
The most significant military casualties of the operation were received during the first few days of conflict and in mid-June. Disposition of these casualties was described in the section, "Extent of Medico-Military Operations" (p. 14).

The medical battalion provided direct support to the 82d Airborne Division's combat brigades from the beginning of the operation until 5 May, when each company reverted to battalion control. Then the medical companies provided support by area.

A series of leapfrog movements by the medical units characterized the first few days of the operation. Company D of the 307th Medical Battalion vacated the Technical Instruction Building at San Isidro on 1 May to make room for the 15th Field Hospital. Since Company C³⁷ was then supporting the 3d Brigade, Company D went into mobile reserve until the next day when it began supporting the 2d Brigade. Meanwhile Company D ambulances and professional staff augmented Company C operations.

On 3 May, Company D moved 14 of its men and four vehicles through Santo Domingo in support of the 2d Brigade as it opened up the corridor (map 4). After getting into the corridor, the Company D commander, CPT

³⁷ Located near the Brigade Headquarters which was across the road from a civilian orthopedic hospital on the eastern outskirts of the city.



Map 4.--Santo Domingo.

- | | |
|--|--------------------------------|
| 1. Headquarters, U.S. Forces. | 4. Company C clearing station. |
| 2. Headquarters, IAPF. | 5. 15th Field Hospital. |
| 3. Company D at Colegio Maria Auxiliadora. | 6. Company C at Camp Randall. |

Elliott, received orders to begin a civic action mission. He received permission from the Mother Superior, Sor Maria Auxiliadora, Salesian Sisters, to locate a clearing station in Colegio Maria Auxiliadora on San Juan Bosco Street. At that time the corridor boundary was the rear wall of the school and firing was heavy in the area. (A battalion aid station was located directly opposite in Colegio San Juan Bosco.) The rest of Company D remained "on wheels" near Company C for a short time, then the whole of Company D was established at the school, where it maintained its base until redeployment in July.

Also on 3 May, the 15th Field Hospital, dissatisfied with its location, moved closer to the city. A surgical team and two hospital wards were moved forward to the area where Company C was set up, about half a mile from Duarte bridge. Later in the day the entire hospital was ordered to the forward location, and when it became operational, most of the flow of combat patients was directed into the field hospital. The 15th was to begin admitting civilian patients at the same time.

Company C had also been directed to begin civic action and its mobile aid team was receiving civilian patients. The company moved in toto to a schoolhouse in town to set up a clearing station ahead of the field hospital, but immediately came under heavy fire and was pulled back. In this action one medic was wounded. On 5 May, Company C set up a clearing station under the Duarte bridge while its mobile aid station went back into the city each day.³⁸

Company B of the 307th Medical Battalion arrived at San Isidro on 4 May to provide medical support to the 1st Brigade of the 82d Airborne Division.³⁹ After establishing in a temporary location during its first two days on the island, the medical company reverted to Battalion control and was positioned adjacent to the Support Command Headquarters near the 82d Division's Command Post at the Military Academy, where it maintained its facilities until November, when it was redeployed to Fort Bragg. While there, Company B provided division-level medical service to the division rear area and unit level medical service for rear elements of the division with no organic medical capability.

After a number of moves to provide area and direct Brigade support, Company C finally found a "permanent" home at Camp Randall in the fairgrounds area near the Hotel Embajador. Not all of the Company's property was ever moved to the Dominican Republic, but at the end of the year it was operating at full personnel strength with a dental, surgical, and holding capability, and with some extra equipment left by Company B.

Throughout their stays in the Dominican Republic, the medical companies operated on a flexible base. They administered mobile aid stations, civilian aid stations at various locations, provided medical service to the Division's troops, and relieved each other at various facilities throughout the city and nearby countryside area.

The 15th Field Hospital and its associated units were not quite so mobile, but they moved a lot. On 3 May, the 15th had displaced Company

³⁸ See footnote 33, p. 31.

³⁹ Report, Commanding Officer, Company B, 307th Medical Battalion, to Commanding Officer, 307th Medical Battalion, 82d Airborne Division, 19 Nov. 1965, subject: After Action Report-Dominican Republic Stabilization Operation.

C at a location east of Santo Domingo. This particular area, rocky and overgrown, was also subject to the adverse effects of weather. The ground became mud when it rained, and the rainy season soon started (fig. 4).⁴⁰



Figure 4.--The 15th Field Hospital during the rainy season.

Meanwhile the 714th Preventive Medicine Detachment and the 69th Medical Detachment (Veterinary Food Inspection) had arrived on the scene, were attached to the 15th Field Hospital, and began their missions as previously described. (The 69th was located at the port of Jaina most of the time, with the responsibility of inspecting all food-stuffs used by the Inter-American Peace Force.) The 545th Medical Detachment (Supply) arrived in toto at San Isidro on 1 May, on which date MAJ Daniel S. Goolsbee, MSC, assumed command.⁴¹

⁴⁰

⁴¹ See footnote 36, p. 32.

(1) Major Goolsbee was replaced by 1LT Robert L. Cooper, MSC, on 15 July, who was followed by 1LT Charles O. Jordan, Jr., MSC, on 19 November. The unit was returned to Fort Bragg, N.C., in December in the administrative move previously described which actually involved leaving equipment and personnel in the Dominican Republic to be absorbed by the 42d Field Hospital. (2) Medical Service Activities Report, 545th Medical Detachment (Sup), 9 Mar. 1966.

On 8 May the unit was attached to the 16th Quartermaster Battalion and 3 days later moved to the Boca Chica-Andrés area, where it occupied part of a sugar warehouse. On 11 June the supply unit moved back with the 15th Field Hospital and stayed attached to it until December.

"The 545th Medical Detachment (Supply) provided the only facilities for receiving, storing, and issuing of medical supplies on the island. Support was given to all units located on the island who maintained any type of medical mission. This included the 82d Airborne Division, Special Forces, 15th Field Hospital, Brazilian and Honduran units, and the Navy and Marines located off coast."⁴²

During the year more than 6,000 line items were requisitioned by the unit while in the Dominican Republic.

The 54th Medical Detachment (Helicopter-Ambulance) of Fort Benning, Ga., was first alerted for possible movement on 2 May. There followed a period of intense confusion among personnel over where the unit would go, how it was to go, and what type helicopters it would use. But by the early morning hours of 3 May, unit personnel and five UH-1B helicopters from Lawson Army Airfield were assembled at Mayport Naval Air Station. Two and one-half days after boarding the USS Boxer, the helicopter outfit, with CPT Kent E. Gandy, MSC,⁴³ in command, was offshore from Santo Domingo on the morning of 6 May.⁴⁴ The aviators flew their craft from the ship directly to San Isidro while land vehicles and supplies were put ashore at Jaina. The motor convoy traveled from Jaina through the city in early darkness and came under fire immediately, but made it to the airport without casualties.

Before the number of helicopters in the unit was reduced from five to two, some of them were stationed for short periods with the Marines on the west side of Santo Domingo, at the Naval offloading site at Andrés, 20 miles east of the city, and elsewhere when needed. Usually two aircraft were kept in the vicinity of the field hospital, to which the helicopter unit was administratively attached.

42

43 See footnote 41 (2), p. 36.

44 Promoted to major during the operation.

(1) Report, Commanding Officer, 54th Medical Detachment (Hel-Amb), to Commanding Officer, 5th Logistical Command, 29 May 1965, subject: After Action Report, 6-26 May 1965. (2) Report, Commanding Officer, 54th Medical Detachment (Hel-Amb), to Commanding Officer, 15th Field Hospital (-), 29 July 1965, subject: Brief of Activities Since Arriving in Dominican Republic. (3) Report, Commanding Officer, 54th Medical Detachment (Hel-Amb), to Commanding Officer, 54th Medical Detachment, 25 Oct. 1965, subject: Typical Briefing Outline (54th Med).

Because of the proximity of the various medical units to the scene of combat activity, the helicopters were not used so much for emergency medical evacuation as for other purposes, such as blood and supply hauls and transport of medical personnel. Most medical evacuation flights which were made were between the field hospital and the casualty staging facility at San Isidro. By 25 October, 192 patients had been transported on 137 medical evacuation missions and there had been 18 blood runs. The unit had flown a total of 487 hours in DOMREP, but much of that time included training for pilot proficiency, since the unit had not been equipped with UH-1B aircraft before deployment to the island.

Meanwhile, back in May, the 15th Field Hospital was still in the mud. By 9 May the hospital area had become "so congested by the number of attached units" that one platoon of the ambulance company was sent to Boca Chica, where it could provide ambulance support to the Rest and Recreation area set up there.⁴⁵

On 18 May the rains became heavier. The next day trucks going into the hospital area had to avoid the roads and push through the brush. The A and D tent, treatment tent, three of the five wards which were set up,⁴⁶ and some other tents were "completely under water."⁴⁷ The following day (20 May) permission was granted by Force Headquarters for the hospital to be moved to an airstrip about two miles from the Duarte bridge (fig. 5) where at least part of the tents would be on hard ground. One unit of the hospital had been kept loaded and in reserve, not even partially set up. This unit was moved first and set up at the new location. Throughout the operation, the full capability of the hospital was never tested, part of it being in reserve at all times until two of the three hospital units and the hospital headquarters were returned to Fort Bragg in July.⁴⁸

No dietitians were assigned to the 15th Field Hospital, so the nurses (there were several female nurses from Fort Bragg and other posts with the hospital) were responsible for serving patients' meals and special

⁴⁵ (1) Report, Commanding Officer, 15th Field Hospital, to Commanding Officer, 5th Logistical Command, 13 June 1965, subject: U.S. Stability Operations in the Dominican Republic. (2) Later the ambulance contingent was reduced to one platoon and ambulances were spread out at collecting points with the 82d Airborne Division, with Force Headquarters, as well as at Jaina and Boca Chica.

⁴⁶ At that time the hospital's five wards consisted of an intensive care unit, a general surgical ward, a male medical ward, a women's ward, and a pediatric ward (the last two for civilians).

⁴⁷ See footnote 45.

⁴⁸ Annual Army Medical Service Activities Report, 15th Field Hospital, 3 Jan. 1966.

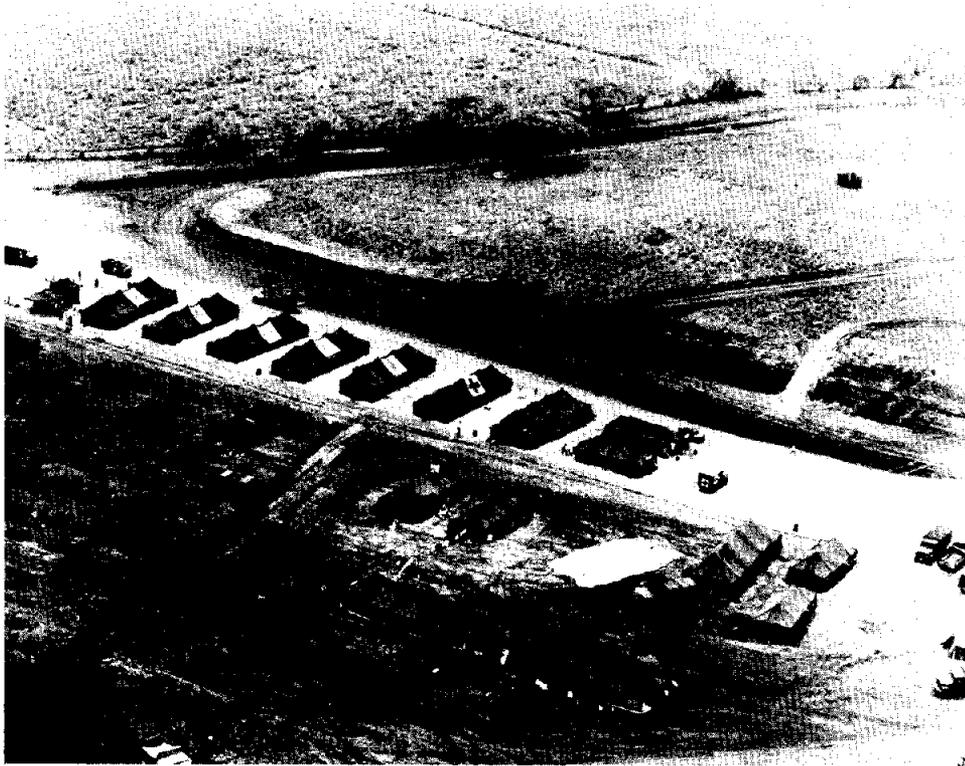


Figure 5.--The 15th Field Hospital relocated on an abandoned airstrip.

diets. Plastic trays and cups, and stainless silverware were used. After the first few weeks, C-rations were supplemented with and later supplanted by B-rations. Even at its location at the airstrip, PX facilities became available, washing machines were on hand, and personnel sometimes got a day off to go to the beach or "safe" areas in Santo Domingo. The work was similar to that at a stateside hospital, except that it was done in fatigue clothing and under tents during the first 6 weeks. During the first few weeks of the operation, mail was dispatched and received three times a week, but this was supplemented by packages and newspapers brought in on the daily flights from Pope Air Force Base.⁴⁹

After a few weeks at the airstrip, more suitable quarters for the hospital were found at the Dominican Naval Academy and the hospital was out from under tents (fig. 6). The move was completed just in time to care for the casualties of the mid-June fighting.

⁴⁹ Horne, MAJ Ruth, ANC: Sequence of Events During the Recent Dominican Republic Situation as Recalled by Major Ruth Horne, 15th Field Hospital Chief Nurse, 30 Apr. 1965-8 June 1965. [Official record.]



Figure 6.--Main building of the Dominican Naval Academy, in which part of the 15th Field Hospital was housed after 14 June.

At the Naval Academy, the hospital usually operated at a 35-to 40-bed capacity (expandable to 100 beds), with its facilities open to civilian emergency cases as well as to any soldier of the IAPF requiring treatment or laboratory work (fig. 7). Hospital personnel also operated a dispensary at the Academy and an additional one at Jaina. The hospital and attached units, except for the helicopter unit, operated in permanent buildings. Helicopter personnel maintained offices under tents on the Naval Academy grounds.

The hospital complex operated in a more or less static situation at the Naval Academy until November, when it was moved 7 miles west of Santo Domingo, on the road to Jaina. There it remained until it was deactivated and the 42d Field Hospital was activated on 10 December 1965. The newly designated unit continued in the same place through the end of the year.

During the year the various medical units on the island operated under the general guidance of the Corps and Division Surgeons and in accordance with their own plans and standing operating procedures to the extent that the situation reasonably allowed. The 307th Medical Battalion and other units also developed new operations plans especially for use in the Dominican Republic. Movement orders were directed by or coordinated with higher headquarters.

After his arrival in the area the Corps Surgeon disseminated medical advice to nonmedical units in the form of USFORDOMREP Medical Bulletin No. 1, dated 12 May 1965 (appendix G). There was no medical appendix to the first command-wide operations order, but the medical appendix to Operations Order 2-65 (appendix H) gathered together the standing policies and



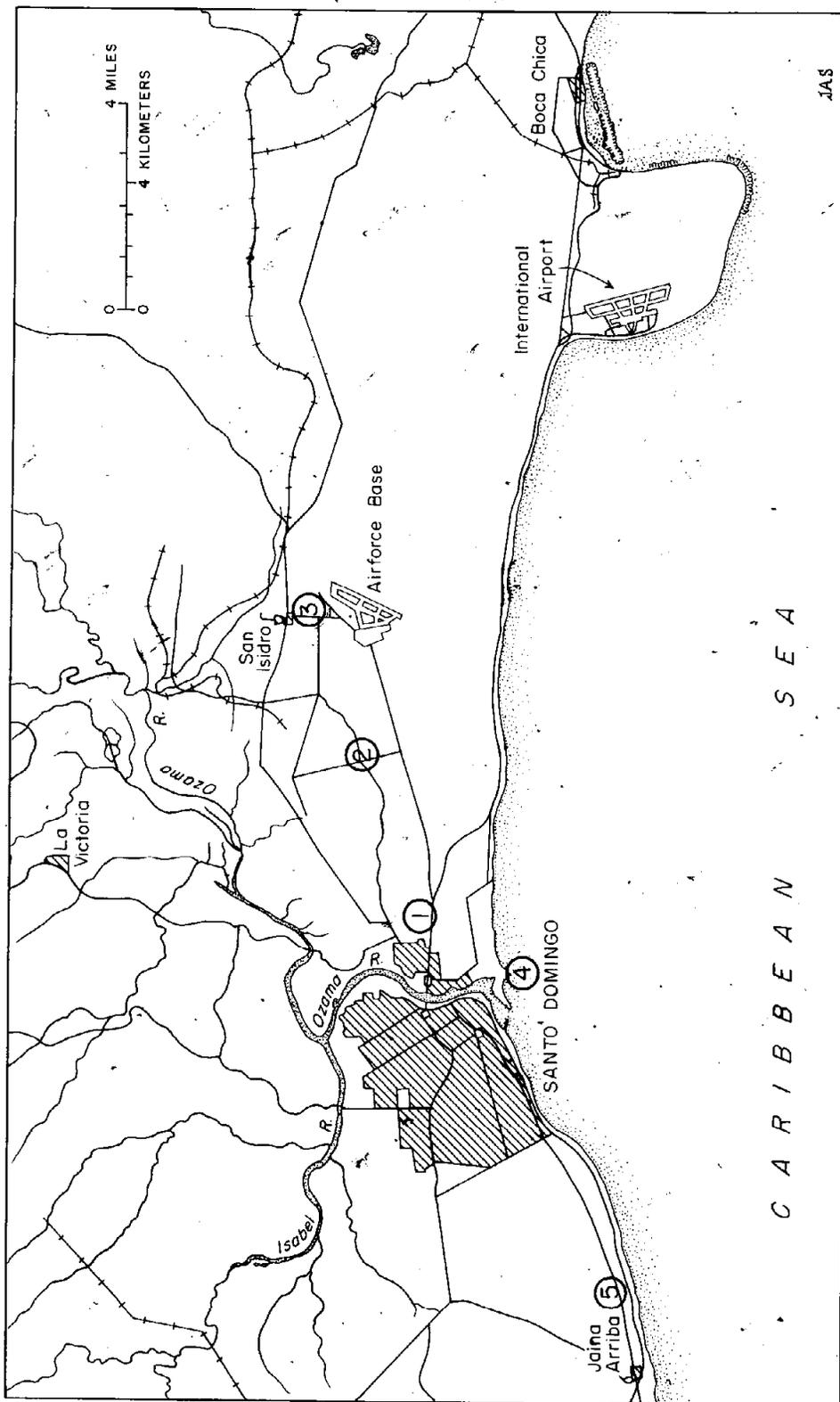
Figure 7.--Ward of the 15th Field Hospital at the Dominican Naval Academy.

those lessons learned through experience up to 8 June. This appendix was revised with the subsequent issue of each new operations order. General policies on medical support at the end of the year were spelled out in an unclassified annex to a classified Letter of Instruction to the Commanding General, U.S. Army Forces, Dominican Republic, from the Commanding General, U.S. Continental Army Command, U.S. Army Forces Atlantic Command, Fort Monroe, dated 10 December 1965 (appendix I).

Civil Action Programs

After 3 May, except for the short period of intense fighting in mid-June, most airborne medical activity for the next several months was directed toward civil aid. The 15th Field Hospital opened its hospital and outpatient facilities to all civilians also (fig. 8, map 5). Meanwhile, support to military operations continued in the usual manner.

Civilian casualties were not as serious as they had been described when the whole 15th Field Hospital was rushed to the Dominican Republic, but even before the 82d Airborne Division had fought its way through the center of the city it became obvious that many people were in need of medical help. By 2 May, battle casualties, diseases welling up out of the filth, and the usually inadequate civilian medical capability made less



Map 5.--See opposite page for legend.



Figure 8.--CPT Albert Trentalance, MC, bandaging the wounds of a Dominican, in the 15th Field Hospital.

effective when many medical people fled the trouble area, all called for the Army's provision of mass medical assistance. A decision to that effect was made quickly. By 3 May all medical treatment units had their orders and opened their tent flaps to civilians.

The first Civil Medical Assistance Team formed, that of Company D, was typical. It consisted of two medical doctors, two senior aidmen, two interpreters, six ambulance drivers, and assistants. Cases too serious to be handled by the teams were sent back to clearing stations or to the field hospital for hospitalization. Treatment and drugs were offered free.

Map 5.--Medical installations in the Santo Domingo area.

1. Location at which Company C was displaced by 15th Field Hospital on 3 May.
2. Location of Field Hospital at small airstrip.
3. Company B worked out of San Isidro.
4. The 15th Field Hospital was relocated in the Dominican Naval Academy building from June to November.
5. The 15th Field Hospital moved to the old Dominican National Nursing School in November.

The first day of service rendered by the units was limited to a few handfuls of people because the word had not spread and the local people were hesitant to approach the Americans. But by 8 May people had started flocking to team locations. By that date the 307th Medical Battalion teams had treated 529 persons and delivered two babies. Many of the patients were battle casualties or persons with serious problems. Company B opened a civilian aid facility at an abandoned police station in Santo Domingo and administered to more than 100 people the first day. In the days following, the figure reached 200 to 300 per day (fig. 9).

Shortly after the civil aid teams went into action, personnel noticed that many patients' complaints were related to poor dental health. A high number of caries was common among the population because of a lack of care and the high sugar content in the local diet. Therefore, an Army dentist was added to each team.⁵⁰ His primary function was relieving pain, extracting diseased teeth, and performing emergency care (fig. 10). However, the dentist with Company D at Colegio Maria Auxiliadora performed restorative and reconstructive work for the resident nuns. This was considered partial payment for the work the nuns did, such as doing the laundry without charge, after all the troops moved in.

Women and children made up the greater portion of visitors to aid stations. Malaria, malnutrition, dehydration, vitamin deficiency, worms, tuberculosis, cancer, elephantiasis, yaws, and leprosy, among other things, were observed and treated.

By 10 May, Division medical personnel had seen more than 2,300 patients and were averaging 500 to 600 callers a day. Medical supplies available for civil assistance (including antibiotics and intravenous fluids) were running low. The Corps and Division Surgeons and representatives of the Ministry of Health agreed that most of the extra patient load caused by the revolt had been taken care of and that it was time to get back to civil affairs policy. That is, civil affairs people were to mobilize local professional people and provide them with supplies to care for their own casualties. The XVIII Airborne Corps ordered the assistance stations closed. Signs referring patients to civilian facilities except in extreme emergency were prepared and put up. Although the 15th Field

⁵⁰ (1) Dentists of the 82d Airborne Division removed 1,770 teeth from Dominicans and made 39 permanent restorations during the year. During the same time they removed 702 teeth for military personnel and made 241 permanent restorations. (2) Medical Service Activities Report, 82d Airborne Division, 28 Feb. 1966.



Figure 9.--Citizens of Santo Domingo awaiting medical treatment in an 82d Airborne Division dispensary in a police station. The high ratio of children was typical.

Hospital complied with the policy, the 82d Airborne Division command immediately requested and received permission to continue offering mass civil aid and its stations were reopened. The thinking was that military medical requirements were low and that public relations and American image benefits from civil aid were high.⁵¹

Also, the free care had brought some more tangible results. One incidence was the case of a 65-year old man who apparently "paid" for his palliative treatment for cancer by reporting on Communist activity and a plan to smuggle arms across the Ozama River. In several other instances also, "tips" resulted in enlightened tactical intelligence for U.S. Forces.⁵²

⁵¹ (1) Historical Activities (DomRep), Office of the Surgeon, Headquarters, XVIII Airborne Corps. [Official record.] (2) See footnote 8, p. 8. (3) See footnote 50 (2), p. 44.

⁵² Brief History of 82d Airborne Division Civil Aid Program in Dominican Republic (29 Apr.-31 July). [Official record.]



Figure 10.--CPT Philip Cuba, DC, of the 307th Medical Battalion, giving dental care to a Dominican child.

Right or wrong, the decision to go ahead with the massive civil aid program within the 82d Airborne Division was made and the precedent was set. Also, 10 May could be selected as a date which marked a subtle change in the character of the medical assistance operation. It took on more of the character of a charity program and less of an emergency operation. Many of the ailments treated were of the chronic type and patients tended to be very old or very young. In some instances, where Army physicians were working in close proximity to civilian medical facilities, civilian physicians even referred patients who could not pay to the Army.

And there were a few complaints from local physicians that the Army was ruining their businesses. However, most of the local physicians

were glad to have the Army's help since they themselves lacked adequate supplies and facilities, as well as any assurances of safety while conducting their practice.

On 14 May, the Sisters from LaGuardia Church donated drugs to the 82d Airborne Division for use in the civil aid program. Two days later resupply through regular military channels began to arrive. (No medical units ever touched their basic load or any supplies for strictly military use in the civil aid program.)

By the middle of May, 9,369 patients had been cared for, including assistance to casualties from a landslide in Villa Duarte where eight were killed and 12 injured.

Before the end of May many drugs on special order began to become available and treatment of pediatric cases became more effective. More than 24,000 outpatient visits were received before June began.

In June, improved rapport with many local medical facilities resulted in the availability of longer, more definitive care for civilians. The Maternidad Hospital, the Orthopedic Hospital, and the Robert Reid Cabral Pediatric Hospital agreed to receive referrals from U.S. medical teams. Such was not always the case, however. Some of the cooperating civil hospitals would reject maternity cases unable to pay for treatment, so that Army physicians were occasionally called on to perform deliveries on patients who returned and to treat cases of severe dehydration in infants at aid stations.

The civilian patient load dropped off during the June fighting.

Since the 82d Airborne Division did not have the laboratory facilities or medical supplies to handle the chronic type of cases which were becoming more prevalent, the Division tightened its policy somewhat as of 20 June. Thereafter it officially offered treatment only to emergency cases or acutely ill patients. A few aid station teams, at the direction of their combat battalion commanders, continued medical service to all comers throughout the year, but this was the exception rather than the rule. Most civil aid teams in the city continued to function until redeployment, but treated only emergency cases.

The new policy and the return of more and more civilian physicians to the city resulted in a drastic drop in the number of people treated in Santo Domingo. With each passing month the numbers continued to dwindle throughout the year. But by the end of June, Division personnel had reported 39,454 outpatient visits by civilians in the city (fig. 11).

On 28 June, the 82d Airborne Division began a new program under the direction of its Commanding General. The medical companies formed



Figure 11.--CPT Robert E. Steward, MC, of the 30/th Medical Battalion, and a local physician examining a young Dominican.

teams which traveled out into the countryside, to small villages such as Parase Estregam, to treat indigent people (fig. 12). The teams would send an advance man into the villages (in the case of Company B, its first sergeant) to seek out the head man, determine the amount of sickness, see if the team would be welcome, and spread the word of its coming. Dysentery and malnutrition were common in the countryside and a wide range of ailments were encountered.

Without question the civil aid programs were the most significant medical activities in the Dominican crisis. The long-range effect of the program will be hard to evaluate, but since the precedent was set, the possible use of mass civil assistance programs will have to be considered in future medical support operations. If they are to be used, programing of necessary supplies into contingency plans will be necessary.

Medical Supplies for Civilian Use

Civil relief supplies for use by civilian agencies represented a large and continuous problem. On 3 May, the Corps Surgeon met with representatives of the Dominican Red Cross, the American Red Cross, the State Department, and the President's emergency aid mission to determine quan-



Figure 12.--A medical team at a farm approximately 25 miles from San Isidro.

tities of medical relief supplies needed.⁵³ A requisition was developed and sent to the United States.

The status of the director of the Dominican Ministry of Health was in doubt at the time and later, so he agreed, as did the conferees, that the Dominican Red Cross, which had a warehouse in a safer location, should act as the single local agency for the control and distribution of the supplies.

In addition to the special requisition mentioned, the 545th Medical Detachment brought in several tons of preplanned civil relief supplies and several Latin American countries contributed food and supplies to the Dominicans.

The Dominican Red Cross processed all the supplies, but the system of distribution was never satisfactory. There were claims that the Red

⁵³ See footnote 8, p. 8.

Cross was discriminatory in its issues, and it appeared to overcontrol supplies. Local hospitals and agencies often found that they could more readily obtain supplies from the U.S. Army than from the Red Cross.

In later weeks the Dominican Red Cross purchased from outside the country supplies which were flown in by U.S. Air Force planes. Several religious organizations also had supplies brought in. Some of the latter were transported by the U.S. Navy.

There were two deficiencies of note in the Army's preplanned relief supplies: few tropical disease medications and almost no pediatric preparations were in the packages.

OPERATIONS IN 1966

Little had changed from the beginning of 1966 to the date the last remnants of USFORDOMREP departed the island on 19 September 1966. The medical activities that had been in such a state of flux in the early weeks of the operation soon reached a constant level, and the medical service provided thereafter to United States troops and Dominican civilians was both efficient and effective. It remained so until the end.

Once the decision to pull out had been made, the medical units in DOMREP began a gradual four-phase withdrawal. Company C of the 307th Medical Battalion, 82d Airborne Division, was the first to leave on 10 August. The main body of the 42d Field Hospital left 6 days later. The two medicine evacuation helicopters on the island remained until 16 September, providing evacuation capability to the command during the withdrawal operation. At least one aircraft was available at the Air Force Base at San Isidro for emergency evacuation to Puerto Rico at all times. Finally, on 19 September, the last ships, carrying the 274th Medical Detachment (OA), departed for the United States.

Throughout 1966, emphasis was placed on preventive medicine activities. The bulk of this activity fell to the 42d Field Hospital. Water testing, insect and rodent control, restaurant inspection, and field sanitation team training were among its chief responsibilities, with other miscellaneous tasks, such as venereal disease control and garbage disposal, also receiving attention.

The most notable of these activities in terms of achievement was the civilian restaurant inspection program, which was expanded in both scope and frequency. All restaurants frequented by U.S. military personnel were inspected each month and then ratings were published in unit daily bulletins. The number of restaurants inspected had doubled since 1 January 1966, and a noticeable improvement in sanitary conditions was soon apparent.

Until March 1966, dental care was restricted to emergency cases because of a lack of adequate equipment. Upon the arrival of two portable, high-speed compression dental units, routine dental care was provided to the command at the 42d Field Hospital.

In addition to providing assistance to U.S. civilian and Inter-American Peace Force military personnel, the Army Medical Service also took part in civic action during the year. Several civic action dispensaries were operated by the 7th Special Forces (TF) throughout the country, and medical assistance was provided in all emergency conditions as requested by the J-5 (civil affairs). Specially significant was the Army Medical Service's response to a typhoid epidemic in San Cristobal during which 500 children at a summer camp were inoculated after sufficient vaccine was provided by the Surgeon's Office.

CONCLUSION

Official studies of problems and lessons learned in the Dominican Republic have been made--and rightly so. The numerous problems encountered during the Dominican operation did not keep the Army Medical Service from accomplishing its mission.

Battle casualties were well cared for and evacuation was efficient and speedy. Training and planning, which are always subject to improvement, had to encompass an operation that developed suddenly and then quickly expanded. Yet despite the brief time available for planning, the Medical Service in DOMREP was a success and U.S. troops did not suffer from any deficiencies.

Alerted units were ready to go when needed, and professional medical staffing was promptly provided by the Office of The Surgeon General. No serious epidemics or diseases occurred among the troops--the outbreak of hepatitis was quickly controlled after the administration of gamma globulin was started, and the rates of diarrheal disturbances were relatively low and finally resolved once better sanitary procedures were enforced. No proven cases of insect-borne diseases developed among U.S. troops, and although venereal disease rates were constantly rising, the Medical Service accomplished all that it could by offering quick and effective treatment.

Probably one of the most noteworthy medical developments of the operation, however, was the more than 54,000 outpatient visits which carried some important side effects. It provided realistic and highly important training for medical personnel; it made medical help available to people in dire need; and it accented a meaningful way of providing politically significant foreign aid quickly during an emergency--the cause of people-to-people diplomacy was greatly enhanced.

Therefore, the Army Medical Service operation during the DOMREP crisis, in the final analysis, must be considered a successful one. The Army Medical Service did much more than "conserve the fighting strength"-- it extended the helping hand of medical knowledge and assistance to a friend and neighbor to the South.

APPENDIX A

Medical Standard Operating Procedures, 5th Logistical Command

HEADQUARTERS
5TH LOGISTICAL COMMAND (-)
Office of the Surgeon
APO US Forces 09478

AJBLC-MD

11 June 1965

SUBJECT: Standard Operating Procedures - Medical

TO: See Distribution

1. The medical complex, 5th Logistical Command, will be hereafter designated US FORCES MEDICAL CENTER, COMDOMREP. It will consist of:

- a. 15th Field Hospital (-)
- b. 584th Ambulance Company (-)
- c. 714th Preventive Medicine Company (-)
- d. 545th Medical Company (Sub) (-)
- e. 69th Medical Detachment (VFI)
- f. 54th Medical Detachment (Air Amb) (RA) (-)

2. These units will be under the command control of the Commanding Officer, 15th Field Hospital. The hospital commander, a field-grade medical officer, will be the Deputy Command Surgeon.

3. The Executive Officer, Medical Section, 5th Logistical Command, is the senior medical administrative officer of this complex and will handle all major administrative directives, etc, under the guidance of the Command Surgeon which have medical and public health connotation.

4. The Command Surgeon, for the CO, 5th Logistical Command, will bear the responsibility for the health and well-being of the command and

SUBJECT: Standing Operating Procedures - Medical

will promulgate medical and public health guidance for the command commensurate with the policies of higher commands. He will collaborate and coordinate with the Surgeon, higher command, but will implement the needs and desires of the Commanding Officer, 5th Logistical Command.

5. The 5th Logistical Command Medical Section, through the Medical Supply Officer, will review, coordinate and formulate medical supply procedures and requisitioning commensurate with standard medical supply policy of higher command. He will also coordinate all services and utility needs for the medical complex.

6. The 69th Medical Detachment (VFI) will be attached for support only to the 16th Quartermaster Battalion, as it is felt that 75% of its effort will be that of inspection of the Class I activity. Yet it is not felt that complete attachment, to include administration, etc, is justified in that there are other activities such as assistance and supervision in rodent control, canine control and animal husbandry for which its capabilities must be utilized.

7. The 714th Preventive Medicine Unit (-), whose duties are peculiarly command-wide, will receive instructions from the Medical Section, 5th Logistical Command through the Commanding Officer, 15th Field Hospital and will submit reports to the Command Surgeon through the Commanding Officer, 15th Field Hospital. Direct coordination and communication with the Medical Section, 5th Logistical Command, is authorized on problems which may otherwise be delayed by administrative action.

8. The 584th Medical Company (Amb) (-) will be responsible to the Commanding Officer, 15th Field Hospital, for transportation and evacuation of patients at the discretion of the Commanding Officer, 15th Field Hospital. All ambulance commitments other than emergency will be coordinated with Medical Section, 5th Logistical Command, through the Commanding Officer, 15th Field Hospital.

9. The 545th Medical Company (Sup) (-) will be responsible to the Command Surgeon, through the Commanding Officer, 15th Field Hospital, for all COMDOMREP medical supply activities. It will coordinate with the MSO, 5th Logistical Command, for all medical supply activities including CONUS depots, etc. The 545th Medical Company (Sup) (-) will provide medical maintenance support, within its capabilities, to all medical units in COMDOMREP.

10. The 15th Field Hospital (-), as the major medical unit, US Forces COMDOMREP, will be responsible for the specific medical support to all other medical units assigned or attached to COMDOMREP. It will operate under a fifteen (15) day evacuation policy, to be elastic as the Commanding

SUBJECT: Standing Operating Procedures - Medical

Officer, 15th Field Hospital, deems commensurate with adequate and competent patient care. The Commanding Officer, 15th Field Hospital, is advised that the Command Surgeon directs that patient care and the health of the command are the primary function of the US Forces Medical Center COMDOMREP. All other activities are secondary to this. Dispensary service, dental service and ordinary sick call will be provided within the complex, but away from the main hospital building. The hospital will provide all services except ophthalmology, urology, pediatrics, obstetrics and gynecology at this time. If and when commensurate professional staff is made available, and the command so indicates a need, such services will be provided. Physical examination, final type, cannot be completed at this time and will not be attempted. Local foodhandler examinations for native personnel to be hired will be performed on a limited basis commensurate with needs and not desires. Major elective surgery will not be attempted at this time.

11. The 54th Medical Detachment (RA) (Air Amb) will operate under the control of the Commanding Officer, 15th Field Hospital. All commitments for emergency air evacuation will be coordinated with the Command Officer, 15th Field Hospital, or his representatives, and, depending on the individual case, will require a physician member on the crew. It is directed that the Surgeon, 5th Logistical Command, be notified of all major emergency evacuations at completion of the evacuation flight.

12. General:

a. All personnel, to include professional, ancillary professional, administrative and enlisted personnel of this medical center, will adhere to the rules of COMDOMREP: - VIZ - Curfew at 1900 hours daily. No Personnel, repeat, no personnel will be outside their compound after these hours. Curfew ceases daily at 0600 hours. Personnel and vehicles dispatched during the hours from 1900 to 0600 will do so only at the express command of the Commanding Officer, 15th Field Hospital, or his designated representatives, and only with a written authorized pass. Such personnel will also word and alternate pass word for that day. Disobedience to these instructions will be severely dealt with.

b. Personnel using the beach facilities adjacent to the copter area will strictly adhere to the instructions published by the 503d Military Police Battalion (copy attached).

c. Uniform regulations will be adhered to commensurate with the job to be done. Soft caps are authorized within the complex. Combat helmets and authorized weapons (unloaded) will be worn when leaving complex for any business.

AJBLC-MD

11 June 1965

SUBJECT: Standing Operating Procedures - Medical

d. It is expected that all personnel who are a part of this medical complex will conduct themselves at all times in a manner to bring credit to themselves, to the medical service and to the command.

I Incl
as

PETER S SCOLES
Colonel, MC
Surgeon

Distribution

CO, 15th Fld Hosp (-)
CO, 584th Med Co (Amb)(-)
CO, 714th Pvnt Med Co (-)
CO, 545th Med Co (Sup)(a)
CO, 69th Med Det (VFI)
CO, 54th Med Det (RA)(Air Amb)(-)

APPENDIX B

Medical Coverage and Procedures in Objective Area, 82d Airborne Division

U N C L A S S I F I E D

X

PRIORITY

FROM: CG 82D ABN DIV

TO: CO 1ST BDE
CO 2D BDE
CO 3D BDE
CO DIV ARTY
CO SPT COMD
CO AVN BN
CO 307TH ENGR BN
CO 1/17 CAV
CO HQ CO
CO MP CO
CO SIG BN
CG XVIII Abn Corps ATTN: Surgeon
CO 15th Fld Hosp

UNCLAS Cite AJDGD 221-DR

SUBJECT: Medical Coverage & Procedures in Objective Area

1. TREATMENT FACILITIES ---Effective 061800 May 65 division level medical service provided on an area basis by following units.

- a. Co D, 307th Med Bn loc VIC 048432.
- b. Co C, 307th Med Bn loc VIC 072439.
- c. Co B, 307th Med Bn loc VIC 187473.

2. Units organic or attached 82d Abn Div will evacuate directly to any of the above installations. Definitive surgical capability available at locations in para 1a and 1b above. Dental services available at any of above locations. Critically wounded patients may be evacuated to 15th Field Hospital loc VIC 085440.

3. Emergency helicopter air evac --- Due to close proximity of definitive medical treatment facilities and lack of suitable helipads in controlled 82d Abn sector of city, in addition to reaction time of alerted A/C, emer air evac will be available VIC 15th Field Hospital. Patients generally considered for air evacuation will be surface evacuated to 15th Field Hospital, resuscitated, stabilized and then transported by helicopter to USAF CSF at San Isidro. Direct radio contact (USAF) from 15th FH to USAF Casualty Staging Facilities.

4. Evacuation & Holding Policy 82d Abn Div --- Division level medical facilities should hold casualties no longer than 72 hrs. Every effort should be made to retain personnel in division channels. Division Psychiatrist will locate with Co C, 307th Med Bn. If hospitalization required is to exceed 72 hrs, patient will be evacuated to 15th FH, by division clearing stations.

5. Reports --- All unit surgeons should establish liaison with division clearing stations for submission of required reports. See Div Reg 525-1. All medical units participating in civil medical assistance should by most expeditious means render reports to Div Surgeon Office. Include number of patients treated, general diagnosis (e.g., medical, surgical, etc.).

6. Commanders are encouraged to reemphasize water discipline. First tentative diagnosis of infectious hepatitis in division 6 May 65; not confirmed.

7. Unit surgeons should recheck immunization records. Smallpox reported at airport, plus isolated cases of Typhoid. All civilians.

8. Soft drinks bearing label "DUMBO" are to be avoided. Information released previously regards foods, water, etc still apply.

9. Unit surgeons will insure all troops are receiving Chloroquine-Primaquin Malaria Suppressants. One tablet per week while in objective areas and one tablet per week for 6 weeks after return to CONUS.

10. Medical supply requisitions from units organic or attached to Division Medical Supply Officer, 307th Med Bn.

Champion 4

T. J. LEPSKI
Lt Col, GS
ACofS, G-4

WESLEY C. SCARBOROUGH
Major, AGC
Adjutant General

APPENDIX C

Confidential Nature of Venereal Disease Information, 82d Airborne Division

U N C L A S S I F I E D

X

ROUTINE

FROM: CG, 82D ABN DIV SAN ISIDRO DOM REP

TO: CO, 1ST BDE
CO, 2D BDE
CO, 3D BDE
CO, SPT CMD
CO, DIV ARTY
CO, 1/17 CAV
CO, AVN BN
CO, SIG BN
CO, ENG BN
CO, DIV HQ CO
ALL STAFF SECTIONS

INFO: XVIII ABN CORPS: SURG
CO, 15TH FH
SURG, 5TH LOG CMD

UNCLASS Cite AJDSU 781 DR

SUBJECT: Confidential Nature of Venereal Disease Information

1. Unit surgeons will not disclose names of individuals who have been treated for suspected venereal disease to their commanders or to other non-medical or unauthorized personnel.

2. Revealing such information violates privileged communication between doctor and patient and is specifically prohibited by current Army Regulations and by Div Reg 40-1.

3. Past experience has shown that the threat of command pressure on individuals treated for V.D. often results in the following:

a. Troopers turning to quacks, pharmacists, etc., for "treatment" (it is a known fact that anyone can obtain a penicillin "shot" for

50¢ at any drug store in Santo Domingo.) In such an eventuality, inadequate treatment is a hazard - relieving symptoms, but not a curative dose. The greater danger is that syphilis may be masked, but not cured by small doses of antibiotics. "Treatment" by unauthorized facilities also includes risk of unsterile techniques with increased chances of infections, serum hepatitis, etc., and possible serious or even fatal drug reactions.

b. Patients with possible V.D. not being seen or recorded or followed up by a doctor; thus possibility of spreading the disease to contacts after return to CONUS.

c. Possible thefts of drugs - "no sweat pills" - obtained illegitimately through non-medical channels, with near certainty of inadequate treatment and consequences noted in a. and b. above (it is a known fact that some of the Troops are already obtaining "no-sweat" pills from unauthorized sources.)

d. Invalid medical statistics.

e. Inability to trace down and treat contacts.

f. Breakdown of the doctor - patient relationship with reluctance and distrust on the part of the patient and inability to obtain a reliable history due to patient's fear that the doctor will "squeal" on him.

g. Last and most important is the possibility that an outbreak of syphilis might be "driven underground" and eventually spread to others after return to CONUS.

4. There are no laboratory facilities currently available to the US Army in the Dominican Republic for confirmation of V.D.; therefore all patients thus far have been treated for V.D. presumptively, on a clinical basis and without lab "proof" of the disease.

5. Unit surgeons will continue to provide information of statistical nature to their commanders as required.

THOMAS M. ALLEN
Captain, MC
Ass't Div Surgeon

ROLAND W EISENBARTH
Capt, AGC
Asst AG

APPENDIX D

Redeployment Physical Evaluation, USFORDOMREP Circular No. 40-12

HEADQUARTERS
UNITED STATES FORCES DOMINICAN REPUBLIC
APO New York 09478

CIRCULAR
NUMBER 40-12

7 June 1965

Expires 6 June 1966

MEDICAL SERVICE

Redeployment Physical Evaluation

1. The following is applicable to commanders of units assigned or attached to USFORDOMREP.

2. Purpose: The purpose of this directive is to prevent the introduction into the United States of communicable diseases endemic to the Dominican Republic, to protect military personnel from the later effects of undiagnosed diseases, and to prevent the infection of individuals who may come in contact with returning personnel with unrecognized illness. Sections II and III of AR 40-12 (Navy General Order No 20, Air Force Regulation 161-4).

3. Pre-redeployment requirements: Each individual who has served ashore in the Dominican Republic will undergo a screening physical evaluation prior to return to the United States. This evaluation is to be conducted by the medical element normally responsible for providing the individuals primary medical support. For personnel returning by surface transportation, this evaluation may be conducted while at sea. For personnel returning by air transportation, the evaluation will be conducted within 24 hours prior to departure from the Dominican Republic. Evaluation should consist of a brief history and limited physical examination designed to detect the presence of acute or chronic illness with particular attention to fevers of undetermined origin, gastro-intestinal infections, jaundice, infectious skin lesions, and venereal disease.

4. Disposition: Unit surgeons should determine the disposition of individuals with positive evidence of disease in accordance with good medical practice and the dictates of preventive medicine as expressed in paragraph 3, above. Requirements for early hospitalization and/or treatment

should take precedence over the individuals desire for immediate return to the CONUS. In cases of communicable diseases, hospitalization or other appropriate restrictions should be placed on individuals until treatment has been accomplished and all danger of transmission of infections to other individuals is passed.

5. Immunization: Provisions of AR 40-562 (AFR 161-13, Navy Bumedinst 6230.1D) which requires smallpox immunization of individuals returning to United States within three years prior to arrival, but not less than eight days previous to debarkation, will be complied with.

6. Post-deployment follow-up studies: Because of the high incidence of syphilis in this area and the inadequate laboratory facilities available in DOMREP, post-deployment serological test for syphilis is recommended for all personnel suspected of having any form of venereal disease. All personnel should be advised of the importance of informing medical officers of their duty in the Dominican Republic should they subsequently become ill within a three month period. All personnel must be reminded of the necessity for continuing malaria suppressive therapy weekly for a period of six weeks after departure from DOMREP. Redeployment orders will include the specific requirement to continue suppressive medication for the six weeks period.

7. Records and Reports: No report is required relative to the requirements set forth herein. Unit surgeons should keep such records as are appropriate to their service to ensure proper and adequate follow-up in those individuals who require it. Subordinate commanders are authorized to devise their own systems for ensuring that each individual receives the evaluation required prior to redeployment from DOMREP.

(USFDR-MD/Tel 216)

FOR THE COMMANDER:

OFFICIAL:

ROBERT R. LINVILL
Brigadier General, US Army
Chief of Staff

Wm. F. Faught
Major, AGC
Asst Adjutant General

DISTRIBUTION:

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E
10 Surgeon, USFORDOMREP

APPENDIX E

Annual Medical Service Activities Report, 82d Airborne Division, 1965

1. GENERAL:

a. This report covers the activities of the Division Psychiatric Section in the Dominican Republic, from May 1965, to November 1965.

b. From 3 May 1965, to 4 September 1965, the Division Psychiatrist and one Social Work Specialist were attached to the 15th Field Hospital, except for two 2-week periods in June and August when they were in CONUS. This location was decided upon, in order to be available to all U.S. Army elements in the Dominican Republic, at the point of evacuation to CONUS.

c. From October 1965, to November 1965, the Division Social Work Officer was in the Dominican Republic with the 307th Medical Battalion, and saw psychiatric referrals from Division only.

2. PSYCHIATRIC ACTIVITIES:

a. The attached report is a resume of the patients seen from May-August 1965, and includes patients from all U.S. Army elements present in the Dominican Republic. The Navy and Marines utilized their own chain of evacuation, but on one occasion the Division Psychiatrist was asked to examine a Navy enlisted man.

The Social Work Officer saw approximately 20 patients, which was the major part of the case load during the first three weeks of his tour. Had his services been extended to Corps and Support Elements, the patient load would have been much higher.

The total number of cases seen is much less than the average for garrison, probably because of considerably fewer board (208/209) cases being processed.

b. The statistics indicate certain trends in the casualties seen. The following table compares the number of cases falling into the various diagnostic categories during May-August in the Dominican Republic, and during another four month period in garrison (January-April 1965).

<u>CLASSIFICATION</u>	<u>DOMINICAN REPUBLIC</u> (May-August)	<u>GARRISON</u> (January-April)
No Psychiatric Disorder	10	20
Acute Situational Maladjustment	8	4
Character & Behavior	46	188
Psychoneurotic	10	5
Psychotic	12	1

Then it can be concluded that the various stresses involved led to an increased incidence of symptomatic disorders, in the categories of Acute Situational Maladjustment, Psychoneurosis and Psychosis.

c. The Psychiatrist saw only one patient which fell into the category of combat exhaustion. This occurred in the first few days of the encounter, when the fighting was most intense. In general, exposure to life-threatening situations and physical deprivation were never sustained enough to give rise to the conditions known to precipitate classical cases of combat exhaustion.

d. It should be noted that most of the cases of acute psychosis did not occur under conditions of fire. Most of them occurred in the period after hostilities were reduced to a minimum (after May), but when there continued to be heavy restrictions of activities, and a great deal of uncertainty as to who and where the enemy was.

e. Not included in the statistics is a group of cases which were seen only on an emergency basis, or heard of via the unit surgeons. These were cases of pathological intoxication, in which, under the influence of alcohol, bizarre or violent behavior occurred. There were a considerable number of such cases, which were handled by sedation. Situational stress undoubtedly played a role in the development of these cases, and they were generally ready for duty the next day.

3. OTHER MEDICAL ACTIVITIES:

a. From 6 May 1965, to 20 May 1965, the Division Psychiatrist and Social Work Specialist assisted various medical units operating in Santo Domingo with civilian medical aid, by working at sick call each morning.

b. From 8 July 1965, to 1 August 1965, the Division Psychiatrist functioned also as Battalion Surgeon for the 1/325 and 2/325, while the respective surgeons returned to CONUS.

c. From 15 August, to 4 September, the Division Psychiatrist also functioned as acting Division Surgeon, during the absence of the Assistant Division Surgeon.

4. OBSERVATIONS OF A GENERAL NATURE:

a. During the week prior to the arrival of the Psychiatrist in the Dominican Republic, there were several "psychiatric casualties" evacuated to Womack Army Hospital, including Marines and Army Personnel, whose conditions were actually not severe enough to warrant evacuation. The psychiatrists at WAH remarked at the sharp decline in such evacuees when the psychiatrist reached the objective area. This would seem to indicate the utility of having psychiatric personnel on the scene as soon as is practical.

b. The Social Work Officer's experiences during the later stages of the operation indicated the value of his being assigned with forward elements during operations where the division has some of its units operating away from Division Main for extended periods.

5. PROBLEM AREAS:

a. Psychiatric

(1) The communication of information from the unit level to the psychiatrist often left much to be desired. This situation could be improved by assigning the Social Work Specialists to work in their respective clearing companies, and obtain the necessary information from accompanying aidmen.

(2) It would have been useful for the psychiatrist to have been more mobile, so that he could make first-hand observations to the forward situation, and consult with unit surgeons regarding the handling of cases.

b. Other Medical Problems

(1) Having been located at the 15th Field Hospital, certain problems were evident in the areas of inter-facility cooperation.

APPENDIX F

Civilian Restaurant Inspection Program, USFORDOMREP Circular No. 40-4

HEADQUARTERS
UNITED STATES FORCES DOMINICAN REPUBLIC
APO New York 09478

CIRCULAR
NUMBER 40-4

13 September 1965

Expires 12 September 1966

MEDICAL SERVICE

Civilian Restaurant Inspection Program

1. The following is applicable to commanders of units assigned or attached to HQ, USFORDOMREP.

2. PURPOSE: The purpose of this directive is to establish procedures and standards for the inspection and approval of local civilian food service facilities for use by U.S. Military Personnel.

3. STANDARDS: Inspection of food service facilities will be conducted in accordance with a check list developed and previously used by the DOMREP Ministry of Health, a copy of which is attached (see inclosure 1). This check list requires evaluation of all sanitary aspects of food service activities and is based on a maximum score of 100 points. Each food service facility inspected will be issued a rating of "A" (96-100 points), "B" (86-95 points), "C" (76-85 points), or "D" (70-75 points), if found acceptable for use by U.S. personnel. The rating will be noted on the permissive letter issued in accordance with reference a. Each approved facility will be re-inspected at regular intervals but not less often than 60 days to insure maintenance of required standards. Facilities that have failed to achieve an acceptable rating may be re-inspected by request of the proprietor upon presentation of evidence that an effort has been made to correct previous deficiencies in the facility.

4. PROCEDURES: Following procedures will be used in implementation of this program:

a. Any commander of a battalion sized unit or larger, any general or special staff section chief of Hq, USFORDOMREP, Hq, 5th Logistical Command, Hq, 82d Airborne Division and the Hq, US Air Force, TF 121, or

the Preventive Medicine Officer of any of these several headquarters may request the inspection of a food service facility believed by him to be a facility of potential use to U.S. personnel. Such a request may be submitted in writing or by telephone to Commanding Officer, 714th Preventive Medicine Unit, Telephone: LAST CHANCE 16. Request will be entered on the schedule of inspections in the order in which received and a record will be kept of the individual filing the request. Requests must include the name of the establishment, its address, and if possible the name of the proprietor. This priority may be adjusted with concurrence of this headquarters, ATTN: ACofS, J1, in order to maximize potential service to troops of the command.

b. A representative of the 714th Preventive Medicine Unit will contact the proprietor of the establishment and schedule an inspection, provided he is desirous of U.S. patronage.

c. Prior to the scheduled inspection, the Commanding Officer, 714th Preventive Medicine Unit will contact the DOMREP Ministry of Health and the Preventive Medicine Officer, USFORDOMREP, and arrange for them or their representatives to be present for the inspection.

d. At the conclusion of the inspection, the proprietor will be advised of the results, and provided a copy of the check-list. If his establishment is approved by the USFORDOMREP Preventive Medicine Officer, he will be issued a permissive letter in accordance with reference a. The USFORDOMREP Preventive Medicine Officer will insure that an immediate notice is placed in the USFORDOMREP Daily Bulletin for a period of 3 days announcing the establishments approval. A copy of the inspection report to include check-list and a copy of permissive letter will be filed with Office of the Surgeon, USFORDOMREP.

e. If the establishment fails to qualify, the proprietor will be advised concerning discrepancies that must be corrected before his facility can be approved, and he will be further advised that a re-inspection will be scheduled upon his request when he has corrected the deficiencies noted. The Commanding Officer, 714th Preventive Medicine Unit will then advise the U.S. individual who requested the evaluation that the establishment has failed to qualify for U.S. patronage.

5. Collateral Activities: In an effort to further improve the overall standards of local food service facilities, the command is concurrently conducting inspections and evaluations of various wholesale food producing and processing activities such as poultry farms, slaughter houses, dairies, beverage producers, etc., and attempting to correlate these results with the disposition of food-stuffs at local restaurants.

Cir No 40-4, HQ, USFORDOMREP, APO New York 09478 13 Sep 65

6. Special Precautions: All personnel must be cautioned that medical approval of civilian food service facilities is an indication only of the sanitary conditions at the specific time of the inspection. Numerous factors can introduce unsanitary conditions within an eating establishment subsequent to the evaluation. In addition, certain specific precautions should be taken in all local establishments and with local vendors because of the impossibility of totally evaluating sources and products. These are:

a. All water, beverages prepared with water, or beverages using ice should be avoided.

b. All milk and milk products, to include ice cream, butter, cheese, sherbet, ice cream on a stick, etc., should be avoided.

c. Patronage of street and sidewalk, push cart, bicycle and "hand carry" food and beverage vendors is a continuing menace to health and must be avoided at all times.

7. References:

a. Circular 600-20, dated 13 Sep 65, this headquarters.

b. Circular 40-5, dated 19 July 1965, this headquarters.

(USFDR-MD/Tel 216)

FOR THE COMMANDER:

OFFICIAL:

ROBERT R. LINVILL
Brigadier General, US Army
Chief of Staff

Wm. F. Faught
Major, AGC
Adjutant General

1 Incl
as

DISTRIBUTION:

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E
20 Surgeon

DOMINICAN REPUBLIC

OFFICE OF THE SECRETARY OF STATE
FOR HEALTH AND SOCIAL AFFAIRS

NATIONAL
HEALTH SERVICE

INDEX CARD FOR THE INSPECTION
OF FOOD ESTABLISHMENTS

Commercial Firm _____ District _____ Street _____ No _____
Owner _____ Representative _____
Capital Assets _____ Monthly Sales Volume _____
Personal M. ___ F. ___ Authorization No. _____ Date _____

1. Location of kitchen (not co-located with quarters, far from unhealthy spots; not directly joined to living quarters)..... 1
2. Insect control (Absence of insects (3); protected exterior openings (1); use of insecticides (1)..... 7
3. Rodent control (Absence of rodent activity, feces, rat holes, tracks (3); striping of doors and other openings (1); rat extermination system (1)..... 5
4. Floors (solid material, smooth, waterproof, in good condition and absence of sawdust from food processing room)..... 1
5. Ceiling (smooth, painted with a light color and in good condition)..... 1
6. Walls and socle (smooth, painted with a light color and in good condition; socle constructed according to standard rules and in good condition)..... 1
7. Doors and windows (well constructed, access doors kept closed or use of automatic doors)..... 1
8. Illumination (sufficient, well distributed and located)..... 1
9. Ventilation (absence of smoke, odors, gases, vapor condensation; adequate temperature)..... 1
10. Water Supply (well distributed, potable (3); condition of faucets and pipes (1); abundance (1)..... 5
11. Water drainage (drains, sinks, absence of dirty water on the floor)..... 1

12. Rest Rooms (independent for each sex, (2); location, halls connecting with other rooms (1); restroom fixtures in good condition (1); automatic doors (1)..... 5
13. Facilities for personal cleanliness (lavatories with running water located in each processing room and rest rooms (2); soap, whisk brooms, clean disposable towels in each processing room (2), soap, whisk brooms and disposable towels and toilet paper in rest rooms)..... 5
14. Wardrobe room (wardrobe room constructed according to standing rules with individual locker, well ventilated, and adequate and closed containers (1)..... 1
15. Garbage and leftovers (collected in adequate and closed containers (1); containers, a minimum disposal of garbage of once every 24 hours (1) sufficient..... 2
16. Cleanliness of Premises (Permanent cleanliness of rest rooms (2); cleanliness of floors in between working periods (2); day by day cleanliness of premises and furnitures (2); cleanliness of walls and ceiling (2)..... 10
17. Miscellaneous (Absences of fowl, domestic animals; foreign items or items not in use, or poisons from the premises, clearance of hallways and stairways)..... 1

EQUIPMENT

18. Furniture (Showcases and shelves of sufficient capacity and constructed with good, solid materials, kept in good maintenance)..... 1
19. Machinery and other items (Number, localization, materials used in their construction, maintenance, dismantable)..... 1
20. Utensils (Adequate material, maintenance)..... 1
21. Facilities for the cleaning of machinery and other items and for the cleaning and the dis-infection of utensils (hot and cold water, brushes, soap, detergents and disinfectant solutions, clean washcloths) (1); adequate installations (1)..... 1

22.	State of cleanliness of machinery and equipment (Cleanliness of tools and machinery, between working periods, cleanliness of the interior of dismountable machines).....	5
23.	State of cleanliness of Utensils (Cleanliness of eating and drinking utensils, kitchen utensils or for dispatching of food).....	5
24.	Disinfection of Utensils (Water temperature and chlorine used in washing).....	1
25.	Utensils drying process (Drip drying, hot air, clean washcloths).....	1
26.	Storage of Utensils (Not exposed to contamination, adequate location).....	1

FOODSTUFFS

27.	Source of foodstuffs and raw material (from authorized establishments, quality and conservation of original condition containers and labeling, codes).....	1
28.	Protection from contamination (Protection from dust, saliva, rats and insects and from contacting dirty surfaces).....	5
29.	Protection from alteration of decomposition (all perishables are maintained at adequate temperatures (under 10 C or over 70 C) (Orderly storage with ventilation) (2).....	5
30.	Adequate process for the separation of alterable foodstuffs such as milk, cream, etc.....	1
31.	Handling of food and utensils (Minimum handling of food (1) adequate handling of utensils (1).....	2
32.	Immediate elimination of spoiled foods and leftovers.....	1

FOOD HANDLERS

33.	Personnel neatness (Adequate and clean working clothes (2), personal appearance and cleanliness (2); clean hands, nails clipped and without nailpolish (6).....	10
-----	---	----

- 34. Personnel Habits (No coughing or sneezing over such foodstuffs, no spitting on floors, no manipulation of money during duty hours, no smoking)..... 5
 - 35. State of Health (No fever, cough, wounds, discharges of pus, etc.)..... 2
 - 36. Documents (Sanitary Carnet and other documentation. Are they up to date?..... 1
- TOTAL POINTS----- 100

Inspector _____ Date _____

APPENDIX G

Health Hazards in the Dominican Republic, USFORDOMREP Medical Bulletin
No. 1

HEADQUARTERS
UNITED STATES FORCES DOMINICAN REPUBLIC
APO New York 09478

MEDICAL BULLETIN
NUMBER 1

12 May 1965

1. PURPOSE: This bulletin is prepared to assist commanders in understanding the preventive medicine programs of this command and to provide them with information relative to health matters in the Dominican Republic.

2. GENERAL: U.S. Military Forces have repeatedly experienced widespread if not epidemic illness when deployed to areas of high disease endemicity such as the Dominican Republic. The most recent example was the experience in Lebanon when diarrheal disease reached critical levels particularly after messes opened and due entirely to poor personal hygiene and unit sanitation. Americans at home live in the most sanitary environment in the world, and hence have lost the natural immunities to disease that peoples from less sterile areas possess. We may be tough and capable soldiers, but from a disease standpoint we are the most vulnerable nation on earth. Our soldiers simply cannot survive when exposed to conditions that other peoples live with daily. There are many diseases prevalent in the Dominican Republic which our troops are highly susceptible to. The information which follows will hopefully assist commanders in planning the control programs within their units and may be used to brief troops on the health hazards they face in this area.

* * * * *

HEALTH HAZARDS IN THE DOMINICAN REPUBLIC

Following are the most significant diseases which our personnel will encounter in this area. This is by no means a complete list, but the entities below are of such prevalence that only careful control measures will eliminate otherwise inevitable infection.

HEPATITIS (Yellow Jaundice) is very prevalent in this area and indeed the local authorities expect an epidemic because of the interruption of usual sanitation services. It is spread by contact with hepatitis patients or the ingestion of food and beverages contaminated with feces. Convalescent

USFDR-SURG

SUBJECT: MEDICAL BULLETIN Number 1

patients can continue to pass virus in their feces for months. This is a very serious illness, sometimes resulting in death, requires long convalescence, and may produce permanent liver damage. MAIN DANGER: Local food, beverages, and ice, eating with dirty hands.

HOOKWORM exists in DOMREP. This parasite enters the body through the skin--particularly the feet of persons walking barefoot over fecally contaminated soil. All soil in the Dominican Republic should be considered contaminated with feces. MAIN POINT: Don't go barefoot here.

MALARIA, DENGUE, FILARIASIS and other mosquito borne diseases. Although the Dominican Republic has had a good mosquito eradication program going for several years, malaria, dengue and other mosquito borne diseases still exist here and these are diseases to which Americans are particularly susceptible. With the onset of the rainy season, the mosquito population will increase rapidly. Malaria suppressive pills MUST be taken by all personnel without fail - one tablet every 7 days to include 6 weeks after return to the United States. To facilitate control the command has established the policy that pills will be taken with the breakfast meal each Monday. Malaria pills have no effect on dengue or other diseases and are not the exclusive answer. Insect repellants and other insecticides and nets should be used. The command will take steps to insure the issue of nets to all personnel.

VENEREAL DISEASE. VD is prevalent in the Dominican Republic. Medical data indicates that syphilis occurs in 15% (1 in every 7 people) of the population and gonorrhea in an even greater number of people. This is an astronomically higher rate than is found in U.S. populations. We cannot legislate morals and non-fraternization and continence are almost impossible to enforce, but troops should be informed of the fantastically high risk they are taking with sexual contacts here.

SCHISTOSOMIASIS. A number of blood parasite diseases exist here which enter the body through the skin from contact with contaminated water. There is little danger from swimming at ocean beaches, but inland streams must not be used for wading, bathing or swimming. One case has already been reported.

INTESTINAL PARASITES of several varieties are endemic to the Dominican Republic. These enter the body with contaminated food (dirty hands, dirty mess gear), contaminated water or ice (soft drinks, snow balls, local ice, etc.) or by the ingestion of raw or rare pork or beef. Troops must not consume food, beverages or ice from other than approved sources, and as yet there is no approved source for food or ice. The Dumbo brand of soft drinks have also been found unacceptable.

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SUBJECT: MEDICAL BULLETIN Number 1

RABIES is widespread here and control measures sketchy. All personnel must be absolutely forbidden to handle local animals, wild or domestic. The mongoose is identified as a specific reservoir of this disease. Any individual bitten by an animal must be immediately evacuated to the 15th Field Hospital for further treatment and evacuation.

* * * * *

FIELD SANITATION

Almost without exception, the sanitation practices of units of this command have been worse than poor thus far. Improvement is mandatory or serious disease problems will shortly occur. Major points of emphasis should be these:

FLY PROOF LATRINES. Where boxes are used, there must be no open places for flies to enter the box or pit. Where slit trenches are used, each defecation must be completely covered with dirt (both feces & paper). Flies that crawl on feces also crawl on food, mess gear and hands.

HAND WASHING FACILITIES. Some means of washing hands must be devised for use near latrines and at meal times.

GARBAGE and rubbish should be collected, burned and/or buried.

VECTOR CONTROL DETAILS. Each company size unit is required by Regulations to have a Vector Control Detail. Many such individuals have been trained in units of this command. Now is the time and this is the place to use them. Fly and mosquito control measures around troop areas can significantly reduce hazards.

* * * * *

The command recognizes the multiple tasks that units and individuals have been called upon to perform as well as the adverse environment in which we are operating. But these many tasks will be made no easier by the loss of significant numbers of men as a result of disease. Such a loss is inevitable unless the sanitary standards and the preventive medicine practices of this command change radically and immediately. The staff is moving ahead as fast as possible to find acceptable sources of food, beverages and ice, as well as recreational and laundry facilities. Until these sources are available local'y procured products must be denied.

USFDR-SURG

SUBJECT: MEDICAL BULLETIN Number 1

The Surgeons Office has Preventive Medicine experts who will be happy to offer such technical advice or conduct surveys as commanders may desire to assist them in their unit control measures.

FOSTER C. McCALEB
MAJOR MC
USFORDOMREP Surgeon

APPENDIX H

Medical Appendix 1 to Logistics Annex M of Operations
Order No. 2-65, USCOMDOMREP

Copy No
USCOMDOMREP
Santo Domingo, D.R.
DL 041424
081500R June 1965
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Appendix 1 (Medical) to Annex M (Logistics) to OPORD 2-65

1. (U) GENERAL SITUATION

a. Indigenous forces. Dominican and foreign nationals other than those of the Inter-American Peace Force (IAPF) and the Organization of the American States (OAS) are to be treated in local civilian or military hospitals. Such individuals, if admitted to IAPF medical facilities, are to be evacuated to local hospitals as soon as medically feasible. Ambulance support for this evacuation may be obtained by calling Dominican Red Cross (Phone 9-4288). Major hospitals available for local support are:

- (1) Orthopedic cases - Dr. Dario Contreras Hospital, Coord: 088439, Phone: 9-1173
- (2) Maternity cases - Nuestra Senora de la Altagracia Maternity Hospital (formerly Julia Molena Hospital), Coord: 040426, Phone: 2-8116.
- (3) Pediatric cases - Robert Reid Cabral Childrens Clinic (formerly Angelita Childrens Clinic), Coord: 024403, Phone: 3-1111.
- (4) General medicines and surgery cases - Moscoso Puello Hospital, Coord: 048457, Phone: 2-8016.
- (5) General medicine and surgery - Aybar Hospital (formerly William Morgan Hospital), Coord: 059448, Phone: 2-2934.
- (6) General medicine and surgery - Gautier Hospital, Coord: 023447, Phone: 2-6071.
- (7) General medicine and surgery - Padre Billini Hospital, Coord: 061423, Phone: 2-2833.
- (8) Military cases - Lithgow Cearo Military Hospital (formerly Professor Marion Hospital), Coord: 035412, Phone: 2-6038.

b. Friendly forces.

- (1) Government of Brazil Forces provide primary medical care to individuals organic to their units.
- (2) Government of Honduras Forces provide primary medical care to individuals of their own units and to individuals of the Government of Nicaragua Forces.

Appendix 1 (Medical) to Annex M (Logistics) to OPOD 2-65

(3) Womack Army Hospital, Fort Bragg, N.C., is primary receiving unit for U.S. patients evacuated to United States from Dominican Republic.

(4) Ramey Air Force Base Hospital, Puerto Rico, is primary receiving hospital for patients requiring immediate medical or surgical care beyond the capability of USFORDOMREP medical facilities.

(5) Rodriguez Army Hospital, Puerto Rico, has been designated to receive selected casualties requiring emergency surgical care not available at Ramey AFB Hospital.

(6) COMPHIBGRU 4 provides primary medical care for forces embarked. May provide for seaward evacuation of casualties in the event of necessity.

(7) Non-U.S., OAS and IAPF personnel will not be evacuated to CONUS. Ramey AFB and Rodriguez Army Hospitals may receive emergency cases. Medical Regulating Officer (CO, USAF Casualty Staging Facility) arranges for further evacuation of non-U.S. personnel to home country.

c. References

- (1) Msg CINCLANT 052204Z, Subject: Whole Blood.
- (2) Msg CINCLANT 161828Z, Subject: Power Pack Medical Evacuation.
- (3) Msg CINCLANT 191710Z, Subject: Whole Blood - Dom Red Cross.
- (4) Msg CINCLANT 220052Z, Subject: Whole Blood Disposition.
- (5) Hqs, XVIII Airborne Corps Medical Field SOP, 1 July 62, with changes.

2. (U) MISSION

a. Mission. To provide medical support to units and individuals of the Inter-American Peace Force and to other U.S. agencies and activities in the Dominican Republic to include general medical, limited surgical, emergency dental, preventive medicine, and food inspection services.

b. Policies and procedures. In consideration of the limited capabilities of medical units available to this Command, medical care must be restricted to military and civilian personnel of the units of the IAPF, the OAS, and to other U.S. military personnel and civilians in the Dominican Republic. Only emergency care will be rendered to foreign non-military individuals and to Dominican nationals. As a part of their Civic Action programs, units may offer outpatient medical care to Dominican nationals when it is clearly in the best interest of the United States to do so. Surgical care will be limited to that necessary for the preservation of life and limb and elective procedures will not be performed.

3. (U) EXECUTION

a. Surgeon's concept of support. Units with organic medical elements provide primary medical support to their own personnel and to adjacent

Appendix 1 (Medical) to Annex M (Logistics) to OPOD 2-65

units without organic capability. 5th Logistical Command provides ground and six ambulance and hospitalization support to all units of the Command. Air Force FORDOMREP provides Casualty Staging Facility at departure airfield and performs medical regulating activities for the Command.

b. Hq Co, XVIII Abn Corps, operates aid station in Juaragua Hotel in support of Hqs, USFORDOMREP; Special Troops, 50th Signal Bn; Det #3, 16th AW sqdn; Prov Signal Det of 507th Tactical Control Group, USAF; Hqs, IAPF; USMAAGDOMREP; 7th SFG (Abn); and 1st Psy War Bn. Provides Front-Line Ambulance and aidman on stand-by duty at Hqs, USFORDOMREP daily between the hours of 0800 and 1700 (Surgeon's Section).

c. 5th Log Command provides evacuation and hospitalization to all units and commands. Establishes 15th Field Hospital (1-Hospitalization Unit) in Dominican Naval Academy Compound at Coord: 075419. Maintains a minimum of two (2) ambulances on-call at Hqs. USFORDOMREP Aid Station (Telephone JUARAGUA Extension 427) for evacuation of casualties from the aid stations of Government of Honduras Forces, USFORDOMREP, 229th AH Bn, Government of Brazil Forces, and other elements in the International Safety Zone (ISZ) to the 15th Field Hospital. Provides primary medical support to 503rd MP Bn and Government of Costa Rica Forces. Provides a minimum of one (1) ambulance on stand-by at each functioning clearing station, 82nd Abn Div to provide evacuation to the 15th Field Hospital. Maintains a minimum of one (1) ambulance and two (2) aidmen with individual aid kits at Fair Grounds logistical base area. Maintains a minimum of one (1) HU-1 aircraft of the 54th Med Det on stand-by at 15th Field Hospital to provide emergency air evacuation from the ISZ to 15th Field Hospital. Pick-up point, USFORDOMREP Headquarters Compound.

d. USFORDOMREP provides Casualty Staging Facility (CSF) at departure airfield, furnishes medical regulating support for all patients being evacuated through their station, and acts as whole blood receiving, storage, distribution, and accounting center for all OAS forces.

e. Reports. Each medical facility will report immediately by telephone to the Surgeon, USFORDOMREP, Phone DRAGON 216/218, any medical incidents likely to be of interest to the Commander or to higher headquarters. Such incidents will include deaths in the station, serious illness or injury of senior officers and other VIPs, accidents or combat action involving multiple casualties, epidemic disease incidence, or the occurrence of unusual disease entities.

4. (U) MATERIAL AND SERVICE

a. Supply directives.

(1) 5th Logistical Command Medical Supply Letter of Instructions #1, 17 May 65.

(2) 545th Medical Detachment (Sup) Authorized Stockage List, 17 May 65.

Appendix 1 (Medical) to Annex M (Logistics) to OPORD 2-65

(3) 5th Logistical Command Medical Supply Letter of Instructions #2, 18 May 65.

(4) 5th Logistical Command Medical Supply Letter of Instructions #5, 29 May 65.

b. Medical Supply

(1) All units maintain prescribed loads of medical supplies and equipment through replenishment requisitions to 545th Medical Detachment (Sup), 5th Logistical Command. Units will not return to home stations with depleted stocks.

(2) All units maintain allowances prescribed in TA 8-100.

(3) Units will ensure that each man is issued six (6) Chloroquine-Primaquin tablets prior to departure from Dominican Republic together with instructions that tablets are to be taken on a one-a-week basis for the six (6) weeks following departure.

(4) Requisitions for replenishment of supplies used in Civic Action support of Dominican nationals will indicate that supplies requested are for Civil Relief.

c. Salvage medical equipment and supplies turned in to 545th Medical Detachment (Sup).

d. Captured medical supplies, civil or military, will not be used in U.S. medical facilities but will be reported to Surgeon, USFORDOMREP, for disposition through Dominican Red Cross channels.

e. Transportation. U.S. military ambulances will not be used outside the ISZ and the LOC. Transportation of casualties outside the zone and transportation of non-IAPF personnel will be by ambulances of the Dominican Red Cross (Phone 9-4288) or of other local hospitals and agencies. All ambulances, both military and civilian, will be given priority consideration at traffic control points.

f. Preventive medicine.

(1) Hqs, USFORDOMREP Medical Bulletin No 1, 12 May 65.

(2) Hqs, USFORDOMREP Circular No 40-12, Subject: Redeployment Physical Evaluation, 6 June 65.

(3) U.S. military personnel will avoid all contact with parrots and all birds of the parrot family. Because of their frequent infection with Psittacosis, an acute generalized infectious disease of viral origin, such birds may not be imported into the United States or any of its' territories.

(4) Units will ensure that all personnel maintain current all immunizations required by USCONARC Standing Logistical Instructions and by

Appendix 1 (Medical) to Annex M (Logistics) to OPORD 2-65

AR 40-562. Immunization Records of all personnel will be screened for Smallpox vaccination. Individuals whose records do not positively indicate a valid vaccination within the past 12 months will be revaccinated as many times as necessary until a clearly positive "take" is obtained.

(5) 714th Preventive Medicine Unit conducts sanitary surveys and analyses on a mission basis. Units desiring preventive medicine assistance or evaluation contact the Medical Section, 5th Logistical Command, Phone: LOGGER 259.

(6) All personnel will sleep under mosquito nets to reduce chances of infection with malaria, dengue, or other mosquito borne diseases. Units without nets will requisition same from 5th Logistical Command.

g. Veterinary services. Veterinary services are very limited and confined largely to food inspection requirements. A small pound is available to confine animals under observation for rabies and the facilities of the Tropical Medicine Research Laboratory, Puerto Rico, are available to this Command to examine specimens for rabies. Individuals who have been bitten and who have captured or killed the offending animal, contact the Medical Section, 5th Logistical Command (Phone LOGGER 259) for disposition instructions.

5. (U) MEDICAL EVACUATION AND HOSPITALIZATION

a. Evacuation.

(1) Evacuation Policy. Division clearing stations - 72 hours. Field hospital - 15 days.

(2) Evacuation of U.S. military, IAF military, and other U.S. and foreign nationals through U.S. Air Force Casualty Staging Detachment, San Isidro Airport. CO, USAF Casualty Staging Facility (CSF) is medical regulating officer for all IAPF forces in Dominican Republic. Parent services lose control of individuals upon admission to CSF.

(3) Previous policy of evacuating personnel bitten by animals is rescinded. Such patients will be held in DOMREP and treated by 15th Field Hospital.

b. Hospitalization. Civilians, other than U.S. and OAS personnel, will be hospitalized under emergency circumstances only. Such individuals will be transferred to local medical facilities as soon as medically feasible.

6. (U) MISCELLANEOUS

Standard medical reports required by current Army Regulations will be forwarded through channels to USFORDOMREP. These include Outpatient

Appendix 1 (Medical) to Annex M (Logistics) to OPORD 2-65

Reports, Beds and Patients Report, Morbidity Reports, Command Health Reports, and the Daily Medical Report required by CINCLANT.

PALMER
Lt Gen

Distribution: Annex Z

OFFICIAL:

HOLLSTEIN
J-4

APPENDIX I

Medical Annex to Logistical Operating Instructions

ANNEX F (MEDICAL) TO LOI

1. (U) References:

- a. Unified Action Armed Forces (JCS Pub #2).
- b. Joint Logistics and Personnel Policy and Guidance (JCS Pub #3).
- c. USCONARC Pamphlet No 700-1.
- d. DA message 722634 DTG 0612109Z July 1965, subject: Logistics Support Policies for Inter-American Peace Force (IAPF).
- e. DA Letter dated 19 July 65, subject: Conference - 21 through 22 June 65, DOMREP.
- f. CINCLANT 091740Z June 65, subject: Medical Care Non U. S. Personnel of IAPF.
- g. USCOMDOMREP USFDR MD 8026 DTG 081633Z Sep 65, subject: Whole Blood Supply.
- h. CINCLANT 101802Z Sep 65, subject: Whole Blood.

2. (U) General.

- a. USCOMARDOMREP is responsible for medical, dental and veterinary services for all US Army Personnel and Inter-American Peace Force personnel.
- b. All phases of medical service will conform to provisions of the 1949 Geneva Convention.
- c. Joint utilization of medical facilities and inter-service agreements for medical support are authorized to avoid unnecessary duplication of resources.
- d. USCOMDOMREP Surgeon will receive and coordinate requirements and monitor the handling and distribution of whole blood. The Whole Blood Program is to be administered as outlined in reference g, and approved by reference h.

e. USCOMARDOMREP will direct the establishment of a MRO. MRO will coordinate with CINCLANT and ASMRO as required.

3. (U) Hospitalization. Casualties requiring hospitalization beyond the specified evacuation policy, as established by CINCLANT will be evacuated to CONUS as soon as medically practicable.

4. (U) Evacuation.

a. Evacuation policy is 30 days. Changes in evacuation policy will be as recommended by CINCLANT.

b. Evacuation will be by air, when available, unless medically or tactically infeasible.

c. Emergency evacuation of special cases, beyond the capability of medical facilities in DOMREP, to Rodriguez Army Hospital or Ramey AFB is authorized. Emergency evacuation of IAPF personnel will be in accordance with reference f.

5. (U) Preventive Medicine.

a. A vigorous preventive medicine program for the protection of the health and well-being of all personnel will be maintained.

b. Immunizations will be maintained current and in accordance with USCONARC Pamphlet No 700-1, "USCONARC Standing Logistical Instructions."

c. Malaria Suppressive Measures. Chloroquine-primaquine phosphate tablets (FSN 6505-753-5043) will be administered to each individual in accordance with USCONARC Pamphlet No 700-1.

d. Water Supply. Only engineer supplies or medically approved water will be utilized for drinking, cooking, bathing, and laundering. Water at engineer supply points will have a minimum of chlorine residual of 5 parts per million after 30 minutes contact time; water of user level will have a minimum of 3 parts per million.

e. Appropriate measures for vector control will be instituted and strictly adhered to by all units as prescribed in USCONARC Pamphlet No 700-1 and AR 40-5.

f. Appropriate measures will be instituted for the prevention of heat casualties.

g. Food and Beverages. No food or beverages will be consumed other than those issued for military consumption or obtained from medically approved sources. Ice will be utilized only from sources inspected and medically approved.

6. (U) Medical Assistance to Civilians.

a. Medical care for US Nationals employed by or attached to US Army Forces will be provided by USCOMARDOMREP.

b. Medical assistance to indigenous civilians may be rendered in emergencies within the capabilities of medical facilities, providing such action does not interfere with or adversely affect the readiness or effectiveness of USCOMARDOMREP. The medical care rendered to these personnel will not exceed the customary standards.

7. (U) Personnel. Personnel accounting and requisitioning will be in accordance with paragraph 6 (Personnel).

8. (U) Records. Medical records will be initiated, maintained and disposed of in accordance with AR 40-400 as changed.

9. (U) Logistics.

a. Department of the Army will continue to provide logistical medical support through SMC Logistical Control Office, New Orleans direct to USCOMARDOMREP.

b. Reference 1d, applies.

c. Supply procedures will be met as outlined in reference 1e.

10. (U) Supply. Request for nonstandard medical items will be forwarded direct to Office of The Surgeon General for further supply action.

