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1/This is the initial report of Headquarters and Headquarters Detachment, 68th Medical Group which arrived in the Republic of Vietnam (RVN) on 7 February 1966 and became operational on 1 March 1966.

ARTICLE I

SIGNIFICANT OBSERVATIONAL ACTIVITIES

2/Enemy Forces. a. The Headquarters and Headquarters Detachment, 68th Medical Group, was alerted for overseas assignment on 27 October 1965.

The next few weeks were used to complete field training, receive filler personnel, and fill equipment shortages. The main body, consisting of the Executive Office and consisting of 6 officers, 1 warrant officer, and 27 enlisted men deployed Fort Bragg, North Carolina, on 11 January 1966. The advance party consisting of the Commanding Officer and the 1st, 2nd, and aЗd Platoon Leaders departed by air on 21 January 1966. The advance party arrived in Nha Trang on 21 January 1966 and the main body on 5 February 1966 and proceeded to Bien Hoa hospital at Long Binh after one week of adjustment to the weather. In the conditions, an extensive program was initiated to prepare our personnel and our equipment for the contingency. Materials were secured for the construction of tent foundations and shelters. All labor for construction, with the exception of interior construction, was on a self-help basis. Personnel worked long, hard hours in accomplishing this task.

While the entire period of preparation and construction, manual work constituted a big part.
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14 May 1966

SUBJECT: Operational Report on 1st Platoon, 1st Co. Quarterly Period Ending (30 April 1966) (A.O. 1st Co. (1) (c))

Communications and a lack of local combat directives and guidance posed a serious problem. With the move of the platoon to the Long Binh area, a consolidated personnel section was established, utilizing clerks from all the units whose records were maintained. This consolidation greatly improved the efficiency of personnel management within the group and insured more rapid processing of personnel actions and consolidation of reports.

b. Space in the Long Binh area (near Long Binh, RVN) coordinates 21°04'59"S, 106°00'00"E, series 1701, was assigned to this unit. The area, formerly a rubber plantation, was in process of being cleared when the main body arrived.

c. The 1st Platoon, 1st Medical Battalion, a unit which was to be assigned to this group, was commanded by a Lieutenant Colonel prior to the Group Commander. As a result, the two officers established a post on 1 February 1966 on order of the Commanding General, 1st Medical Command. The Group Commander, however, when the new Group Commander returned to 0600 on emergency leave (subsequently on 197), the CO of the 3rd Medical Battalion also became CO of the Group and held both positions until 12 April 1966 when a new Battalion Commander was designated. The final result was the Group Commander who brought the unit to AH was back in his original assignment.

d. The advance party coordinated plans for the arrival of the main body, obtained that few local directives which were available from higher headquarters; requisitioned station-type property, obtained personal items of equipment for the on-coming main body, and arranged for logistical support, including engineer and signal.

e. After arrival of the main body, self-help material (e.g., lumber, nails, sandbag, engineer shovels) with which to build all tents and other construction requirements were requisitioned. The land was ready for occupancy on or about 15 February 1966. The unit immediately began constructing all tents and a shower unit. The engineers constructed the latrines. Since that time, work has continued, even to this day, to improve operating and living conditions.

f. The Group has an operational on 1 March 1966. However, there were some actions the Group took even before that date. For example, in the midst of establishing command to war recorded to lose to the request for erecting other medical units (e.g., generators, air conditioners) for 1st Medical units due to arrive in the next 10 days. Difficulty was experienced in attempting to conduct day-to-day operations while at the same time, but that is: the layout of the Group headquarters and processing medical patients through the recruiting, water distribution, and requisitioning units. The solution was to work longer hours seven days a week and 105, strength.

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17 May 1966

Subject: Operational Report on 3rd Medical Group for Quarter Period Ending
(30 April 1966) I An. Cdr-3 (M) (4)

In addition, and until the 4th Medical Group became operational in May 1966, this Group was also responsible for inter-locus medical services such as veterinary, dental, and preventive medicine for US and MACV in all of SVN.

b. There is no separate Field Army level medical service in SVN. U.S. combat and combat support units located in III and IV corps tactical zones are under Field Force Vietnam II located in long Binh. This is equivalent to a U.S. Corps type headquarters. The 6th Medical Group supports those forces with Field Army and Corps level medical service and maintains liaison with that headquarters for that purpose.

c. The 6th Medical Group provides aeromedical evacuation from unit and division level medical elements to evacuation and medical hospitals under the group. It also provides aeromedical service to combat service support units in III and IV corps tactical zones.

4.(b) Organization. a. Upon arrival in-country this Group was assigned to the 1st Logistics Command. Assigned to the group on 1 March 1966 were thirty-eight (38) units consisting of teams, hospitals, companies, and a medical battalion, MAD. To reduce the span of control units were further assigned by this headquarters to other units so that the following were directly commanded and controlled by this headquarters:

MAD 58th Medical Battalion
4th Medical Detachment (M)
93rd Medical Detachment (M)
20th Preventive Medicine Unit (Service)(Field)

3rd Field Hospital
3rd Surgical Hospital (Mobile Army)
Medical Company (Air Ambulance)
346th Medical Detachment (M)
93rd Evacuation Hospital

b. The main body of the 17th Field Hospital and the 36th Evacuation Hospital arrived in-country on 10 March 1966. The 17th Field Hospital, with one hospitalization unit, opened operation of the Navy hospital in Saigon. The 36th Evacuation Hospital moved into partially completed buildings (Butler Type) at Vung Tau. Both units began operational on 1 April 1966. The 17th Field opened with 1,000 beds. The 36th Evacuation Hospital, because of incomplete construction, opened with 50 beds, but later in April, as construction progressed, expanded to 2,000 beds. It will expand to its full capacity of 400 beds as construction, water, and power permit.

c. The 17th Field hospital was assigned to this headquarters on 1 April, 1966. While no orders have been issued to date, the 36th Evacuation Hospital will be assigned to this group.

d. On 31 March, 1966 the 6th Medical Group was relieved from assignment to the 1st Logistics Command and assigned to the Medical Service (Provisional), an interim organization until the replacement 4th Medical Group arrives in-country.

e. The 4th Medical Detachment (M), 36th Preventive Medicine Unit (Service)(Field) and the 43rd Medical Detachment (M) were relieved from assignment to this group and were assigned to the Medical Service (Provisional) on 1 April, 1966. When for this is not three units, 2nd inter-locus (both 4th Medical Group and 6th Medical Group plus) Medical Service support. This latest action reduced the Group's span of control from eleven to eight major units.
f. The Medical Company (5th Evacuation) (Provisional) a command and control unit for the medical element (a) (helicopter base) was reorganized on 1 April, 1966 to include it 2 officers and 6 enlisted men. As a result, it consisted of 1 officer and 1 enlisted man which were not sufficient to provide a paper control of four 15-bed stations.

5. (c) Operations. a. The 3rd Medical Hospital, located at Binh Dio, SVN, was deployed on 16 January 1966 to Binh Dio. It was located in II Corps Tactical Zone to support Operation大多. The hospital was placed under operational control of the 3rd Medical Group for the operation. Problems associated with this deployment: the hospital was "self-sufficient" in semi-permanent building at Binh Dio, was using mostly station-type equipment, and in general was not "mobile" as a medical hospital (mobile myst). As a result, a large amount of effort had to be expended to bring the unit up to its authorized equipment allowance. This equipment had to be literally transferred from other sources, because of the area of operations it was going into, male nurses had to be transferred in to replace the female nurses. Although the hospital is designed to be "mobile", it was less than 60% of its authorized cargo vehicles, since the unit was deployed to internally transfer six of its 25-ton cargo trucks on 15 April, 1966. These shortages were obtained by issue or internal transfer. An additional three 25-ton cargo trucks, over 50% authorization, were also loaned to the unit to transport additional expendable supplies above that authorized in the unit establishment.

b. This headquarters was taken by the 1st Medical Center to support Operation MARIAN, a search and destroy operation conducted by elements of the 1st Infantry Division in the I Corps Tactical Zone. On or about 1 April, 1966, the problems associated with this operation: the 5th evacuation hospital at Van Can, which was used to provide medical attention for the operation, just (as always) received its complement of personnel and was in the midst of construction and was not yet operational. By an all-night's work, it managed to establish 50 beds to meet the beginning site of the operation. Plans were to have an evacuation area to be provided from this point. There is no ambulance unit in Van Can except for the 2 ambulances and not to a 1st Aid Station. Therefore, 4 ambulances had to be delivered to Van Can from resources in I Corps. An officer and a 1-ton truck and a 1-ton truck with radio were delivered to Van Can for the purpose of providing an operational team to handle medical evacuations.
Subject: Operational Report on Japanese Locomotive for Quarterly Period Ending
(30 April 1926) No. C-280-28 (1) (7)

Due to support 14th Infantry Division elements (e. g., attack) in Operation Sogel, which commenced on 24 April 1926, this headquarters provided a special surgical capability made up of personnel from the 3rd Surgical Hospital, 3rd Div, and 3rd Field hospital. The team consisted of 24 personnel, including two surgeons, the general medical officer, and two specialists. This team was commanded by Major Peter Bowes, Commanding Officer, 3rd Surgical Hospital. This provisional team is being tried here for the first time. An after-action report will be submitted by major elements in order to provide a basis for evaluation of this concept. The operation was based at CH Y Mi. This headquarters also provided aero-medic evacuation from the operational area to our hospitals.

The aforementioned operations are mentioned because they required more than the normal planning, support. Routine operations supported by this Group have not been included here.

6(d) Planning. a. Because of the large number of malaria admissions in the II Corps tactical zone it was necessary to transfer, several times, 50 to 100 cases to 69th Medical Group hospitals located in III and IV Corps tactical zones. As a result of the large number of available beds, action was taken on 27 April 1926 to expand the number of operating beds. A survey made on that date indicated that the following medical treatment facilities could expand:

(1) 3rd evacuation hospital - 144 beds by moving assigned personnel in non-patient buildings to tents, or, 100 beds could be made available by double bunching assigned personnel. This was authorized on 29 April 1926. This hospital had 70 beds available; 50 were used and observed on 29 April.

(2) 5th evacuation hospital - 45 beds could be made available on 8 April 1926 by deactivating the 150-bed capacity. In addition, 50 beds could be made available on or about 1 May by utilizing the partially completed buildings on the hospital site. It was so ordered, 50 beds immediately and 50 more beds on 1 May. It is still more beds are required, and if approved by the 60th Yung Tzu Sub-base, the dispensary at Yung Tzu could be extended to 50 beds.

(3) 60th Medical Company (215). This unit is a replacement at the 60th operating 40 beds but capable of operating 80 beds. It was observed that sufficient personnel be moved to long block to set up 40 beds without reducing the 40 beds now at the loci.

(4) 11th Field hospital. This unit can expand by setting up 25 beds in its present space. It needs a new with very uncomfortable existing; 20 more beds could be set up. This, as an extreme emergency measure 60 beds could be set up under existing space outside the building but heat and flies would be a distinct disadvantage. No action was ordered at the time.

(5) 3rd field hospital. This hospital could set up 5 tents, 50

-2-4, each around the 15 patients in the space below a building. This would provide 30 beds. No action was ordered at the time.
SUBJECT: Operational report on lesions formed for quarterly period ending
(30 April 1966) 208 C.O. 179 (d) (i) (2)

(6) 3rd Surgical Hospital. This hospital could not fit up 4 tents,
CP, large, under care of 15 patients in the area around the hospital.
With nurses and 261 specialist working 12 hours a day, the personnel
shortage could be met. No action ordered at the time.

b. (1) Related to the problem of a heavy admission rate caused by
malaria, a new treatment regimen is prescribed by the director of Medical
Services, Lt. 1st Medical Center for Plasmodium falciparum malaria cases.
This regimen consists of combined anti-malarial treatment with quinine and chloroquine
as indicated: Day 1 to 4: quinine sulphate, oral 650mg every 6 hours for 4 days
(total dose 2600mg). Day 5 to 9: chloroquine, oral 250mg every 8 hours for 3
days (total dose 2250mg). Intravenous quinine can be used at the
discretion of the attending medical officer.

(2) On day 7 of the so called malaria therapy regimen, each patient
will be started on DDS (dimidium diaminidap). One tablet (25mg) will be given
daily thereafter for a period of 24 days.
(3) All patients the are clinically stable and without parasitaemia
may be discharged to duty after completion of quinine and chloroquine therapy of a
15th day of treatment. At the time of discharge sufficient tablets of DDS
will be given each patient to insure completion of the 28 day course of DDS therapy.
The remaining period of time that DDS must be taken after discharge will be
specified in writing and given to the patient upon discharge from the hospital.

(4) The above discharge procedure is also applicable to all current
convalescent malaria patients except those under a protocol evaluating a specific
malaria treatment regimen.

(5) The objective of this treatment program is to return individuals
to a duty status in approximately two weeks with full recognition that less than
52 ray radiation.

(6) At the time of discharge, a notification will be expeditiously
sent to the CO of each patient. This notice will state "(name, rank, SS, and
organization) is convalescing from malaria. He was started on a 28 day course of
DDS on (date). It is necessary for him to take one DDS tablet daily through (date).
Please take necessary action to insure his daily taking of the DDS which has
been given him. The necessity of this daily dose cannot be over-emphasized.

7. Inspection.

a. The following units were inspected by this headquarters

inspected on 23, 1st Medical Center
3rd Field Hospital - 3 April 1966
33rd Evacuation Hospital - 15 April 1966
95th Medical Battalion - 20 April 1966

b. The method of inspection by this headquarters follows this procedure:

(1) The inspection is conducted at each unit several days in advance,
for each area to be inspected,
(2) The entire inspection team meets with the staff of the inspected
unit.
14 May 1966

ADDENDUM: Operational Report on Exercise OICOM FOR quarterly period ending
(30 April 1966) No. OICOM-12 (11) (b)

(3) The Group Commander outlines the purpose of the inspection
emphasizing the Group’s desire to correct the unit being inspected.
(4) A time is selected for the exit briefing.
(5) Each inspector piles off with his counterpart of the inspected
unit.
(6) After the inspection, a copy of the completed check list
is left with the unit and one copy retained by the inspector.
(7) At the exit briefing the unit inspected is informed of the major
deficiencies uncovered.
(8) Follow-up in five days by each inspector to assure himself
that deficiencies uncovered were corrected.

8.6 Physical Security. a. The threat of the security of US personnel,
equipment and installations in South Vietnam is continuous. The threat may be in
the form of terrorist activities, civil disturbances or natural disasters.
This wide variety of hazards demand the maximum physical security measures possible
under existing conditions.

b. This headquarters is vigorously pursuing a physical security
program aimed at reaching every individual within the medical command of the
66th Medical Group. This program is being implemented by the development of
sound and realistic physical security measures. This is accomplished by:
(1) Designating an officer on order at each medical unit or installation
as physical security officer.
(2) By establishing and maintaining liaison with designated
physical security officers of higher and lower headquarters.
(3) By conducting frequent physical security surveys of all medical
units under this headquarters. These surveys are designed to evaluate the adequacy
of existing safeguards, to identify deficiencies and to determine and recommend corrective action.
(4) By developing, reviewing and updating all physical security
cds’ local securitymanual, director manual and MIB/66 security annexes.
(5) By familiarizing all personnel with the revisions of each
plan, conducting special training and by conducting a minimum of one practice
physical security exercises each month.
(6) By presenting a physical security briefing at the monthly
medical commanders conference conducted by this headquarters.

9. Organizing. a. The advance party of a unit destined for the Republic
of Vietnam should arrive approximately 30 days prior to the unit’s
arrival. This would allow time for drawing up plans for arrival of the main
body, obtaining local objectives under which the unit will operate, getting acquainted
with higher and lateral headquarters, ensuring that local medical facilities
are properly laid out, obtaining self-help material, and arranging for logistical
support including engineer and signal.
14 May 1966

SUBJECT: Operational Report on Medical Support Network for Quarterly Period Ending
(30 April 1966) (Ap 6-126-66 (A) 4)

This would require for a smooth reception, location, and establishment of the entire unit.

b. Because of the conditions of war in RVN during every unit installation highly susceptible to guerrilla attack and because of the emphasis of physical security placed by higher headquarters, it appears that a full time physical security officer should be added to Group Headquarters. This problem is not being studied at the headquarters, and if results justify, a PMG change will be submitted. The Group Physical Security Officer would be responsible for the security of Group Headquarters and for inspecting physical security plans and defensive measures of subordinate units.

c. To command and control medical units throughout a widely dispersed area, as was the case in Vietnam, is a difficult task for a Medical Battalion headquarters which can only command and control units in Corps tactical zones III and IV in Vietnam during the period May 1965 to February 1966.

Sufficient medical command and control units should be deployed initially to avoid assigning excessive numbers of units widely dispersed to a single headquarters. During 1965 medical units arrived more rapidly than did command and control headquarters.

10. [Personnel] Operating under a combat service support role has shown a deficiency in personnel allocations under 101-0-126. Although the 60th Med Cp has assumed the role of consolidation of all medical records and statistics from subordinate treatment facilities, the IC does not provide for medical records personnel, 101-712. In addition, this unit has the responsibility for monitoring the medical supply functions of subordinate units, the IC provides for a medical supply specialist, grade 8-7, 101-7610. However, this is unrealistic since several subordinate units have medical supply parents in the grade of 2-7. A modification has been submitted requesting addition of a medical records specialist, grade 6-5, 101-7610, and a medical supply expert, grade 2-7, 101-7610.

It is recommended that the IC 0-0-21 be expanded to provide these positions and that augmentations be filled prior to deployment to a combat area.

b. Due to the large number of patients requiring special diets in a section and Field Hospitals, it is recommended that a Dietitian be assigned to RVN in the capacity of a consultant to all hospital units. Recommend that cooks trained in dietary work be assigned by RVN to each hospital.

c. In the area of equipment maintenance, emphasis has been placed on commander and operator responsibilities. Since this Group Headquarters is not authorized technically qualified personnel to inspect field units, we have had to rely upon direct support personnel to perform these duties. To provide a built in capability for control, supervision, and training of assigned maintenance units, proceed that maintenance action similar to that authorized in para 60, 10-1-126, headquarters field unit battalion, field unit, headquarters and headquarters battalion, field unit, headquarters and headquarters battalion, field unit.
April 1966

d. Many difficulties have been encountered due to lack of adequate electrical construction material and insufficient generator power. In the 93rd Evacuation Hospital, interior locally produced wire fixtures and outlets were installed in the building. These installations have been unsatisfactory, resulting in overloaded circuits and short life of light bulbs and fluorescent light ballasts. These power outages could also create a critical situation in the operating room or patient treatment areas. Engineers are replacing the present wiring on an as-needed basis available.

Power generators organic to hospital units are inadequate to operate additional medical equipment, refrigeration and air conditioning or circulating fans required in this climate.

Recommend that installation of an acceptable wiring system and increased generator capacity be included in early phase of each hospital construction program.

e. Newly arrived medical units have experienced difficulties in obtaining refrigeration required to store biologicals and blood and for food service operations. Organic refrigeration is inadequate for operation in this climate. In-country authorizations provide insufficient refrigeration, however supply agencies have only responded to demands after constant pressure has been exercised.

Medical treatment facilities require air conditioning for critical areas such as operating rooms, laboratories and wards. Available air conditioners are not always adequate to needs of the units.

Recommend plans be developed thereby refrigeration and air conditioning for hospitals units be installed prior to the time the hospital becomes operational.

f. Prior to the arrival of the organization, the advance party requested all office furniture and 7A equipment on 21 January 1966, using priority 05. As of this report only two or three items have been received. Shortage of adequate file cabinets for classified documents and office machines to compile statistical reports have hindered this unit's normal operations.

According to operating logistical units, 02 and 05 priorities have been passed to their supporting logistical activities without recording demand at local level. As a result, 12 and 17 priorities may be available and should be assigned to the units in a timely manner, making the material possible on an as-needed basis of 05 priority is received.

Recommended procedures be reviewed and changes be initiated to ensure that realistic priorities are assigned to requests and that material is issued according to assigned priority.

g. Incoming hospital units usually arrive with 15 to 20 excl. and female nurses. In the past, recreation for these nurses has been very limited. Living conditions are crude, a medical facility are limited. Households furnishings are inadequate and recreational areas are non-existent in many cases.

Recommend that infirmary buildings, medical facilities and showers be created and available for occupancy upon arrival of the personal in-country. Additional items such as clothes and supplies should also be available for immediate issue upon arrival of the unit.
14 May 1966

SUBJECT: Operations Be Quiet on 13, 15. The Annual Report Quarterly Period Ending
(30 April 1966) 15 00 GMT (A-4/6)

II. (a) Communications. Because of the fixed location of Group Headquarters,
C&I communications available is not adequate to reach the combat brigade's
and division's clearing stations which may times operate past the range capability
of the radio.

Recommend three radios of at least 100 mile range capability be provided
Group Headquarters for adequate communication with each unit clearing stations.
These radios will provide ability to maintain liaison with the clearing stations
simultaneously.

MED has been admitted to provide for the additional communications.

II. (b) Location. At the present time there is an imbalance between equipment
authorized by the field equipment list and the field hospital equipment. In the
cases of the 3d Field Hospital and the 1st Field Hospital, each of the 100
equipment is equal to the unit's present mission since these units occupy permanent
locations in Saigon and are equipped with station type property as well as
clutter items from the assembly. The rest of the field items are being stored in
combat containers, placed in isolated, or internally transferred to other
medical units.

On the other hand, all medical units require additional equipment to
accomplish their assigned mission which is in excess of normal 50/0 mission.
Procedure for authorizing equipment under LDA 096-59 requires that each
set of field be justified. This generates a tremendous administrative load
and delays receipt of needed equipment.

Recommend that commanders of medical facilities in permanent or semi-
permanent situations be permitted to request required equipment and supplies
in authorized in para 7, 15 06-59.

Annex II

15. Field mobility of mobile hospitals, (Mobile Army)

(a) Need: In our current war, almost all medical units in direct
support of combat temporary locations by 50/0 hospitals located at fixed
locations. This is possible to the extent these combat units operate from a
“base camp.” However, at times the operational area is too far, from a
time-distance factor, to maintain the ability to a fixed hospital site.

(b) Advantages: Mobile hospitals (wholly or partly) mobile in order to
locate near the unit. Mobile has to obtain support combat operations. The
mobile hospitals can be set up to 100 miles from a fixed hospital site while
though operating from a “base camp.”

b. Personnel: (See necessity for stationing of medical record
facilities, Mobile 300, Mobile 400, Mobile 500, Mobile 600, Mobile 700,
to total 0-120.)
SUBJECT: Operational Report on Lessons Learned for Quarterly Period Ending
(30 April 1966) #33-0610-20 (II) (4)

OBSERVATION: Operation in a combat support area poses two additional areas of
responsibility upon a Medical Group normally not required in a peacetime
support role. These additional roles are: Consolidation of medical records
and reports and monitoring the medical supply functions of subordinate medical
treatment facilities. This C-222 can be provided for medical records
and reports only as C-4, Medical Supply Specialist, 100 TMC3.

COMMENT: Experience has shown that there is a definite requirement for a
medical records clerk, grade 3-6 and a medical supply sergeant, grade 3-7 in the
headquarters of a medical group. Table C-222 should be changed to include
personal allocations for these positions.

c. SIGN: Self-Help Construction

GUIDELINES: Upon arrival in country, units moving into permanent or semi-
permanent field locations are required to construct floors and tent frames on
a self-help basis. Since most units do not have qualified carpenters or tools,
considerable time, effort and material is unnecessarily expended to provide
satisfactory operational and billet areas. Assistance to incoming units
should include:

(1) Plans and drawings of self-help projects be provided to unit.
(2) Bill of material be provided unit.
(3) Technical engineer assistance be given to unit during initial
construction phases.

(4) That suitable lumber (new or usable damage) and nails be
stocked and made readily available for framing units.
(5) That power tools be brought with the unit or made available
upon arrival in country.

GUIDELINES: Prior to departure from CONUS, units should develop plans for
self-permanent locations upon arrival in country. They should also augment
their C-10 KIS equipment with certain hard to get items such as light fixtures,
electric outlets, and plumbing fixtures as well as other items with which they
can improvise and improve their living conditions.

Richard L. Young
MC 2/1, Medical Corps
Commanding
Operational Report - Lessons Learned, HQ, 68th Medical Group

Experiences of unit engaged in counterinsurgency operations, 27 Oct 65 to 30 Apr 66.

CO, 68th Medical Group

14 May 1966

N/A

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