

Chapter Seven

Humanitarian Relief and Assistance Missions in the 1970s

In the post-Vietnam era, particularly in the early days of the 1970s, many aspects of Army Nurse Corps life were less than ideal. Moreover, the war-weary American populace was firmly opposed to supporting overseas combat operations. Nonetheless, when the call came to participate in relief or humanitarian missions, Army Nurse Corps officers responded quickly and with enthusiasm. They made worthwhile contributions to the disaster relief operations in Nicaragua and Guatemala and in Operations New Arrivals and New Life. They also readily shared their expertise and acumen when asked to do so by U.S. international allies and friends.

Just after midnight on 23 December 1972, an earthquake shook the Nicaraguan capital city of Managua. Although the temblor measured in the moderate to serious range at 6.25 on the Richter scale, several factors intensified the effects of the shock and created a disaster with significant destruction and casualties. The effect of the earthquake was even more devastating because of the location of the epicenter in a vulnerable, heavily populated downtown area; the fragile mortar-and-tile construction of dwellings; the unfortunate timing, when most citizens were indoors asleep; and the ensuing fire that raged unchecked for days because of high winds and a disrupted water supply.

The Nicaraguan government immediately asked the United States to provide some measure of medical assistance because all local hospitals in Managua were destroyed. U.S. Southern Command responded to the call by deploying two field hospitals—an Air Force Tactical Hospital based at MacDill Air Force Base, Florida, and 100 beds of the Army's 21st Evacuation Hospital, garrisoned at Fort Hood, Texas.¹ General Lillian Dunlap handpicked Lieutenant Colonel Jane High to serve as chief, Nursing Service, for the 21st Evacuation Hospital Team. The Army Nurse Corps placed 23 Army nurses and 30 enlisted nursing staff from Darnall Army Hospital at Fort Hood on alert. With many personnel on holiday leave, selection of staff was complicated by concerns about reducing the fixed fa-

cility's staffing to a dangerous level. Nonetheless, by 1800 hours on 23 December 1972, the Corps had notified nearly all of the deploying personnel. Throughout the night, those deploying completed necessary preparations, such as making finance arrangements, receiving immunizations, and reviewing personnel records. Local staff issued field clothing and equipment to the minority of Army nurses who did not have such gear, but summer-weight fatigues—so important for comfort in the expected hot and humid environment—were unavailable for issue. At noon on Christmas Eve, the first of several groups of the hospital's staff and its equipment departed from Texas and arrived in Managua by dusk that same day. The first three Army nurses and a number of enlisted service members then bunked down at a staging area adjacent to the rubble of what was formerly the Managua General Hospital. Other cohorts of the 21st Evacuation Hospital arrived in Managua in subsequent sorties. The original contingent arose at 0600 hours on Christmas morning and, before eating, began erecting their tantage. By noon, the hospital was operational and admitted its first patients, two children with meningitis and a two-year-old postoperative nephrectomy patient. At the end of the first day, the inpatient census numbered 35 patients. By 1 January 1973, five wards with 20 beds each were functional. At that time, the total census averaged 49 patients per day. Army nurses worked 12-hour shifts, either from midnight to noon or from noon to midnight. This arrangement allowed both shifts to enjoy a few hours of sleep in relatively cool temperatures. After a week, High wanted to close some wards and consolidate patients so that the work shifts could be shortened. However, the hospital commander elected to maintain the status quo, feeling that closed wards would require posting guards to protect equipment and supplies from looters.

As the first week passed, several more Army nurses arrived in Nicaragua, including three officers from Reynolds Army Hospital at Fort Sill, Oklahoma. At peak, 30 Army Nurse Corps officers participated in the effort. By the beginning of the new year, Nicaraguan doctors and nurses gradually began to replace their American counterparts. The focus of the workload then shifted from the inpatient to the outpatient setting, where the ambulatory workload averaged 385 patients daily. Finally, on 5 January 1973, Health Services Command (HSC) released all Army Nurse Corps officers from the mission and redeployed them back to their home units in the continental United States.

The overall mission in Nicaragua was generally successful, although several minor setbacks surfaced. For example, the x-ray facility lacked a darkroom in which to develop film. Since the majority of patients presented with fractures, they could only be immobilized until the film could be developed. The functioning of the operating room was delayed by the need to process instruments. Essential surgical instruments, originally received in depot packs, came coated with cosmoline, a petroleum jelly-like rust preventive agent. They had to be cleaned by hand before use. The Central Material Section could not operate its autoclaves because no 220-volt cable was available. Deficiencies in all types of supplies were an added complication. Although aircraft efficiently delivered supplies as planned, the medical logistic warehouse was overwhelmed, understaffed, or dis-

organized and was unable to locate and deliver specific supplies and pieces of equipment. Furthermore, the US Southern Command was unprepared to resupply needed expendable items. Over the course of the mission, it filled only one supply requisition and responded with “due outs” for the 10 additional typewritten pages of requisitions.

The type of supplies also conflicted with the mission requirements. Although there were many pediatric and obstetrics patients, planners had included no pediatric or obstetrics supplies or medications in the original supply issue. The preponderance of the supplies naturally was geared instead to the demands of combat medicine, not disaster relief. Other deficiencies included a lack of field safes to store narcotics and valuables securely; too few military police for crowd control; limited shower and laundry facilities; and inadequate blood supplies, vaccines, water, fuel pods, generators, organic mess facilities, and vehicles. The minimal care ward was unexpectedly inundated with individuals with supportive care needs, like geriatric patients, the debilitated, the blind, and paraplegics. Caring for these patients called for adjustments in expectations, staffing, and equipment. Weather was equally trying. Dusty winds gusted constantly. Oppressive heat intensified the state of affairs.²

Although difficulties arose in the work setting, off-duty living conditions were correspondingly annoying. All 35 officers and enlisted women assigned to the unit were initially billeted in a cramped general purpose medium tent and subsisted on C-rations for the entire duration of the mission.³ Creature comforts such as personal space and appetizing meals certainly raise morale, and their absence has an equal and opposite reaction. Nonetheless, conditions in the field can hardly be expected to approach the standard of living enjoyed at home.

Despite hardships, there was some good news. The first maternity case at the hospital produced a baby girl whose parents named Christina. The news media highlighted this human interest story and labeled the operational site “Camp Christina, Fort Hood, South.” Excursions to the nearby Pacific coast beach for a few staff chosen by lottery also helped to boost spirits.⁴

Operational conditions experienced during the disaster relief operations in Nicaragua seemed to ignore the imperative for adequate preparations and provisions, a lesson relearned in the mid-1960s in Vietnam and once again promptly forgotten. The success achieved by the task force deployed to Nicaragua can be attributed in large part to the adaptability and field expedient skills of participating Army nurses and other dedicated service members and to the relatively brief mission, just under two weeks. Sad to say, the Nicaraguan experience was a microcosm of the shortcomings of the Army Medical Department (AMEDD) and the Army in the immediate post-Vietnam era.

A few years later, Army nurses received another call to provide assistance. In the spring of 1975 after the fall of Vietnam, more than 100,000 South Vietnamese fled their homes and lands in Southeast Asia, attempting to escape the threat of marauding North Vietnamese Communists. Forced to leave their country with few or no possessions, they sought refuge. In the spirit of humanitarianism, the U.S.



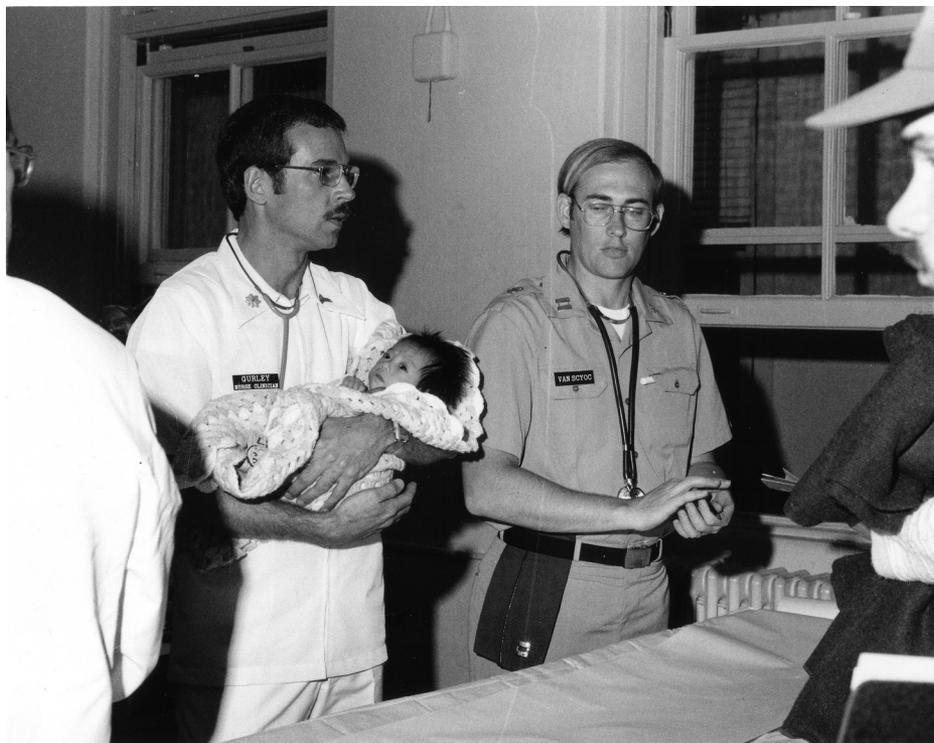
Army nurse clinician Captain Miller provides care for a newborn Vietnamese baby during operations New Life and New Arrivals. An Army physician stabilizes the baby's head while a civilian nurse shares her observations.

Photo courtesy of Army Nurse Corps Archives, Office of Medical History, Falls Church, VA.

government aided them and subsequently initiated a massive effort to resettle the displaced Vietnamese.⁵

Hence, in April 1975, Operation New Life began. At that time, the Department of Defense (DoD) established refugee reception centers at Orote Point on the island of Guam; at Fort Chaffee, Arkansas; and later at Fort Indiantown Gap, Pennsylvania, all supported by the Army. Ultimately, the Army processed 55 percent of all the refugees at the latter two sites. The Navy maintained a similar immigrant station at Camp Pendleton, California; and the Air Force was responsible for another such refugee center at Eglin Air Force Base, Florida. The center on Guam was the initial screening point for all refugees. They then were channeled to one of the four continental U.S. sites for more extensive services.⁶ Operation New Life became Operation New Arrivals on 1 May 1975.⁷

Because a large percentage of the boat people were in poor health, with many suffering from various maladies common to developing countries, DoD delegated



Army nurse clinician Major Gurley holds a Vietnamese infant while discussing the child's condition with its attentive Vietnamese parents during operations New Life and New Arrivals. An Army physician listens to the conversation.

Photo courtesy of Army Nurse Corps Archives, Office of Medical History, Falls Church, VA.

to HSC the responsibility to provide the refugees with certain health care services in the Army-sponsored centers. In all, about 97 Army Nurse Corps officers participated in the overall mission, with nine officers assigned to Guam, 50 to Fort Chaffee, and 38 to Fort Indiantown Gap.⁸ Several nurse clinicians (Army Nurse Corps nurse practitioners) participated in operations New Life and New Arrivals and provided primary care in the refugee camps. This was the first instance where the AMEDD augmented field units with advanced practice nurses.⁹

The chief of the Army Nurse Corps selected Lieutenant Colonel Jeanne Hoppe to deploy from Hawaii to serve as the chief nurse of the 1st Medical Group on Guam. With the initial flood of refugees, Hoppe was in dire straits with too few staff.¹⁰ To augment the nursing staff, she asked the Red Cross, local hospitals, and the civilian population for assistance. Many volunteers responded. As a result, Hoppe had two to three additional nurses every day, including several who were formerly medical missionary nurses in Vietnam. Transportation initially was a



Although assigned to the 702nd Medical Clearing Company on Orote Point, the westernmost point on the mainland of Guam, Army Nurse Corps officer Lieutenant Colonel Jeanne Hoppe, second from right, pauses with three medical missionary nurses. The three had formerly served in Vietnam. All of these nurses volunteered to care for refugees during operations New Life and New Arrivals. Photo courtesy of Army Nurse Corps Archives, Office of Medical History, Falls Church, VA.

problem, but one quickly resolved when the commander of the 1st Medical Group made a vehicle available, allowing Hoppe to travel to supervise staff. Originally, everyone was working 12-hour shifts. But when the flood of immigrants subsided, eight-hour shifts with days off became the routine. Patient loads included both outpatients and inpatients, with 90 percent of the latter being pediatric cases.¹¹ Hoppe assigned the medical-surgical nurses to clearing companies that treated 1,800 ambulatory patients per day at the outset of the deployment and, by June 1975, treated approximately 800 to 900 patients per 24-hour period. Although Hoppe concluded that “all the nurses . . . performed in an outstanding manner,” she expressed some dismay with the nurses’ lack of preparation to function in a field setting.¹² She observed that “TOE [Table of Organization and Equipment] training in CONUS ‘is inadequate’.”¹³ The Army mission on Guam concluded on 15 July 1975.¹⁴

HSC support at Fort Chaffee spanned from 29 April to 22 December 1975. In all, 50 Army nurses served there under chief nurses Lieutenant Colonel Velma J. Barkley and later Lieutenant Colonel Maurine Hill.¹⁵ The Fort Chaffee health care facility, which was vacant for nine years, was a wood-frame World War II

cantonment configuration with separate ward buildings connected by open-sided ramps.¹⁶ The structure had been maintained in fair condition as a contingency for future mobilizations, but it initially required extensive cleaning. Soon after the buildings were occupied, structural and engineering problems materialized.¹⁷

When First Lieutenant Stephanie Velsmid reported in to the 47th Field Hospital, which had deployed to Fort Chaffee, and helped to open the obstetrics ward, she spent the “first two days . . . cleaning and scrubbing walls and floors.” Then the exposed plumbing pipes and fixtures began to leak, and Velsmid explained that the staff spent “half the time mopping up these little puddles. Last night the ceiling pipes let loose and flooded the whole hallway!” As always, supplies were problematic. Although pitocin was available, ergotrate and methergine were somehow unobtainable. Neither were medication cards available. Velsmid took to “tearing up small pieces of paper to make med cards!”¹⁸

Meanwhile, operating room nurse Captain Diane McDermott wrote that they desperately needed 5 percent dextrose in water in liter bags for intravenous administration. Instead, they were “swamped” with saline, an unsatisfactory substitute. McDermott vowed that “someday, sometime, I’ll look back on this mission and smile; but I think it will be a long time from now.”¹⁹

On a more positive note, the hospital’s first delivery was a little girl weighing 7 lbs. and 1 oz. on 7 May 1975. At the baby’s birth, the father emotionally exclaimed, “I have lost all of my possessions but now I have gained a new joy!” Velsmid remarked that the refugees were “very kind and grateful for every little thing we do for them. Their attitude . . . is surprisingly optimistic for people who have lost family, most of their possessions, and their country.”²⁰

Conditions in the upper administrative echelons were little better than those on the ward level. As days of little irritants passed into months of ongoing hassles with no resolution on the horizon, compounded by the stress of being away from home in a situation where everyone had to make do with what little was available, conflicts and personality clashes emerged. As late as August 1975, no one assigned to the 47th Field Hospital understood the unit’s mission. With no unifying mission and no common goal, varied ends resulted in disparate means. The hospital commander refused to allow Lieutenant Colonel Maurine Hill, the 47th Field Hospital’s chief nurse, to comply with guidelines passed down from the Forces Command chief nurse. He forbade Hill to go on consultation visits to community health nurses in the Vietnamese village or to the outlying Vietnamese dispensaries. Patient care concerns and dispositions were equally difficult. One patient, diagnosis unknown, was hospitalized, probably unnecessarily, for 80 days. Several malaria patients were hospitalized for several weeks. A schizophrenic patient regularly fled the ward, causing frustration for all concerned. Several patients on the infectious ward had provisional diagnoses of tuberculosis, a dreaded disease that few of the younger nurses had previously encountered.²¹

The challenges met by the five Army Community Health Nurses (ACHNs) deployed to Fort Chaffee contributed significantly to the mission’s success. One ACHN supervised American Red Cross volunteer nurses in the initial reception

center. There both volunteers and ACHNs dispensed “advice, fluids, infant needs, and minor analgesics.” These nurses also “identified and questioned pregnant women, the elderly and disabled, and those who appeared ill.” In addition, the preventive medicine officer assigned one ACHN to each of three cantonment areas where refugees were housed. These ACHNs dealt with minor medical problems, provided care for convalescents or those with chronic illnesses, implemented case findings by seeking those who were ill but unable to reach out for help, supported epidemiologic investigations, and sponsored health education offerings. They later organized and supervised minor illness clinics in each of the three living areas and staffed the clinics with Vietnamese health professionals. The preventive medicine officer assigned the fifth ACHN to the epidemiology section. In this role, the ACHN carried out “epidemiologic surveillance and investigations.” This effort involved “collecting and tabulating medical screening, inpatient, and outpatient data; . . . providing follow-up for medical screening; . . . conducting contact tracing and interviewing; and . . . investigating disease outbreaks.” The ACHNs’ interventions yielded various positive outcomes that contributed to the atmosphere of welcome, monitored sanitary conditions, enhanced refugees’ quality of life, provided day-to-day comforts, maintained family cohesiveness, and prevented large-scale morbidity and mortality.²² The ACHNs’ role was key to the mission’s success.

In retrospect, the minor, daily aggravations of deploying to the field did not eclipse the yeoman’s service provided by those members of the AMEDD that participated in the relief mission at Fort Chaffee. In spite of daunting circumstances that persisted for 90 days for many deployed personnel, they provided high-quality health care for the 36,000-plus refugees who passed through the center.²³

When the refugee center at Fort Chaffee, Arkansas, reached its capacity of 24,000 evacuees, DoD had to find an alternate site.²⁴ On 22 May 1975, another center opened its doors at Fort Indiantown Gap, Pennsylvania, and remained in operation until 15 December 1975.²⁵ Indiantown Gap accommodated more than 17,000 refugees in World War II era barracks painted white with green trim and situated on 22,000 acres of gravel and grass in Pennsylvania’s Blue Mountains.²⁶

The 42nd Field Hospital deployed from Fort Knox, Kentucky, and initially catered to the health care needs for the population at Fort Indiantown Gap. Lieutenant Colonel Vera Nolfé served as the unit’s chief nurse.²⁷ The 42nd Field Hospital settled into the installation’s cantonment hospital building that had been mothballed since 1953. Here, too, preparations involved significant elbow grease. Major Louis Tardif, a nurse anesthetist, who deployed with the 42nd Field Hospital from Walter Reed Army Medical Center, remarked that the staff searched in storage areas there and found an operating room table and cabinets that were “basic, operational, and simple.” They scrubbed the table “down every morning, whether we plan[ned] on using it or not.” As of 20 June, the total number of operative cases included one appendectomy and several births.²⁸

Lieutenant Colonel Mary Dewan was an ACHN whose home unit also was Walter Reed Army Medical Center. On Mondays, Wednesdays, and Fridays, De-



A group of Vietnamese refugees carrying their few belongings enter their assigned living quarters at Fort Chaffee Refugee Center in Arkansas on 5 June 1975. U.S. Army photograph released by Department of Defense, Washington, DC.

wan could be found in one of two *tram te tuu dong*, or mobile health clinics, set up in an Army van. The “tailgate medicine” vans brought basic primary care to the refugee quarters that were located a few miles from the hospital. Through the doors of the vehicle, staff distributed over-the-counter preparations, helped to screen patients for common maladies, and set up clinic appointments for the refugees.²⁹ The two mobile health clinics provided assistance for an average of 700 patients daily. Fortunately, Dewan had a competent interpreter to facilitate her communications with her clients. For the remaining two days of the work week, Dewan and her associate conducted home visits to patients recently discharged from the hospital.³⁰

Forces Command and the Office of the Surgeon General agreed on a 90-day rotation policy for staff. However, the average overall time spent by the AMEDD personnel on temporary duty at the camps was 71 days. The purpose of the rotation policy was to mitigate personnel difficulties by replacing partial or total units assigned to the relief mission.³¹ Thus, as summer ended, the 15th Combat Support Hospital from Fort Belvoir, Virginia, replaced the 42nd Field Hospital.

The incoming unit subsequently reduced itself to a 10-bed holding facility and operated a community medical center for routine outpatient obstetrics, optical, and dental appointments. When a medical officer judged that a refugee required hospitalization, an ambulance transferred the patient to nearby institutions such as Hershey Medical Center in Hershey, Pennsylvania, or other hospitals in nearby Baltimore, Maryland.³² As the number of expatriates decreased and requirements for care declined, the commander refused to reduce the staff correspondingly, perhaps fearing that another influx of immigrants might overwhelm a diminished staff. Although nursing administrators felt that the facility was overstaffed, the commander insisted on maintaining a one-for-one replacement system as outgoing staff returned to their home units. With very little to do, 13 Army Nurse Corps and five Medical Corps officers remained more or less idle, a state of affairs that seemed incomprehensible to many in an era when Army Nurse Corps assets were at an all-time low.³³ Nevertheless, the 15th Combat Support Hospital stayed at Fort Indiantown Gap until the mission closed at the end of calendar year 1975.³⁴

Also among the tribulations of Fort Indiantown Gap was the emergence of a large number of cases of respiratory illness. The refugees were accustomed to the tropical climate of Southeast Asia. With impaired immune systems plus the stress of monumental change and a lifelong exposure to war and poverty, many succumbed to infectious diseases, pneumonias being the most serious.³⁵

In the final analysis, operations New Life and New Arrivals cost the AMEDD much but yielded great benefit in assisting a deserving population of displaced persons. On the debit side, financial expenditures for medical supplies, equipment, and other health care costs from the massive humanitarian enterprise totaled more than \$2.5 million in 1975 dollars, excluding personnel costs.³⁶ Effects felt in selected HSC medical treatment facilities as a consequence of the absent personnel included random increases in patient appointment waiting times, cancelled leaves for nurses, consolidated wards, and some 12-hour duty shifts for personnel. At Fort Campbell, Kentucky, the commander suspended activities of ACHNs for two weeks.³⁷ The intangible emotional losses of those that deployed and were consequently separated from their loved ones, families, and friends must not be ignored. These costs are not easily quantifiable but are a noteworthy feature of any such mission.

Overall, significant advantage came from the operation. The large-scale humanitarian assistance provided to the great masses of displaced Vietnamese refugees who were in truly dire straits ranks first. The AMEDD also learned valuable lessons about the conduct of these missions that had applicability to future, as yet unanticipated, combat missions. Operations New Life and New Arrivals tested and refined the AMEDD's emergency operation plans and highlighted areas of readiness that clearly needed improvement.³⁸ Many of those mobilized, for instance, were not Process for Overseas Rotation qualified. Furthermore, most of the senior Army nurses lacked the lightweight summer fatigue uniform. Many could not obtain these uniforms at their home stations, in which case the Academy of Health Sciences issued the uniforms to the senior officers.³⁹ Finally, participa-

tion in this disaster relief situation undoubtedly paid substantial dividends “in the peacetime mission of patient care through deepened and improved competencies in nursing practice.”⁴⁰

In a related effort, AMEDD personnel cared for hundreds of Southeast Asian orphan babies at various HSC installations in April 1975. Referred to as Operation Babylift, the humanitarian relief mission involved the air evacuation of children, mostly orphans, from Indochina after the collapse of the South Vietnamese government. The state department, DoD, and various volunteer American relief agencies collaborated to place these children with adoptive families within the United States. Along the way, nurses and other personnel at military treatment facilities cared for the infants, many of whom were suffering from a variety of illnesses, such as conjunctivitis, otitis media, skin diseases, chicken pox, malnutrition, dehydration, upper respiratory infections, and pneumonia. AMEDD personnel at Tripler Army Medical Center, Letterman Army Medical Center, Madigan Army Medical Center, Fitzsimons Army Medical Center, and Fort Benning, Georgia, cared for the children both in hospital settings and in centers outside hospitals specifically set up to house the evacuees.⁴¹

Tragically, one of the Air Force air evacuation flights that transported the Vietnamese babies crashed when taking off from Ton Son Nhut Airbase in Vietnam in April 1975. Many of the orphans and two of the medical crew died in the accident. One of those who perished in the line of duty was an Air Force flight nurse, Captain Mary T. Klinker. Operation Babylift concluded on 6 May 1975.⁴² The short-term venture was but one of many contributions made by military nurses in the name of good will and humanitarianism.

In this same period, the AMEDD once again answered the call to provide humanitarian relief assistance to earthquake victims, this time in Guatemala. On 4 February 1976, a massive earthquake measuring 7.5 on the Richter scale struck; its epicenter was approximately 38 miles east of Guatemala City. The state department originated the request for foreign medical assistance, and Forces Command, HSC, and the Office of The Surgeon General coordinated the type of support to deploy. They opted for the 100-bed 47th Field Hospital from Fort Sill, Oklahoma, as a suitable unit to participate in the mission, perhaps because the 47th Field Hospital had a considerable amount of recent field experience. Six months before the Guatemalan disaster, the 47th Field Hospital had spent four months (from April to August 1975) at Fort Chaffee providing health care for the Southeast Asian refugees. When the earthquake struck, the 47th Field Hospital was conducting a field exercise. HSC immediately put personnel on alert, and they mobilized quickly. An advance team flew without delay to Guatemala and selected the hospital site on a picnic grove at the edge of a mountain lake near Chimaltenango, a small Indian village 31 miles southwest of Guatemala City. The main echelon followed straightaway, and the 47th began operations on the evening of 6 February 1976.⁴³

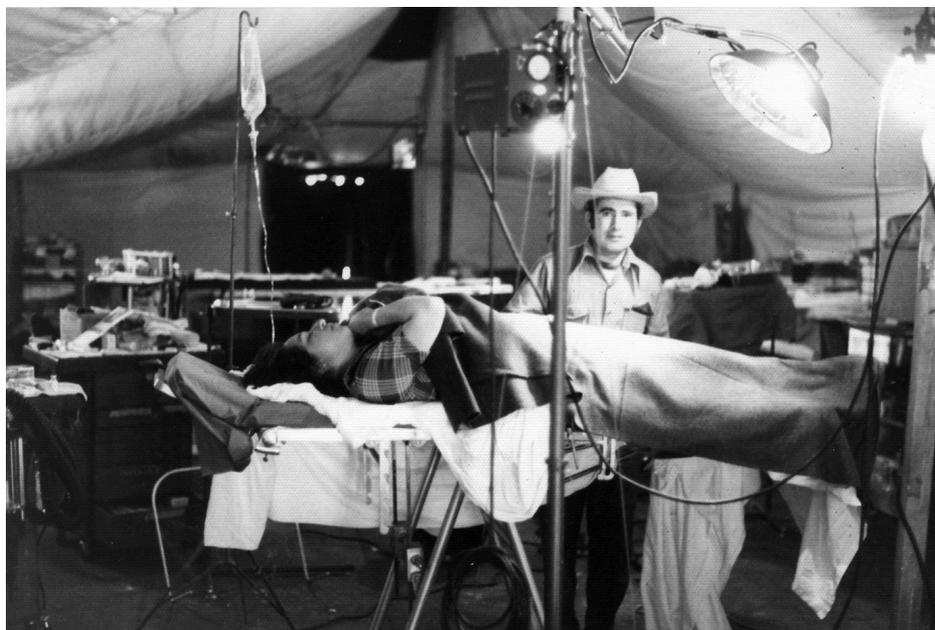
Most of the 26 Army Nurse Corps officers who joined the unit came from the Fort Sill, Oklahoma, Medical Department Activity. However, HSC pulled others,



In this photo, Captain Margaret Kulm lends a hand with a native patient who sustained crushing injuries during the Guatemala earthquake of February 1976. Although she was head nurse of the 47th Field Hospital's pediatric ward, Kulm and all the multitasking Army Nurse Corps officers who deployed to Guatemala assisted and provided care wherever help was needed. Photo courtesy of Colonel Peggy Jane Newman, Great Falls, VA.

including the chief nurse, from units at Fort Sam Houston, Texas.⁴⁴ Among the nursing personnel who deployed to Guatemala were two ACHNs who worked with the preventive medicine staff and three nurse clinicians (practitioners). Two of the three clinicians, prepared as adult ambulatory care specialists, functioned in the dispensary and were deemed "extremely effective." Little demand existed for the services of the third, an obstetrics/gynecology clinician, so she worked as a staff nurse on the obstetrics/pediatric ward.⁴⁵

The majority of casualties cared for at the tent hospital had suffered orthopedic injuries. About 30 percent of those treated carried a diagnosis of a fractured pelvis.⁴⁶ Other cases involved various crushing injuries, other fractures, and lacerations.⁴⁷ A number of babies, including a set of twins, also were delivered at the hospital.⁴⁸ Captain Margaret Kulm, head nurse on the pediatric ward, noted that a few of the newborns were premature, but all of the infants thrived. The older children on the pediatric ward bore emotional as well as physical wounds and would "often wake screaming from nightmares." Frequent aftershocks also distressed the smaller tots.⁴⁹ Reassurance and comfort played a large part in the treatment regimen of these patients.



This Guatemalan couple share a quiet moment immediately after birth of their twins at the 47th Field Hospital during the Guatemalan earthquake of February 1976. Staff observed that the period of labor was quite precarious with the new mother lying on a flimsy field bed. The sparsely equipped hospital also had only one isolette, so both newborns closely shared their first external accommodation. Photo courtesy of Colonel Peggy Jane Newman, Great Falls, VA.

A number of operational snags emerged during the mission. Supply deficits were again a major concern. Much needed items that were in insufficient quantity or nonexistent included plaster, Ace bandages, slings, x-ray film, pediatric anesthesia equipment, surgical instruments, gloves, suture, urinary drainage systems, chest tubes, intravenous fluids, needles, administration sets, and replacement light bulbs.

The unexpected cool weather precipitated other difficulties. Before deployment, the unit failed to issue any TA-50 equipment, and thus members of the 47th were not protected from the elements.⁵⁰ Captain Sandra Hamper recalled that no one had anticipated cool weather, with nights as low as 28° F and afternoons lower than 70° F, and many were uncomfortably cold.⁵¹

Public relations was among the many frustrating issues that surfaced with this mission. The chief nurse, Lieutenant Colonel Marbeth Michael, perceived a need for a public information officer in future deployments because many individuals wanting to explore the hospital appeared on the scene “and occasionally they were disrespectful.”⁵² The commander added that these individuals were major irritants. They were the “curiosity-seekers and reporters . . . and Americans who turn[ed]

up and demand[ed] to be fed because they are taxpayers.” The commander made it a policy to furnish meals for “only those volunteers who work[ed] alongside his men and women, such as two medical students and a Guatemalan woman who [was] a trained nurse.”⁵³

Cultural differences and communication problems also emerged. A throng of family members wishing to visit hospitalized victims caused substantial strife and misunderstanding. To deal with the crowds, hospital authorities asked Guatemalan soldiers to restrict entry into the hospital compound, an action that “seemed absurd to local peasants.” An American physician who had resided and practiced among the Indians in the neighboring villages for 14 years disclosed the natives’ view of the American presence. He explained that a number of families wished “to take their relatives out of the Army hospital because . . . the Americans don’t speak their language, don’t understand them and never explain anything.” This expatriate American physician allowed that the 47th Field Hospital “was ‘doing a good job’ and ‘keeping a low profile.’” Notwithstanding, he concluded that the Army “practiced a medicine unadapted to the customs and lives of the people it served.” Other observers summarized their viewpoints by stating that the American contributions to the relief effort were “overstaffed, overorganized, and slow.”⁵⁴

A total of 69 officers and enlisted medics from 19 HSC organizations deployed to Guatemala and provided disaster relief.⁵⁵ The 47th Field Hospital spent a total of 12 days in Guatemala and cared for about 700 patients, most of whom were treated on an outpatient basis.⁵⁶ Like all relief missions, it too was an amalgam of unfortunate and worthwhile components.

Although the humanitarian assistance operations of the 1970s seemed to be plagued by difficulties, they were—in the final accounting—significantly constructive. Not only did the mission provide “succor [to] countless victims of nature’s wrath who might not otherwise have received help,” but they also were a source of growth and development for the AMEDD institution and fulfillment for those who personally furnished the relief. Army historian Gaines M. Foster concluded:

Civilian emergencies provided more realistic experience in the care of mass casualties than most training exercises, and participating units learned a great deal about operating in an environment that resembled combat. Moreover, the personnel felt a sense of accomplishment that came from helping people in need and using the skills they had worked to develop. Successful disaster relief missions, in sum, improved technical skills while they increased morale and esprit. They thereby strengthened the Army Medical Department as well as aided civilians.⁵⁷

The Military Training Team (MTT) effort that involved sending two Army Nurse Corps officers to Jordan was another type of foreign assistance. The Jordanian government and the AMEDD jointly conceived and implemented the MTT to educate approximately 40 senior Royal Jordanian Medical Corps nurses in the current trends in “nursing administration, methods of instruction and hospital management and operation.” The goal of the MTT was “to provide the Jordanian nurses with enough ‘know-how’ so they [could] form their own cadre of teachers”



Two non-English speaking members of the Guatemalan protective forces flank Army Nurse Corps officers Major Nancy Nooney, left, and Captain Peggy Jane Newman, right, on the picnic grounds where the 47th Field Hospital erected its tents near Chimaltenango, Guatemala, after the February 1976 earthquake. The local militia guarded the hospital compound.

Photo courtesy of Colonel Peggy Jane Newman, Great Falls, VA.

to pass on their acquired knowledge and skills.⁵⁸

The Army Nurse Corps selected two officers, Colonel Marian C. Barbieri and Major Mary Lou Spine, to participate because of their extensive backgrounds in the education of military nurses.⁵⁹ They departed from their respective home stations, Fort Dix, New Jersey, and Letterman Army Medical Center, California, on 14 November 1976 for orientation at HSC, Fort Sam Houston, Texas, from 15 to 19 November 1976.⁶⁰ Then they went to Jordan, arriving in Amman on 21 November 1976.⁶¹ The two settled into their lodging, a spacious but no-frills second-floor flat, and began their work as expeditiously as possible.⁶²

Barbieri and Spine spent an initial assessment period observing at the Princess Muna College of Nursing (a three-year diploma program and an 18-month practical nurse course), at the King Hussein Medical Center, at the 1st and 2nd Field Hospitals, and at the Amman Military Hospital. After the initial assessment process, the two U.S. Army nurses presented several iterations of a two-day lecture

series on the basics of nursing administration and principles of teaching. This didactic program was followed by a practicum geared to the individual needs of the particular faculty and staff members.⁶³ By February 1977, the two made other significant contributions, such as assisting the Jordanians to write job descriptions and administrative procedures and helping their hosts to restructure the existing nursing department. They also were setting up a staff development program and helping the college faculty to implement a new curriculum.⁶⁴ As of March 1977, Barbieri and Spine had prepared suggestions for the professional development of members of the Royal Jordanian Nurse Corps. These recommendations included tentative plans for Jordanian Army nurses to participate in observer training programs with selected counterparts in the U.S. Army Nurse Corps and in educational offerings such as the operating room, intensive care, and nurse clinician courses sponsored within the United States by the U.S. Army Nurse Corps.⁶⁵ By the midpoint of the six-month temporary duty, Barbieri noted that the “feedback we do receive is our best reward and serves as an incentive to plug ahead. Our hope is to build a bit of self-confidence for . . . our counterparts. . . . We hope to encourage self-reliance.”⁶⁶ In April 1977, the pair “oriented the staff of one of the Field Hospitals to the intricacies of process audit.” They noted that they “would have preferred to do [a] retrospective audit but discovered nursing notes, if they exist, are not made a permanent part of the chart.”⁶⁷ One of the team’s final efforts was to promote and set up a supervisory level of employees in the King Hussein Medical Center hierarchy between the matron and the head nurses to improve supervision and coordination in the large, widely dispersed facility. Many of the staff were unwilling to accept this change. One new supervisor was markedly unenthusiastic because she feared “that if the need arose for her to correct” one of her assigned head nurses, “the disciplined person would complain to the supervisor’s mother.” At first the American nurses could not fathom this Jordanian nurse’s way of thinking. However, the supervisor’s concern was sincere. “In the light of the very strong family influences that prevail[ed] in this culture,” Barbieri and Spine realized that the new supervisor’s apprehension about the “possibility of someone tattling on her to her mother” was indeed a terrifying prospect.⁶⁸ The pair ironed out many similar cultural wrinkles while they were in the Hashemite Kingdom of Jordan.

The two Army Nurse Corps officers’ copious correspondence shows that their days were saturated not only with professional activities, educational offerings, and consultation, but also with various social events and extensive sightseeing. Local Jordanians, the embassy staff, and other American military families assigned to Jordan entertained Barbieri and Spine in a series of dinners, teas, receptions, and parties. They attended the Royal Jordanian Military Academy’s commencement ceremony and shopped in bazaars and souks, finding a variety of native arts and crafts. They also visited the ruins of a first-century city called Jerash, picnicked on the edge of the Dead Sea in view of the city of Jericho and the Mount of Olives, and visited Damascus and bought tablecloths. Barbieri and Spine realized a special dream when they toured Egypt and the Holy Land in

April. In their last days in Jordan, they spent some time with Bedouin families in their desert tents “to assess health needs of the nomadic tent dwellers.” In February 1977, Spine was promoted to lieutenant colonel. The Americans arranged for the promotion ceremony to take place in the Princess Muna College of Nursing with Jordanian Army dignitaries, college staff and students, and U.S. military attachés from the embassy in attendance. Barbieri and the chief of the Royal Jordanian Nurse Corps pinned the silver leaves on Spine’s uniform. A reception that followed featured “tea and sweets.”⁶⁹ Barbieri and Spine took advantage of many opportunities while serving in the Middle East, and they lived every minute of their six-month temporary duty in Jordan to the fullest.

The duo wrote in their final communiqué that they were beset “with ambivalent feelings.” They explained that although they were

. . . pleased to be returning to our family and friends on US soil, we were saddened to leave behind our foster family and newly acquired friends on desert sands. In six months we became very close with the Jordanians with whom we worked and felt that we had just reached an optimum level of productivity where concepts and ideas were beginning to be transferred into action. This phase is always the most satisfying but leave it we must with hopes that the seeds we planted take hold and continue to grow.⁷⁰

Six years later, the Army Nurse Corps provided additional support to the Jordanian Army. From 12 February to 12 March 1983, Major Annette R. Aitcheson, an Army nurse from the U.S. Army Institute of Surgical Research at Brooke Army Medical Center, Texas, advised the staff of the Jordanian Army Burn Treatment Centre. While in Amman, Jordan, Aitcheson presented lectures to Jordanian physicians and nurses on various aspects of care for “the thermally injured patient”; demonstrated specialized equipment such as the Laminar Flow Isolator, the Clinitron Air Fluidized Bed, and the IVAC infusion pump; and helped the nurses to develop policies and job descriptions. However, one of the greatest challenges for the mission arose from the fact that the Jordanian Army Burn Treatment Centre was not yet operational. Without actual burn patients, “the clinical application of the didactic and theoretical data” was impossible.⁷¹

Professional and cultural conditions Aitcheson encountered in Jordan were marked by vivid contrasts. On the one hand, some of the physical facilities were state of the art. The Queen Alia Heart Centre, for instance, was “one of the best equipped and clean” institutions that Aitcheson had ever seen.⁷² Also, the Jordanians billeted Aitcheson at a four-star hotel, a first-rate establishment that served gourmet meals, and provided her with transportation and “afforded [her] every possible courtesy and respect.” On the other hand, there was a complete “absence of Standards of Nursing Practice.”⁷³ Additionally, nursing documentation was sparse to nonexistent, and nursing care plans were not used at all.⁷⁴ When a protracted snowfall happened during Aitcheson’s visit, employees failed to report to work and staffing levels were inadequate. Those nurses already on duty were forced to work “two to three additional shifts” to maintain coverage.⁷⁵

At the conclusion of her visit, Aitcheson made several recommendations. She proposed appropriate staffing levels, training, supplies, and equipment necessary

for quality care in the Jordanian Army Burn Treatment Centre. She suggested that several Jordanian Army nurses spend three months at the U.S. Army Institute of Surgical Research to learn necessary skills for caring for critically burned patients. Finally, Aitcheson advised that a MTT consisting of a burn nurse administrator, a critical care staff nurse, and 91C licensed practical nurse revisit Jordan in the future to evaluate the “prior training” and build on these previous educational efforts.⁷⁶

One year later, a team consisting of Aitcheson, Major Kathryn Robertson, and Staff Sergeant Joe Constantine returned to Jordan and discovered numerous improvements in practice, such as the use of standard nursing care plans and evidence of better nursing documentation, both of which bore witness to the motivation and diligence of the Jordanian nurses. However, Aitcheson noted that “if the nurses write too much [on their nursing notes] then the Records Department complains and the chart must be thinned out (permanently).”

Overall objectives for this 1984 mission included striving to improve the quality of nurses notes, changing “the nurses’ attitude of patient care from a task . . . to an holistic orientation,” implementing a “multidisciplinary approach to burn care” involving physical therapy and social work in the patient care effort, and developing “a diet that will meet the increased nutritional demands of the burn injured patient.” However, some disappointment inevitably accompanied progress. Aitcheson wrote:

Everyday when we think we have a good grasp of the situation, the realities of the culture and the economic conditions rocks us on our heels. Today we had to sit down, again, and decide what it is we can and cannot change.⁷⁷

The trio of U.S. Army visitors managed some diversion and rest with a trip to Azrat, an oasis in the nearby desert, but even that adventure was rife with challenges. They attempted to camp out with a Jordanian nurse on a cold 30° F night. Aitcheson revealed that “like true soldiers we tried to brave the freezing temperature and howling winds as we huddled around the barbecue grill . . . in two and three blankets.” Eventually, however, they “packed up and spent the night in the rest house.” In the morning, the band of intrepid campers awoke to a desert dust storm. Aitcheson philosophically remarked “so much for our first adventure.”⁷⁸

Several years later Aitcheson articulated her guiding philosophy, writing:

As nurses, we each have a responsibility to assist in the growth of nursing throughout the world. Nurses in the United States can participate in developing nursing colleagues in third world nations. It is only through consistent and knowledgeable practices throughout the world that nursing will be recognized as the sole authority on nursing care.⁷⁹

Although challenges were many and progress was slow, long-term gains were significant. Much credit can be attributed to the optimism of those altruistic Army Nurse Corps officers who traveled to Jordan and shared their knowledge and expertise in spite of attendant hardships. Moreover, the Jordanian nurses’ willingness to internalize the proffered advice and their enthusiastic efforts to improve

their professional practice were laudable. Few, if any, other allied military nurses were eager to endure the trauma inherent in the professional growth process.

No Army Nurse Corps officers participated in combat operations during the immediate post-Vietnam War era. At that time, the prevailing state of affairs dictated that deployments not exceed the boundaries that defined the term 'operations other than war.' However, the more or less peaceful operations that occurred at that juncture exhibited many telling attributes. For example, the readiness planning that occurred before the deployments in the 1970s was nominal and lacking in refinements. The deficient levels of readiness were similar to those that existed just before the onset and during the early days of Vietnam and other prior wars. Army nurses coped with the deficits that were one consequence of meager planning by functioning with ingenuity and implementing field expedient strategies. In the final analysis, the missions of that time generally were successful, furnishing the required amenities and assistance to the populations they served. The deployments also profited those who provided the support and the Army organization as a whole by supplying very useful, practical field experience. Finally, the deployments triggered essential development and underscored the imperative to improve readiness planning on a regular basis. Readiness planning as an ongoing process would be acknowledged as a prime necessity in the years to come.

Notes

1. Raymond L. Coultrip, "Medical Aspects of US Disaster Relief Operations in Nicaragua," *Military Medicine* 139 (December 1974): 879–83. Gaines M. Foster, *The Demands of Humanity; Army Medical Disaster Relief* (Washington, DC: Center of Military History, U.S. Army, 1983), 168–70.

2. Jane High, "Information Copy, Nursing Service, Managua, Nicaragua Disaster." Typewritten Document (TD), 22 January 1973; and Jane High to Madelyn Parks, Handwritten Letter, 1 January 1973 (both in Army Nurse Corps Collection [ANCC], Office of Medical History [OMH]).

3. The general purpose medium tent measured 32 feet long and 16 feet wide. <http://www.imsplus.com/ims66b.html> (accessed 28 June 2005). Jane High, "Information Copy, Nursing Service, Managua, Nicaragua Disaster," TD, 22 January 1973; and Jane High to Madelyn Parks, Handwritten Letter, 1 January 1973 (both in ANCC, OMH).

4. *Ibid.*

5. Department of State, Bureau of Public Affairs, Office of Media Services, "Humanitarian Aid to Viet-Nam," News Release, 15 April 1975; and Department of State, Bureau of Public Affairs, Office of Media Services, "Indochina Refugee Resettlement," News Release, August 1975 (both in ANCC, OMH).

6. *Report of the Surgeon General United States Army Fiscal Years 1976–1980* (Washington, DC: Office of the Surgeon General, Department of the Army, 1988), 165–67. Richard R. Taylor, "Landmarks Point to Army's Future," *U.S. Medicine* 12 (15 January 1975): 46. Robert Shaw, "Health Services in a Disaster: Lessons from the 1975 Vietnamese Evacuation," *Military Medicine* 144 (May 1979): 307–11.

7. Carolyn M. Feller and Debora R. Cox, *Highlights in the History of the Army Nurse Corps, 100th Anniversary Edition* (Washington, DC: U.S. Army Center of Military History, 2000), 48.

8. *Report of the Surgeon General United States Army Fiscal Years 1976–1980* (Washington, DC: Office of the Surgeon General, Department of the Army, 1988), 165–67. The Army Nurse Corps After Action Report stated, "over 100 ANC officers participated in this mission." Virginia L. Brown, "After Action Report—Operation NEW ARRIVALS," Typewritten Disposition Form, 26 January 1976, ANCC, OMH.

9. Richard R. Taylor, "Landmarks Point to Army's Future," *U.S. Medicine* 12 (15 January 1975): 41.

10. As of 9 June 1975, seven Army nurses were in Guam. They included Hoppe; the two Army Community Health Nurses, Lieutenant Colonel Anna Frederico and Captain Mary L. Criswell, who were assigned to an epidemiology detachment, the 152nd Medical Detachment; captains June Sekiguchi and Mary F. Faupel; and first lieutenants Ollie B. Gray and Rebecca Atwood, who were assigned either to the 423rd or the 702nd Medical Company (Clearing). Jean Hoppe to Edith Nuttall, Typewritten Letter (TL), 9 June 1975, ANCC, OMH.

11. Edith Nuttall, "Nursing Activities, 1st Medical Group, Guam," Telephone Conversation Record from dialogue with Jeanne Hoppe, 6 June 1975, ANCC, OMH.

12. The MOS (Military Occupational Specialty) for Medical-Surgical Nurse at that time was 3438. Other MOSs in existence then were 3430, Nurse Administrator; 3431, Community Health Nurse; 3437, Psychiatric/Mental Health Nurse; 3442, Pediatric Nurse; 3443, Operating Room Nurse; 3445, Nurse Anesthetist; 3446, Obstetric and Gynecologic Nurse; and 3449, Clinical Nurse, or one who "functions in first level nursing care activities." The specific digits had meaning as well. The first digit, 3, indicated an AMEDD MOS. The second digit, 4, specified an ANC or AMSC officer. The final two digits identified the specialty with the ANC. Academy of Health Sciences, U.S. Army, "Nursing in Army Hospitals," Study Guide 310, 102–12, November 1974, ANCC, OMH. Jean Hoppe to Edith Nuttall, TL, 9 June 1975, ANCC, OMH.

13. Edith Nuttall, "Nursing Activities, 1st Medical Group, Guam," Telephone Conversation Record from dialogue with Jeanne Hoppe, 6 June 1975, ANCC, OMH.

14. *Report of the Surgeon General United States Army Fiscal Years 1976–1980* (Washington, DC: Office of the Surgeon General, Department of the Army, 1988), 167. *U.S. Army Health Service Command, Annual Historical Review, 1 July 1975 to 30 September 1977* (Ft. Sam Houston, TX: Historical Office, HSC, 1979), 120.

15. *Report of the Surgeon General United States Army Fiscal Years 1976–1980* (Washington, DC: Office of the Surgeon General, Department of the Army, 1988), 166–67. Carolyn M. Feller and Debora R. Cox, *Highlights in the History of the Army Nurse Corps, 100th Anniversary Edition* (Washington, DC: U.S. Army Center of Military History, 2000), 48. Edith Nuttall, "Information, 47th Field Hospital, Fort Chaffee, Arkansas," Telephone Conversation Record from dialogue with Maurine Hill, 5 August 1975, ANCC, OMH.

16. Joel C. Gaydos and others, "A Preventive Medicine Team in a Refugee Relief Operation—Fort Chaffee Indochina Refugee Camp (April–July 1975)," *Military Medicine* 143 (May 1978): 318–21.

17. Lillian Dunlap, *33 Years of Army Nursing* (Washington, DC: U.S. Army Nurse Corps, 2001), 292. James B. Dalton, "Conditions at Fort Chaffee Refugee Camp," TL, 12 June 1975, ANCC, OMH.

18. Stephanie Velsmid to Ward 7, Handwritten Letter, 8 May 1975, ANCC, OMH.

19. Diane McDermott to Lieutenant Colonel Carr, Handwritten Letter, 11 May 1975, ANCC, OMH.

20. Stephanie Velsmid to Ward 7, Handwritten Letter, 8 May 1975, ANCC, OMH.

21. Edith Nuttall, "Information, 47th Field Hospital, Fort Chaffee, Arkansas," Telephone Conversation Record from dialogue with Maurine Hill, 5 August 1975, ANCC, OMH.

22. Joel C. Gaydos and others, "A Preventive Medicine Team in a Refugee Relief Operation—Fort Chaffee Indochina Refugee Camp (April–July 1975)," *Military Medicine* 143 (May 1978): 318–21.

23. Department of State, Bureau of Public Affairs, Office of Media Services, "Indochina Refugee Resettlement," News Release, 2, August 1975, ANCC, OMH.

24. *Ibid.* Lillian Dunlap, *33 Years of Army Nursing* (Washington, DC: U.S. Army Nurse

Corps, 2001), 292.

25. *Report of the Surgeon General United States Army Fiscal Years 1976–1980* (Washington, DC: Office of the Surgeon General, Department of the Army, 1988), 167.

26. Department of State, Bureau of Public Affairs, Office of Media Services, “Indochina Refugee Resettlement,” News Release, 2, August 1975; and Ann Butler, “Waiting for Acceptance,” *Pittsburgh Press Roto* (26 October 1975): n.p., Newspaper Clipping (both in ANCC, OMH).

27. Connie L. Slewitzke, “Indian Town Gap Military Reservation,” Memorandum for Record, 21 May 1975, ANCC, OMH.

28. Vickey Mouze, “Ft. Indiantown Gap: WRAMC Personnel Doing Their Part to Improve, Restore Health of Refugees,” *The Stripe* (20 June 1975): 6.

29. OTC preparations are medications that can be purchased without a prescription. Certain cough and cold remedies, aspirin, and specific ointments are examples of OTC items.

30. Vickey Mouze, “Ft. Indiantown Gap: WRAMC Personnel Doing Their Part to Improve, Restore Health of Refugees,” *The Stripe* (20 June 1975): 6.

31. *Report of the Surgeon General United States Army Fiscal Years 1976–1980* (Washington, DC: Office of the Surgeon General, Department of the Army, 1988), 166–67.

32. John Romer, “Refugee Work: A New Experience,” *Army Times* (3 December 1975): n.p., Newspaper Clipping, ANCC, OMH.

33. Edith Nuttall, “Information from Chief Nurse, Indiantown Gap, PA,” Telephone Conversation Record from dialogue with Dorothy Nelson, 9 October 1975, ANCC, OMH. Lillian Dunlap, *33 Years of Army Nursing* (Washington, DC: U.S. Army Nurse Corps, 2001), 293.

34. John Romer, “Refugee Work: A New Experience,” *Army Times* (3 December 1975): n.p., Newspaper Clipping, ANCC, OMH.

35. Lillian Dunlap, *33 Years of Army Nursing* (Washington, DC: U.S. Army Nurse Corps, 2001), 292–93.

36. *Report of the Surgeon General United States Army Fiscal Years 1976–1980* (Washington, DC: Office of the Surgeon General, Department of the Army, 1988), 167.

37. Virginia L. Brown, “After Action Report—Operation NEW ARRIVALS,” Typewritten Disposition Form, 26 January 1976, ANCC, OMH.

38. Lillian Dunlap, *33 Years of Army Nursing* (Washington, DC: U.S. Army Nurse Corps, 2001), 294–95.

39. Virginia L. Brown, “After Action Report—Operation NEW ARRIVALS,” Typewritten Disposition Form, 26 January 1976, ANCC, OMH.

40. Academy of Health Sciences, U.S. Army, “Nursing in Army Hospitals,” Study Guide 310, 96, November 1974, ANCC, OMH.

41. Virginia L. Brown, “Impact Statement on Vietnam Orphans,” Typewritten Document, 11 April 1975; “Arrival of Sea Orphan Evacuees, Fort Benning, GA,” Memorandum for Record, 11 April 1975; Virginia L. Brown, “Information on “Operation Baby-Lift” in CONUS,” Telephone Conversation Record from dialogue with Edith M. Nuttall, 14 April 1975; Ron Taylor, “Benning’s Babes, 171 Vietnamese Orphans Find Temporary Home,” Newspaper Clipping from *Columbus (GA) Journal-Constitution*, n.p., n.d. (all in ANCC, OMH). “Operation Babylift,” *Army Times* (30 April 1975): 27.

42. Mary C. Smolenski, Donald G. Smith, and James S. Nanney, *A Fit, Fighting Force, The Air Force Nursing Services Chronology* (Washington, DC: Office of the Air Force Surgeon General, 2005), 33–34.

43. *Report of the Surgeon General United States Army Fiscal Years 1976–1980* (Washington, DC: Office of the Surgeon General, Department of the Army, 1988), 172–74.

Gaines M. Foster, *The Demands of Humanity; Army Medical Disaster Relief* (Washington, DC: Center of Military History, U.S. Army, 1983), 170–71. Richard B. Taylor, “Army’s Programs Fitted to Mission,” *U.S. Medicine* 13 (15 January 1977): 49. “Massive Quake Smashes Guatemala,” *Washington Star* (4 February 1976): A-1. “GIs Ease Quake Victims’ Pain,” *Los Angeles Herald-Examiner* (20 February 1976): A-10.

44. Marbeth G. Michael, “Nursing Service After Action Report,” TL to Thomas C. Birk, 15 March 1976, ANCC, OMH. Gaines M. Foster, *The Demands of Humanity; Army Medical Disaster Relief* (Washington, DC: Center of Military History, U.S. Army, 1983), 171. “HSC’s Medical People Help Field Hospital Care for Guatemala’s Earthquake Victims,” *HSC Mercury* 3 (April 1976): 4–5.

45. Marbeth G. Michael, “Nursing Service After Action Report,” TL to Thomas C. Birk, 3, 15 March 1976, ANCC, OMH.

46. “Five Brooke Nurses Weather Shocks, Cold to Aid Victims,” *HSC Mercury* 3 (April 1976): 5.

47. “HSC’s Medical People Help Field Hospital Care for Guatemala’s Earthquake Victims,” *HSC Mercury* 3 (April 1976): 5. Gaines M. Foster, *The Demands of Humanity; Army Medical Disaster Relief* (Washington, DC: Center of Military History, U.S. Army, 1983), 171.

48. “GIs Ease Quake Victims’ Pain,” *Los Angeles Herald-Examiner* (20 February 1976): A-10.

49. “Five Brooke Nurses Weather Shocks, Cold to Aid Victims,” *HSC Mercury* 3 (April 1976): 5.

50. TA-50 is the field equipment issued prior to deployment. It can include any number of objects, such as web gear, canteens, ponchos, and helmet liners, to name but a few crucial items. Marbeth G. Michael, “Nursing Service After Action Report,” TL to Thomas C. Birk, 1–3, 15 March 1976, ANCC, OMH.

51. “Five Brooke Nurses Weather Shocks, Cold to Aid Victims,” *HSC Mercury* 3 (April 1976): 5.

52. Marbeth G. Michael, “Nursing Service After Action Report,” TL to Thomas C. Birk, 4, 15 March 1976, ANCC, OMH.

53. “GIs Ease Quake Victims’ Pain,” *Los Angeles Herald-Examiner* (20 February 1976): A-10.

54. Gaines M. Foster, *The Demands of Humanity; Army Medical Disaster Relief* (Washington, DC: Center of Military History, U.S. Army, 1983), 171–72.

55. Spurgeon Neel, “HSC Guatemala Earthquake Assistance,” in Department of the Army, Headquarters, U.S. Army Health Services Command, *Commander’s Notes*, CG HSC Bulletin No. 4-76 (April 1976): 1, Record Group 112, Entry 452, National Archives.

56. *Report of the Surgeon General United States Army Fiscal Years 1976–1980* (Washington, DC: Office of the Surgeon General, Department of the Army, 1988), 174. Gaines M. Foster, *The Demands of Humanity; Army Medical Disaster Relief* (Washington, DC: Center of Military History, U.S. Army, 1983), 171.

57. Gaines M. Foster, *The Demands of Humanity; Army Medical Disaster Relief* (Washington, DC: Center of Military History, U.S. Army, 1983), 174–75.

58. U.S. Army Health Services Command, Public Affairs Office, “Army Nurses Depart for Jordan,” News Release No. 470, 19 November 1976, ANCC, OMH.

59. Marian C. Barbieri, Interview by Susan Steinfeld and Wynona Bice-Stephens, 10, 11, 14–16, and 19–20, 12 May 1988, U.S. Army Center of Military History, Washington, D.C., ANCC, OMH.

60. Marian C. Barbieri, “Effectiveness of Training Report (RCS CSGPO-125),” Typewritten Report, ANCC, OMH.

61. Marian C. Barbieri, "Nursing Administration and Education MTT-JO-0025-77, Interim Report—20 January 1977," Typewritten Report, ANCC, OMH.

62. Barbieri and Spine sent regular letters to Brigadier General Madelyn Parks full of candid, humorous details chronicling their circumstances, challenges, and experiences. Their letter dated 2 December 1976 tells of their hospitable welcome, spartan living conditions in a "cold water flat," erratic transportation provided by a chauffeur who carried a sidearm and spoke no English, social engagements, and their initial efforts to educate. Marian C. Barbieri and Mary Lou Spine to General Parks, TL, 2 December 1976, ANCC, OMH.

63. Marian C. Barbieri, "Nursing Administration and Education MTT-JO-0025-77, Interim Report—20 January 1977," Typewritten Report, ANCC, OMH.

64. Marian C. Barbieri and Mary Lou Spine to General Parks, TL, 2 February 1977, ANCC, OMH.

65. Marian C. Barbieri and Mary Lou Spine to General Parks, Typewritten Letter, 7 March 1977; and Marian C. Barbieri and Mary Lou Spine to Director, Royal Medical Services, JAF, "Suggested Plan for Further Education for Royal Jordanian Nursing Services Personnel," TD, 5 March 1977 (both in ANCC, OMH).

66. Marian C. Barbieri to General Parks, Handwritten Letter, 12 March 1977, ANCC, OMH.

67. Marian C. Barbieri to General Parks, TL, 1 April 1977, ANCC, OMH.

68. Marian C. Barbieri to General Parks, TL, 10 May 1977, ANCC, OMH.

69. Marian C. Barbieri and Mary Lou Spine to General Parks, 2 December 1976; Marian C. Barbieri and Mary Lou Spine to General Parks, 15 December 1976; Marian C. Barbieri and Mary Lou Spine to General Parks, 20 January 1977; Marian C. Barbieri and Mary Lou Spine to General Parks, 2 February 1977; Marion C. Barbieri to General Parks, 26 April 1977; and Marion C. Barbieri and Mary Lou Spine to General Parks, 10 May 1977 (all TLs in ANCC, OMH).

70. Marian C. Barbieri and Mary Lou Spine to General Parks, TL, 10 May 1977, ANCC, OMH.

71. Annette R. Aitcheson, "RCS CSGPO-125 (Effectiveness of Training of Mobile Training Team)," TD, 5 April 1983, ANCC, OMH.

72. Annette R. Aitcheson, "Annex (Unofficial Report)," TD, n.d., ANCC, OMH.

73. Annette R. Aitcheson, "RCS CSGPO-125 (Effectiveness of Training of Mobile Training Team)," TD, 5 April 1983, ANCC, OMH.

74. Annette R. Aitcheson to General Slewitzke, Handwritten Letter, 11 March 1984, ANCC, OMH.

75. Annette R. Aitcheson, "Annex (Unofficial Report)," TD, n.d., ANCC, OMH.

76. Annette R. Aitcheson, "RCS CSGPO-125 (Effectiveness of Training of Mobile Training Team)," TD, 5 April 1983, ANCC, OMH

77. Annette R. Aitcheson to General Slewitzke, Handwritten Letter, 11 March 1984, ANCC, OMH.

78. *Ibid.*

79. Annette R. Aitcheson, "US Army Burn Nurse Consultant Assignment Jordan," *Medical Bulletin of the US Army, Europe* 43 (September/October 1986): 45.