INTERVIEW I

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G: --the use of chemical agents which created, I'm sure you know, a great furor at one time. CS or tear gas and CN which I think is a--produces a nauseous effect.

N: Nausea, yes.

G: In most cases, they were designed as riot control, I think, but did we get a lot of expansion treating casualties caused by these agents?

N: No, it was primarily something to get people out of holes in the ground and caves and to control riots. The effects are temporary. They don't really require a lot of treatment. There's a lot of crying and wiping of eyes, but no toxic effects.

G: I see. What about defoliants? Now, at the time did we know very much about possible aftereffects of defoliants, Agent Orange?

N: No, I don't think we did, and I'm not really all that much concerned about the herbicide Orange. We used it operationally, of course, just to clear fields of fire and to deprive the enemy of his concealment, particularly along riverbeds. And there was a whole lot of it sprayed over there to clean back the vegetation. Another use that could have been made of it was to deprive the enemy of foodstuffs, but that wasn't used there. That's another

capability, if you wanted to really get to somebody, is to destroy their food. But this was strictly a tactically designed way of protecting the troops that were moving along the river.

G: Right.

N: And the interesting side point there, I think, would be that to the United States rivers are considered a barrier, whereas to the enemy, the Viet Cong, rivers were considered to be avenues of approach. I think one of our problems was that when your barrier becomes the enemy's avenue of approach, you've got to do something in order to get better visibility, so we could observe him better and he could not be as concealed as if we just left the brush growing down to the river bank.

G: Right. Did you happen to see an article the other day about the son of Admiral Zumwalt, I believe, is suffering from a systemic sort of cancer, I think?

N: Well, with the contaminant that's in Agent Orange, the dioxin that causes the trouble, it's not good at all, it's bad news. But I don't think that the problem is anything like it's exposed in the press. My experience has been that after every war the underachievers come up with something related to the war, whether it's shell shock or whether it's gassed in World War II or whether it's battle fatigue in World War II or whether it's Agent Orange in Vietnam. We do know that Chloracne, this bad kind of acne you can get from the Agent Orange itself or from the dioxin. But all of these things about attention span, sexual performance, these things you can't quantitate. And then when the government comes out with all of these free medical attention and anybody that can go across here to Audie Murphy [Hospital] and present himself and say he was in Ranch Hand in Vietnam and he is entitled to free medical

care for anything--insomnia. And I've seen this happen after every war. There's a group of people that are having trouble making it and they always come up with something to get on the public dole.

G: What about self-inflicted wounds? I guess this is always a problem in war, isn't it?

N: Yes, it's always a problem. Shooting a left toe off, a right-handed guy, but I don't think it was any more of a problem or any big problem over there. I was more concerned about safety things, people that would have a stove explode on them or a Honda motorbike accident. And I got concerned about it because we had a policy that anyone that was evacuated offshore out of Vietnam with a battle injury would receive tour-completion credit and would not have to come back in. If we could treat him in country and turn him around and send him back to his division, okay, but if we evacuated him out, then he got tour-completion credit. And then some of the personnel people decided that that shouldn't be just for battle wounds, that should be for illnesses also. I was quite concerned about broadening the thing to include accidents and illnesses as well as combat wounds, because down at the unconscious level where people are safe or unsafe, you are developing a secondary game. So that if I wanted to be home with my family at Christmas the year that I was first there, all I had to do was to go up in the Highlands, up at Pleiku, and get malaria. And the falciparum malaria took three--well, took about forty-five days to treat. And our policy in country was thirty days. So I would get evacuated off to Japan and then my war was over; as soon as I was cured, I could come on home. Well now, how can we get people to roll their sleeves down and to use the insect repellent and put the mosquito net over them

in order to stay out there for a year, when they could ignore all of these preventive medicine things and get home for Christmas? But when the personnel general officer asked me if I could guarantee that we could prevent malaria, I had to tell him I couldn't. He said, "Well, I think if a guy goes up there, whether he gets shot by the enemy or whether he gets zapped by the mosquito, he's still a casualty up on the hill there." But this was just honest difference in opinion as to--I was concerned about providing secondary gain for anyone that did things that they shouldn't do, and a self-inflicted wound would come in there, a guy that's just had it up to here and he wants to get home. But I don't know that it was any problem. I'm not concerned with that.

G: So it turned out not to be a serious thing?

N: No.

G: Did medical people have to give testimony in cases where you suspected a wound was self-inflicted? Was that--?

N: Yes. Regulations have a set procedure where you have to appoint an investigating officer to see if the injury or the time lost from duty was due to their own misconduct. And according to article 32, investigator as he goes out as part of his dossier of information, he has to get the copy of the morning report and the hospital admission thing. There has to be a medical statement in there as to the nature of the wound and they usually want you to make some kind of a judgment as to whether it was or could have been self-inflicted or not.

G: That kind of puts some pressure on the medical--

N: It sure does. We don't mind describing the wound and how big the point of entry and the exit, but as to who shot who and then to get it worse, it can be the man's own gun. The ballistics people can track that down, but they have to clean their guns and they lean them against a tree and there's always some feasible story that they have as to how it happened. But we know, for instance, that there are a whole lot more left toes, big toes, shot off than there are right.

(Laughter)

G: Roughly in proportion to the right-handed people?

N: Yes, yes, to the population.

G: Well, it seems to me that the nature of the M-16 might discourage--

N: Yes, that may be one reason why we didn't have more of it; it wasn't worth it. Because you can't just barely shoot yourself with an M-16. You do shoot yourself.

G: Another one of the controversies of course was the drug problem in Vietnam and I guess you--did this change over time? My impression is that it wasn't so serious in the early days.

N: You're right. Interestingly enough, the American soldier is a subculture of the overall American culture, so if you compare the twenty-year-olds in Chicago or New York or Memphis with the twenty-year-olds in the army, they are pretty much the same, you know, background and culture-wise. Now, it's true that if you take this guy and he migrates over to a place like Vietnam that the drugs are more readily available over there and are less expensive over there. So even though they have the same druthers, the probability of following through and using the drug would be greater out in a place like Vietnam because

of the expediency of it, the convenience and the access to it, and the cost. But during my two tours there, it wasn't much of a problem at all, but then later when the national resolve began to falter and Vietnam became an unpopular war and the guys thought they had kind of been had, they thought the military had been sent to war all by themselves again, like in Korea. And you heard things like "War is too important to be left up to the generals." Well, I certainly agree to that.

I don't think the country should ever send the military out to fight again by themselves. The last proper war we had was World War II and the whole country went to war. My wife was a riveter out on the West Coast, had rationed shoes and you couldn't get much gasoline. But in Korea and then certainly in Vietnam, they just sent the military out there and went on about business as usual back home. So I think about 1970 when it became apparent that there was no real national resolve or national backing for the war that the kids did start the drug bit.

But I was back home then. I was deputy surgeon general and I got to watch it from the Washington level, having to set up treatment centers and evacuate them back to the States. But it wasn't that way at all up until about 1970.

G: When the problem did rise up, were things like overdoses a problem?

N: Yes. The stuff was not standard at all and then there's the hashish that's--like the heroin and cocaine, it was just all over. Sometimes it would be just talcum powder that the guys would get and pay a good price for, and inject, and other times it would be the straight stuff that hadn't been cut at all. So they had no idea at any given time how much they were

really putting in their arm. So we did have a problem there, particularly when the instance of the use went up, the frequency of the overdose would go up, too.

G: Right. How about the transmission of disease using contaminated paraphernalia, syringes and so on?

N: Yes, that was a problem and that's why I think hepatitis went up a little bit toward the end. During the two times that I was there, the 1965 to 1969 time frame, hepatitis, for instance, wasn't much of a problem. But about the time the drug problem came in, the hepatitis, particularly the kind that--serum hepatitis that you get from transfusions or from the use of contaminated needles, went up. I think there's just a normal corollary to the increased sticking of needles in arms.

G: Right.

What about this phenomenon that's called post-traumatic stress disorder? How do you read that?

N: Okay. This is a term that was popular in Vietnam for the combat-exhausted and for the shell-shocked. In World War I it was called shell shock; in World War II we called it combat fatigue or combat exhaustion, and in Korea it was called combat fatigue. The term that I always used and I prefer--it was not used in Vietnam at all--and that is acute adult situational maladjustment. The acute means that it came and it will go, and the adult means that you are a mature individual. It's not a simple sign of immaturity. And situational implies that it's environmental, external and just an overwhelming thing of a temporary nature. And then maladjustment signals that it's an adjustment thing, it's not a malfunction;

it just needs a little adjusting. So you bring them out of the line but keep them up in their unit and you give them twenty-four or forty-eight hours of rest, maybe a little barbiturate sedation, and then send them right back.

And we try to keep them forward, we try to treat them immediately, we try to treat them over a brief period of time. We never make them patients. They are always soldiers, they make up their own cots, they go to the mess hall and eat their own food. But we found out in World War II that if we evacuated them back even to clearing, back to the division level and put them in cots with sheets and had nurses that we'd lost them. Only about ten per cent would go back to the units. But if you treat them well forward so they'll expect to go back, then you are using your bonding there and they don't want to let their buddies down.

The psychology up there is very interesting. We talk about flag and country and things like that, but the primary loyalty is to the other guys in that squad and what keeps a soldier going is the feeling that he must not let the other guys in that squad down. Now, when he was pulled out of the line because he just can't take it anymore because of the acute adult situational maladjustment, is that if he comes back he feels very guilty about letting his guys down, "Now what are they going to do without me? Are they going to get killed and I'm not going to die?" So as quickly as possible, you rest the guy up and then get him back up to the unit, and we were able to get about 70 per cent of them back that way.

G: That's interesting, but what about these cases you hear about: nothing, the veteran is normal in all respects until weeks or months after he gets back and then he has--

N: Well, that's just the thing that the underachievers have after every war. They always want to go back somehow and blame it on the war, and maybe it happens in occupational medicine where they blame it on working in the plant or something like that. But in the military there's so many guys together and I guess they rub off on each other and they hear each other's stories. But there's not only a propensity to blame anything that you can't do or that happens to you bad like a deformed child or losing your job or becoming a drunkard or an addict, if you can somehow go back and base it on a fact that you were assigned overseas and you were subject to combat and some herbicide Orange and all that, I think it's all a manifestation of that. But some of them get pensions for life.

The World War II--sometimes you can look at yourself better than other people. The French treated their people--World War I--they treated their people up forward and the Brits brought their people back to England. And they had the same experience I was talking about a moment ago. The British way of bringing them back to the rear area, some of those people are still drawing pensions and they're still disabled psychiatrically. There is a condition and it does need to be treated, but I think it's a crutch, far too much. So many people are out there doing their job in the military and they don't have any of this, and you take the people that complain about it and look at their track record, it's like Charlie Brown "Why is everybody always picking on me," sort of thing.

G: It would be interesting to do a comparison with their track record before they went in the military.

N: Right. That's a good point, because you know we don't change many people after they're eighteen. When the kids come to us at age eighteen, they are pretty well set in concrete as to how they're going to cope with stress, how they're going to cope with adversity. And I'll admit, as I did on the drugs, that we provide them a more open opportunity to screw up, maybe. But the propensity to screw up was there; it came off the street with the recruit. And I think these psychiatric behavior reactions, you go back and find out that's how they acted in school, these are the temper tantrums they had when they didn't get what they wanted. And we have a propensity in the military to give things a high visibility, we dress different.

But I found the difference in the military and the civilian is more sartorial than it is real; it's more how we dress and what our customs are and how we greet one another when we pass on the street. But there's no real down-deep basic difference between the twenty-two year old guy in the army and the twenty-two year old guy working for Firestone. But we send him halfway around the world and provide him not a lot to do all the time and ready access to street drugs. We do give him a less favorable environment. But the guts of the guy is there, we don't do much. Sometimes we wish we could change them. But it's hard to change anyone eighteen years old, make them good or make them bad.

G: Maybe I don't even need to ask how you feel about judges who give juvenile offenders a choice of the army or a juvenile home.

N: No, that's a cop-out. That's just to avoid the problem. We're overcrowded in our jails and it costs a lot to keep people and the military is short on personnel and you can rationalize this around and maybe the army will make a man out of him, the family has failed, and maybe when the sergeants get hold of him, and the captains--I can see where a judge could persuade himself. And then of course the kid would rather go off in the army until he gets caught up there. He'll eventually get caught up there just like he did back home.

G: When we get finished, I want to tell you something along that line, but it doesn't need to go in here.

What do you think would have been the impact from a medical point of view of modifying the one-year tour policy into something different, say, a two-year tour or a point system or some alternative?

N: Well, I've thought a lot about that and I actually discussed it with General Westmoreland on a couple of occasions. In favor of the one-year tour is the fact that anybody can do anything for one year. In the previous wars and services it had been the duration plus six months, you know, until the war is over. But everyone that came into Vietnam knew that three hundred and sixty-five days later he was going to rotate out. Now, that was good on morale, because you don't get the frustration of no end, that's why the air force had the fifty missions. It's some kind of a target, firm, that you can work against and count the calendar.

Against it is the tremendous requirement for replacements and the fact that everyone has to get acclimatized. When people are moved over there, even without the enemy, there's the time change, you know, the jet lag and then they have to get their upper

respiratory tract infection because their viruses are a little different. And then they've got to get their diarrhea and then they always get a skin rash. And that all happens in about the first six weeks. But then they level off and they don't have much problem from then on. So you just got more people, with the one-year tour, you got more people out there sick because they're getting trained or getting acclimatized.

General Westmoreland was always very straightforward with personnel, and he said that the reason he liked the one-year tour was that it was completely fair to everyone. He said if we went to the sixteen months that we had out in Korea, or something like fourteen months, it means that somebody's going to spend two Christmases over there and somebody else is going to spend only one. So this was Westy's straightforward, honest way of dealing with things, and with the one-year tour if you get there the day after Christmas, you'll be there the next Christmas. If you got there Christmas day, then you'll be home for Christmas the next time. So that's sort of the thinking of it.

Now, when we started Vietnam we had--it was called a limited war--we only had twenty thousand troops in country when I got there. Then we went on up to something like six hundred thousand, big number. So it was pretty easy for the machine back home to support a one-year rotational policy with only twenty thousand troops. But then later it became multiple tours. So if you're going to go over there with a guarantee of serving only one year, you've got to admit that if the war continues to run, you may be back two more times for one year each. So that's the good news and bad news; the good news is the one-year tour, the bad news is if you're a career soldier you may go over there three times.

I went over twice. But I still think the one-year tour made most of the sense from the morale standpoint, and I think that was one of the several factors that kept our neuropsychiatric rate down.

We do a lot of bragging about the efficiency of our medical system in Vietnam. We had the helicopters there but we also had the medical teams on a twenty-four hour alert. So that when we brought the helicopter in with radios and we told them what type blood the guys needed, we told them exactly what surgical teams to have ready, and these people were ready just like MASH in the TV. But you couldn't expect the Southwest Methodist Hospital over here to maintain that kind of readiness forever, because these guys were out there only for one year and there wasn't anything else wholesome to do. So that's why, like MASH, everybody was there all the time ready for those helicopters. So it was a little bit different.

But I think a one-year tour is great. As far as the doctors are concerned, it was particularly, I think, beneficial, because we had seven hundred doctors in Vietnam and it went on for about ten years, I think. So we had ten times seven hundred. What is that, seven thousand physicians now seated all over the United States that know what to do when the train hits the school bus. And when they're up in Dakota and someone gets a fever, they say, "Have you traveled out of the country lately?" You know, they don't write everything off as pneumonia. Now, I'm not recommending a Vietnam-type experience as far as continuing the education for doctors, but I think this also helped with the line officers.

While it's true that combat on the Eurasian landmass would be entirely different than in Southeast Asia, we've got guys that have commanded in every grade in combat from lieutenant to general officer. The Russians have been fighting by proxy and they don't have this. Now, even though the techniques will be different, the confidence of a battalion commander over in Europe that's commanded a company out in Vietnam, it's just having done it before, pride and confidence. So I think that this is again in favor of a one-year tour instead of a small part of the army being over there for three years like in Germany. This way everybody gets to go his year and if necessary another year. I kind of liked the one-year.

G: On balance you think it's a good idea.

N: Yes, I do.

G: How hard was it to keep new doctors coming in? I mean, as you say, seven thousand physicians, and of course they had to have some training, too, because how many of them knew how to treat a gunshot wound when they arrived?

N: They usually came here to the Medical Field Service School, now called the Academy of Health Sciences out at Fort Sam. They'd train there and then they were deployed ordinarily from there right directly on out into Vietnam. Then they came back and finished up their obligation, their patriotic obligation, the rest of the two years. And we tried to get them somewhere near their homes, so they could start their real life again. We had something called the Berry Plan, because old Dr. Berry was the one that conceived of the idea where--

G: Is that B-E-R-R-Y?

N: Yes, like the berry in a raspberry.

Under this plan an individual instead of coming on in to the military because of his age, he would be exempted from coming in the military if he signed a contract, for what they called a delayed or deferred commissioning. So he would go ahead and finish his medical school and then take his residency training in whatever specialty he wanted. But then he knew at the end of that time, he had to put on a uniform and come in and do his two years. So we had a stable of people out there in the various training programs ready to come in.

But one of our major problems on that was the difficulty in making long-range projections. In combat we need a lot of surgery, we need orthopedics, neurosurgery, cardiothoracic, et cetera. Whereas in the peacetime army, it's more of a balanced thing. We need pediatricians and psychiatrists and that, so we deferred these guys for seven or eight years later. Then when it came time for them to come in, we didn't really need them. Vietnam had come and gone. So then they felt put on, that they were deferred for a valid military requirement and here we are using them out in dispensaries, in emergency rooms, because we don't need cardiothoracic surgeons. So they wanted to say it's a new ball game and let's forget the contract. So there was some moving people around.

There was a well-known physician here in town, his son went through the army program but the army didn't need him, but we were able to get him transferred to the air force and he was assigned out here at Wilford Hall. And there were cases that had to be handled like that. But when you defer, there should be a demonstrable, valid, military

requirement. But that was based on the fact that there was a war going on and by the time the six or seven years rolled by, the war went away and then we had a lot more surgeons than we needed and not enough of the other kind.

G: Right. General Westmoreland wrote that malaria was the only thing he lost sleep over.

N: Yes, it was a problem. That's the nearest thing to a medical problem we had when I was out in Vietnam. For two thousand years every November malaria goes up in the Vietnam-Thailand area. It has to do with the monsoon; it was to do with the mosquitoes and the breeding. And then the French were in there and then later the Vietnamese and they were using pesticides, but not in strength, and so a resistant strain of mosquitoes, anophelinae mosquitoes, came up that were resistant to the types of pesticides that we were using. For example, if you've got a hundred mosquitoes and then the pesticide knocks off ninety-eight of them, that leaves two super mosquitoes and they procreate a hundred more. So maybe there's four or five super mosquitoes and then you come up and spray again and the first thing you know you have selectively screened and bred a breed of super mosquitoes, where they carry the falciparum malaria which is a parasite that eats up the red blood cells.

And then we use chloroquine on that, but again in that part of the world they were not getting adequate full doses, heavy doses for ten days. They would give medicine until the fever went away. Well, again, the two super parasites procreated a hundred more super parasites and then we get rid of all the--it's like the wolves and the caribou. And then we would get rid of the weak ones and so almost in a laboratory we bred a super mosquito and

a super falciparum, so the nature of the game is to try to keep one drug ahead, one pesticide ahead and one drug ahead of the disease. Well, the mosquitoes with their mutations and their genetic functionings were getting ahead of us, so Walter Reed Army Institute of Research was busy almost full-time trying to come up with a new family.

Westmoreland worried about this so much that at one time he asked me if I thought he ought to move the 4th Division out of the Central Highlands. My reaction was that there must be a good military reason for having them in there, which it was. So we would come up with something that would reduce the malaria. Now, the Walter Reed people at that lab in Kuala Lumpur, which is over in Malaysia, and we knew ten years ahead of time that this resistance, this chloroquine resistance and the DDT resistance was coming, and that's why they were cranking out new drugs and testing them everywhere. So it wasn't like something where they'd say, "Oh, gee whiz, we're in trouble now." But General Westmoreland was concerned and when he was talking about moving a seventeen- or eighteen-thousand man division out of Highway 19, which linked the middle thing there that he was concerned. But we'd come in with something called dapsone, diphenal, disulphul--well, DDS [diaminodiphenylsulfone].

The reason I'm puzzling here is that Vice President Humphrey was out there and I was briefing him on malaria. And I hadn't realized he was a pharmacist; I knew it, I just didn't think about it. And he started pumping me about the chemical formula. But this is an interesting medicine that was used for leprosy with the French people out there, and they noticed that in the leprosariums that the patients being treated didn't get malaria, whereas

the attending personnel did. Well, instead of dismissing this as a cross protection, that leprosy protects you against malaria, they looked at the drug that was being used to treat the leprosy and fortuitously it just turned out to be good against the malaria.

So what we did was that we had a team from Walter Reed came out there and we ran a test up in the Central Highlands with the 4th Division and we added daily dapsone to the weekly chloroquine-primaquine, and we were able to reduce the incidence of malaria by 50 per cent and then the relapse rate which had been running about 20 per cent, people needing a second round, was reduced to about 5 per cent. And then the period of hospitalization was reduced from the forty-five days down to twenty-five days, which got it in under our thirty-day policy, which meant we could keep them in country and not lose them administratively by tour completion credit, if you follow what I'm saying.

G: Yes, sir.

N: So dapsone came along there and being very candid about it, General Westmoreland said, "What does this drug look like? Is it going to hack it or not?" And I said, "The numbers aren't in and the research team is over here field-testing it. It will be another thirty days." And he said, "I don't have another thirty days. Do you think it's good?" I said, "Yes, I think it's good. I think it's the way to go."

He said, "Okay. Implement." And then the team chief who later became a general officer, Tigertt, real brilliant fellow--

G: What's his name?

N: Bill Tigertt, T-I-G-E-R-T-T. He's the executive manager of the tropical medicine thing up at Johns Hopkins in Baltimore. They had just finished a meeting. Well, he was furious with me for pre-empting him, you know, his test was not over and here General Westmoreland, based on the Staff Surgeon's advice, decided to implement and use the dapsone. And now that I'm in academia sitting here looking at the committees for the protection of human subjects, we took a big risk there, because if we had taken a drug that was not approved--and you can do it overseas in a military exigency situation. But we started using, on a mass scale, a drug that had never been approved for this particular thing. But there was a war going on and we were doing a lot of other things that we wouldn't do in San Antonio over there. So fortunately as far as we know up until now the drug is all right and it's still accepted.

But General Westmoreland was very concerned about that and he was sensitive, too, because he told me a story that when he was appointed to be the COMUSMACV [Commander, U.S. Military Assistance Command, Vietnam] that he went out to Walter Reed and visited with General MacArthur. And General MacArthur was very concerned about committing U.S. troops in the jungles of Southeast Asia. He felt that they couldn't survive there, much less carry out a war there. So General Westmoreland listens very carefully to anything that General MacArthur said, and he had some real misgivings about it. Everything else went fine. All of the usual endemic diseases over there, the plague and typhus, cholera and stuff never bothered U.S. troops due to our sanitation, due to the

command emphasis on preventive medicine. But the nearest to being right that General MacArthur was was the warning about malaria.

G: Of course, he'd gone through New Guinea with. . . .

N: Yes. And our rate wasn't all that high. Our rate in Vietnam was about half of what it was in the Southwest Pacific, but then it's where it was. You might have some base units with no malaria at all and then you've got a combat battalion that's 50 per cent down with malaria. So that's what was bothering General Westmoreland.

G: Right, right.

You said you were in aviation medicine, aerospace medicine I guess is more correct. What about pilots as a special medical problem in Vietnam? Of course, there were thousands of them to deal with.

N: Well, they were there and they operated primarily out of fixed bases. That was another medical plus in Vietnam, was we had these fixed, reasonably secure bases where we had our little airfields and where we also had our hospitals; we always put our hospitals where the air centers were. Then the combat units would be as if they were on a string that was about ninety miles long. A rock and you stand here and you swing that string around, the search and destroy missions which you support them with helicopters not only medically but logistically in firepower and communications. So they played a very key role to prosecuting the war and also providing the medical support. The helicopters that I knew most about were the “Dust-off”, and they're not only an excellent way to move individual

patients quickly to the proper hospital to take care of their condition, but then they're also a tool of medical management.

I think when I was back out there on my second tour and I was the army surgeon then and commander of the 44th Medical Brigade, that I probably had more control of my resources than any other staff surgeon has ever enjoyed, because I literally had these helicopters flown by medical crews with MSC aviators that knew the medics. As a result of having those helicopters, I could use all my hospitals all the time if the surgical lag, which is the time you come in the front door until you get your turn on the table, when the surgical lag got above an hour, we would just by radio, single sideband, divert the casualties to another hospital. Or if I had an eye case, we could tell the helicopter to take him to the hospital that had the eye-team center. So I was able to use all my hospitals all the time which means that I didn't have to move them every now and then to keep them tucked up under the tail of the division. Because a patient dies in so many minutes, not so many miles, and if we could still move them that ninety miles in twenty-five minutes, it was just like in World War II having the hospital right up in the division rear area.

Whole blood is a good thing to talk about. It's very perishable and by having helicopters available we didn't have to establish whole blood depots up in each battalion aid station. And by not having to do that, we didn't need refrigerators. And by not needing refrigerators, we didn't need generators to provide the electricity to run the refrigerators to keep the blood. But we could keep the blood back at the hospital. Then as the helicopters went back and forth, they would take the proper type of blood when they went up and then

if in the old days you had hospital 1 through 5 supporting division 1 through 5, well, maybe division 1 was getting clobbered and hospital 1 was inundated and over here at division 5, hospital 5, they were playing bridge, you know, and drinking coffee. Whereas with the helicopters, it gives you a matrix there to where you can use them all all the time, so you don't need as many of them.

We found out that two orthopedic surgeons operating together can do the work of three or four if they were individually. So we didn't have to staff every hospital with one of each kind of specialty, because we had control at all times. And then the air force did a beautiful job out there. We had a grid concept, whereas the air force primarily evacuated north and south, say, from Da Nang on down to Vung Tau and Saigon, whereas the army was east or west. So we did the retail. We'd go up on the hill and get the one sucking chest wound that has to go right now and bring him over to a hospital located along the seacoast. Then we could ask the air force to come by once a day and scarf up the patients that we had been bringing across. And these patients had the same serial numbers, the same dog tags, but they were entirely different patients. The sucking chest wound, by the time he got back to the hospital and got his whole blood and was resuscitated and the wound was closed, he had to go on back maybe to Japan. But then he was not the same guy Tuesday that he was on Monday. So the two air systems really complemented each other.

Our pilots worried us a little bit about the malaria, about taking the chloroquine. And as long as the pilot was flying, or as the pilot was back at his base area, he had no problem. But at any time he could end up wearing that jungle, you know, bail out, crash.

So we went ahead and gave them the chloroquine-primaquine, but we watched them pretty close and didn't have any real problem with it.

G: How about fatigue?

N: Fatigue was a problem. A lot of it was boredom. Fatigue is real interesting, it's impossible to define and it's even more difficult to quantitate. Things that will make you tired, I might consider recreation, relaxation. And pilots are a funny bunch. To them, flying is not really stressful. Sitting here at this desk would be. Whereas to most of us, getting up and flying, particularly combat flying, is pretty stressful. And the problem I had was that the line officers, the aviation unit commanders kept wanting me to come up with a magic number of hours. And the reason they wanted me to do that was twofold. One is that everything in aviation is related to hours. You have to have two hundred hours to qualify, you have to fly four hours a month to get your pay and you have to fly a hundred hours a year to stay on flying status. You pull the engine out at five hundred hours. So everything has got to be reduced to hours. And the other reason is that if a doctor will give them a number, then they can turn around to the corporal and say, "Put a board up there and make sure none of these jocks fly more than thirty-two hours a month."

And that is an oversimplification of a much more complex problem, because things such as mess halls and sleeping arrangements, mail distribution, a letter you got from home or a letter you didn't get from home. Now these are the day-in, day-out, hourly things that commanders and supervisors should worry about. And it was making it too easy on them to give them a number, because then they're covered, you know, if they keep that number

below that number they're all right. And I never did, to my satisfaction, explain that to these guys, and they're all my buddies in army aviation.

I always located dispensaries--we had some medical detachments and we located them up at the airfields, and that was the only part of the non-divisional medical service that I didn't own in the 44th Medical Brigade. Because if the 1st Aviation Brigade had these OA medical detachments, which all had flight surgeons, then they got preferential location at the airfield. See, they were not tenant units, they belonged to the aviation command which ran the airfield and they were usually right in the same building with base operations. Whereas if I had parochially insisted on there being medical brigade units, then they would be down on the grassy strip somewhere down there.

So General Bob Williams, who commanded the aviation brigade at the time I was there, second time, he was the biggest operator of medical care outside the 44th Medical Brigade and then with my forty-four dust-off helicopters, I was the biggest operator of aviation outside of the 1st Aviation Brigade. So over the years we've fought this battle as helicopter evacuation: is this just another use of army aviation or is this a medical function which happens to involve the use of helicopters? So it depends on are you listening to the director of army aviation or to the surgeon general? Really, it's both. But we adamantly say it's a medical function and we use helicopters just like we use generators and jeeps and ambulances. The other one says no, this is just another application of army aviation. There's communication, there's fire, there's troop delivery, re-supply.

But the aviators did pretty well. There's one anecdote that a young captain that was with me at Rucker, and I sent him over and he was one of the first flight surgeons to go over. That's when we were sending one of these little medical detachments with every company of helicopters that was going over. Later when these companies became battalions and battalions became aviation groups, then we didn't send an eight-man detachment with each company. But he was there and had a big morale problem, boredom, they'd go out every night and shoot the fruit bats when they would come across the airfield going to wherever the fruit was.

And they had a problem with drinking, particularly solitary drinking among the aviators. They are feeling sorry for themselves, poor baby, and get in front of the mirror and put the bottle out there and start writing a letter home. "All the other guys went into town tonight, dear, but I'm staying home here thinking of you." So he was unable to get these guys to get out of their hooches and go to the club, where they would have the support of the other guys. So he started a rumor there in the compound that solitary drinking is a form of latent homosexuality and these guys couldn't stand up under that stigma. So he flushed them all out of the hooches. Then their buddies began to listen to them and sort of treat them and sympathize with them.

G: Starting a little creative malpractice. (Laughter) That's a good story.

N: Yes, but that was a big problem, was the sheer boredom between aviation missions, that caused us more trouble.

G: I have a parenthetical question. What is labyrinthine stimulation?

N: Oh, that is vertigo. If you're flying an aircraft and you have your semi-circular canals, you know, the ones that tell you where your head is and which way you're turning, if they are being stimulated in two different planes at the same time, that's called a Coriolis [force]. In other words, you're making a turn to the left and suddenly you think there's something up there and your head's going around with the aircraft and you look up and you get in two planes at once and then you get very nauseated. I call it Coriolis, but labyrinthine stimulation is more descriptive of what it really is. The space guys are having a lot of trouble with it.

G: I can imagine with weightlessness and so forth.

N: And you can't get them to talk much about it, about who has it and who doesn't, but they really get sick up there because you've got these little otoliths we call them, little ear stones is what the word means, and there are tips of these hairs in the labyrinth and as you turn one way or another, they lag, inertia, like a seatbelt type of inertia they lag, but they've been used to having the one G all the time. So you have that one G subtracted from whatever movement you're doing, but then suddenly when you go up there and the one G is not there to subtract, they've run into a lot of problems with it. But usually it's a learning thing. It takes them a couple of days to get over it, and it seems like it's hitting the women harder than the men. But then there haven't been that many women put up there yet. But this is another manifestation of the labyrinthine stimulation.

G: I see. We've talked about mosquitoes of course. Everybody knows what kind of a problem they were. Were other kinds of pests much of a problem?

Tape 1 Side 2

N: Potentially they were, but due to I guess our concern about it, and we had pretty heavy preventive-medicine units in there, with the scrub typhus, bubonic plague, which is the fleas and the rats. The others didn't bother us at all. Now they were in the civilian population. And in fact at one time there I was a little concerned about underreporting. I would get the hospital commanders and admonish them that we don't hide any of this stuff, we've got to get it out in the open, before we've got a real problem and don't know about it. But just didn't have it.

Rabies was another concern, because you know us soldiers like dogs. So we passed rules like one dog per company or one dog per airfield, and it was just a continuing battle but the commanders were all behind it. I think maybe I was a little higher location, but it seemed to me like there was more command concern and emphasis in Vietnam than previous wars I've been to about getting with the preventive medicine. They usually want to leave it up to the doctors and the medics. I've got to fight a war over here; you take care of all that stuff and keep me out of trouble. But over there it was from the top all the way down.

An interesting thing about plague is that plague had been a problem in the ports, in Hue and Da Nang and places like that, because the grain came out of the paddies, rice fields, and came down to the ports. And so the rodents were down there. Well, in Vietnam during the war, we began to ship them grain, so the flow of grain, instead of coming from the piedmont down to the ports was coming in through the ports and going out through

distribution channels. And rats got out into places where we hadn't had any rats before, and there was an unenlightened population, probably people with no particular resistance. But we had a high index of suspicion. And then we have a lot better drugs than we had fifteen or twenty years ago, chloramycitin and things like that to treat plague. It's not the serious disease it was in [the] Black Plague in England.

G: How about leeches? Everybody was talking maybe because they're so photogenic, I don't know, but are they any particular problem?

N: No, we had a lot of soldiers wading particularly near the Mekong Delta and down in that area, but it was not much of a medical problem. Now that you've mentioned it, I don't recall ever hearing anybody talk about it.

G: I suppose the bites might get infected, but that would be—

N: Would be all.

G: Of course, leeches were not unknown as a medical treatment at one time.

N: We used to use them to let blood.

G: What, for bruises, serious bruises? That was one way to clear them up, wasn't it?

N: Yes. One interesting problem that we ran into there with the tri-service is that the navy had the hospital ship. It was either the *Sanctuary* or the *Repose*, and Vietnam is a peninsular war. Seems like the last two wars were fought on something that looked like a scrotal sac. In Korea and Vietnam we were able to keep a hospital ship right offshore in the line with our evacs, and [in] this are seven-hundred-and-fifty-bed general hospitals. That's the good

news, because you've got something up there that you can, as the line goes back and forth in the Korea model, that will keep up there.

But periodically the hospital ship has to go back to Subic or somewhere to reprovision and for maintenance. So it would set sail. It was under the Seventh Fleet. And I would apprise General Westmoreland that we were going to lose the ***Repose*** for three or four days while it goes back and provisions and they'll take some patients back to the hospital there. Westmoreland said that "that's the only kind of hospital I ever heard of that could go AWOL," as they would just pull a ship, because their shipmaster is a line officer and he's got a medical complement with a physician. But the guy that runs the ship is the captain and his rules say that all ships have to go back and get their oil and their grease and their blower stacks cleaned.

And then another time it happened which was I think a little bad, we were going to take the marine battalion and put them ashore down at Vung Tau to come up toward Saigon to clean out some these irregular forces you've been reading about, the RuffPuffs, the Regional Forces, Popular Forces. So they wanted to bring the hospital ship off station up at Da Nang and bring it down to support this one battalion of marines that were going to be attacking toward the army's Third Field Hospital. So I objected to the navy side of the house, and was told that this was normal doctrine, that whenever they had marine amphibious landing force, they always had a hospital ship off shore supporting it. I said, "Yes, but you're usually assaulting a hostile beach where the further you go in, the further you are away from medical care. Whereas here you are attacking toward a fixed hospital."

And he said, "Oh, I want to show the mobility of this hospital ship. Every now and then we get under the gun about why do we need hospital ships." But I had to go to General Westmoreland to go to whoever he went to to get them to keep that hospital ship up there and not bring it down to support eight hundred people wading ashore. But these were the sorts of incongruities you run into.

G: I suppose he'd have had to go back to CINCPAC [Commander in Chief of the Pacific Fleet] for that.

N: Yes, Admiral Sharp.

G: How about snake bite?

N: Surprisingly, no problem. They had them in there, some real mean ones, but I guess an occasional guy got bit. Was there anything in the book about it, I don't recall—?

G: I don't recall much. That's one of the reasons I asked.

N: Well, they had these--we used to teach the troopers about the palm vipers, the little things, but they're--

G: Little green ones?

N: Little green ones that are right up here where you do this when you go through the brush. Then they had some squeezing-type snakes I used to see around the hooches there, the constrictors, boas.

G: Of course, they're not particularly dangerous to people.

N: No. And they had some fer-de-lance in there, which are pretty mean. But as far as it being a problem, I'm not aware of--

G: Did you ever see one of those big centipedes that they have over there?

N: Yes.

G: They were the scariest looking things I ever saw.

N: Yes, they were that.

G: You said that we ultimately identified about half of the fevers of undetermined origin that were reported. Have we made any progress with that in the interim?

N: Yes, we have better screening procedures for antibodies. What we would do is to take the serum, acute serum and then the chronic serum ten days later, and then we mix it with these various things like rickettsia, influenza, just the various things. And then by seeing the precipitation and everything, we are better technically at that, but I'm more at the operational level.

It's nice statistically to look back and see what it was that was in there, but you sort of treat them all the same. You know, the bed rest and good nutrition and avoid secondary infection. So it's of more research interest as to what is there in there that causes these people to have trouble. Now, we do a lot of this when we are doing a medical intelligence workup. For instance, if we are going to send a team, area-study team, into a country, say, somewhere in Africa, what we look for are the diseases that the children have. Because the U.S. troops when they go in are going to get what the children have. They're not going to get what the old folks have, because the old folks have developed all kinds of immunities and everything.

So for purposes such as this, is to go into a village and then take serum and then see what is the prevalence of the various viral type. Every year they come up with another ten or twenty of them. So we are better at that, but as far as logging somebody in and trying to get a positive diagnosis, a discharge diagnosis, to send him back to the unit, we still say FUO [Fever of Undetermined Origin]. It's a cluster of things, it's an otherwise miscellaneous, that sort of thing.

So it really is not cost-effective from the medical management standpoint, is to try to run down each one of these that's admitted. If it's malaria, you've got a specific treatment and if it's scrub typhus, you've got a specific treatment. Dengue, get into things like that, a lot of them were breakbone fever, dengue fever. By the time you get through with all your gyrations, the patient's well and you're not going to do anything different. Now, the purists say that's no way to do it, you ought to really know at all times what you're dealing with. But it gets to a point where how much time and money and other resources you want to put into coming up with a name that long for a disease that's already cured.

G: Right. Have there been any health problems among the veterans' population that seem to be unique to the Vietnam experience?

N: Well, there's this hysteria about herbicide Orange, and we do know that some of these guys that got splashed on get Chloracne. We know that the people that work out in the pesticide plants and herbicide plants get it. But when it comes down to these behavioral abnormalities and sleep disorders and things of that nature, I don't know.

And then you get the occasional deformed child, and whether they come forward faster to complain or whether there's really an increased incidence. The air force did a big study over here at Brooks under Lathrum, George Lathrum, outstanding epidemiologist, and they found, and everyone says naturally, that there was no association at all. When they took the control groups and the groups that flew the Ranch Hand missions, there's no real statistical difference, but the credibility is not there, they probably should have gone to some university somewhere and had it done by an outside agency.

There's a lot of political--a lot of these people vote; a whole lot of people went through Vietnam and they exercise a lot of political clout. So Texas even, over and above the federal assumption of responsibility, Texas saddled Dr. Bernstein in the Health Department with surveillance for people in Texas. So any doctor that comes up with anything, there's a questionnaire that's supposed to be filled out. We just keep digging the hole deeper and deeper politically, in my judgment.

But there was concern about something called melioidosis back when I was out there. That's the Vietnam time bomb. And it's a glanders-type spore that's mostly in horses, but it gets down in the soil and lies dormant. Under the right conditions, you know, the moisture and the heat and all like that, it can become active again and germinate. And there was some concern about troops out there in the paddies getting melioidosis and it may lay latent in them for fifteen or twenty years. And that's the time bomb. But it turned out to be, as of the time that I was looking into it which was ten years ago now, that there was nothing to it. It was a potential threat.

But malaria was the only thing, and we did have some secondary imported cases from that. Some kid would come back and maybe not take his six-pack, his six chloroquine-primaquines, and then he goes down into [Inaudible] County, Mississippi or something and then two or three cases of malaria sprout up. But we can usually trace that back to the index case and do something about it.

G: Right. I was going to ask about malaria relapse and that sort of thing.

N: Well, we used the six-pack and then we went up to eight, but they still call it the six-pack in the troops. This was a problem with rapid transportation. Back in my previous wars, you had time on the ship to do all this and get cleared on the way home. So the Department of Health and Human Services, they wanted us to put some kind of a quarantine but it wouldn't fly politically. They wanted us to put an incarceration camp out in California somewhere, and then when the kids flew back, you know, their tour was completed, they'd stay there from three weeks to four weeks to make sure they weren't going to come up with any of these bad diseases. But no one would tolerate that. But it was a proposal.

G: It reminds me of the British member of parliament who wanted all the soldiers coming back from India to wear a yellow band on their sleeve for a year after they were back.

N: Yes? I'd never heard that one. But this was the concern about spreading these diseases. And even on some of our armament that MPCs [Military Personnel Centers?], M-13--M--

G: 113?

N: 113. They had to be steam-cleaned and everything there at Cam Ranh Bay before we could clear them, and the Department of, well, Health again, they delegated to MACV [Military

Assistant Command, Vietnam], namely my office, the certification authority to certify these vehicles. Well, the logistics command commander there said it was holding up his war, it was taking time to do all that, and he wanted to go on and get those things out of there, because he had a quota each month. He had to send so many back to the West Coast to get refurbished. And all we needed was to get a little plague brought back in a 113 into San Francisco and be the first plague epidemic in the United States. And then they would as a minimum have withdrawn our authority to certify these vehicles clean. But we'd find pieces of human tissue in there. You know, somebody had blasted a tank and--we were interested more in rats and things like that.

G: Were rats a problem? I know we had people bitten sometimes.

N: Yes, rats were a problem.

G: Then you would have to take a series of shots, wouldn't you?

N: That's right. Any animal that you didn't catch. Around here it's the coons. Boys go out hunting coon and they get bit, you say, well, that's a provoked attack, it wasn't a wild animal attacking you. You're out on a limb and the coon bit you. But then when it comes down to writing it off, you say, "No, we better take the shots," because rabies is a bad one, they all die.

G: And then they're a lot easier to take now, aren't they, than they used to be?

N: Oh, yes. We don't have the paralysis anymore and we don't have the acute pain. They keep coming, the state of the art, they keep coming up with a better one every five years or so.

G: Who was General Westmoreland's physician, or did he have a physician *per se*?

N: I was when I was there, and then when I came home, my replacement was invited to live with General Westmoreland. Now, we didn't take care of him clinically. We were not that naive. What I would do is determine what problem he had and then I knew who in town was best at that if it was an orthopedic thing. He carried out a very rigorous physical conditioning. He always has.

By way of background, I was a young major as division surgeon of the 82nd Airborne at Bragg, and Lieutenant Colonel Westmoreland, who had been a colonel with the 9th Division during the war, he had been reduced like a lot of them were. So he and I started our acquaintance there as chief of staff and surgeon of the 82nd Airborne. Then in Korea I commanded the 30th Medical Group and he had Blackjack which was the airborne combat team, 187. Then it was only natural when he went in as COMUSMACV in Vietnam that as I came out of the Industrial College, I asked to go over there and serve with him. So when I got over there and went to the Rex Hotel, he invited me to come and live with him in his villa, 60 Tran Quy Cap, right across from Circle Sportief Saigonaise [?], the swimming pool. He would get out there every day and play tennis, and Cabot Lodge, who was the ambassador, would swim. I used to sit there and have lunch and watch COMUSMACV playing tennis over here and Ambassador Lodge swimming over here.

But Westy fell one day and thought he had sprained his wrist, and after about two days of resisting anything being done about it, I realized he probably broke the navicular bone, which is a little boat-shaped bone in here; that's why they call it navicular. I got him over to see Sterling Mutts, who was a young major commanding the Third Field Hospital,

who was a board-certified orthopode [?]. So they put General Westmoreland in a cast here down to here and he said for at least six weeks. Well, that got translated for six weeks. So he put it on the calendar and then came the six weeks and he wanted to get the thing off. Well, he was not a spring chicken anymore, and he needed another week or ten days, but he got real upset that we had reneged on our agreement to take his cast off in forty-two days. Then every morning he would come down with his boots. He couldn't lace his boots up. So he would get up on a pedestal and his senior aide and I would get down on our knees and lace up COMUSMACV's boots. That would have made a picture. Hero-worship.

(Laughter)

G: That would have. Was his health a concern at any other time?

N: No, in fact this worried me because I knew the pictures would come home with him with a cast on, so I got with the Chief of Staff and I prepared a press release that General Westmoreland, COMUSMACV, had a mild fracture of his right wrist while engaging in his strenuous physical conditioning program. So they ran it by Westy and he said, "I was playing tennis." I said, "You can't tell the people back home that you're playing tennis when their kids are up on the line." He said, "That's what I was doing. I'm not going to fake anything over here." So he rewrote the press release and it went out that he broke his wrist playing tennis. That's why this thing that's going on now just strikes me as so utterly--I mean, if you won't lie about a wrist.

Let's see, there was something else. Oh, we had a farewell party for the chief nurse who's mentioned in the book [*Vietnam Studies: Medical Support of the U.S. Army in*

Vietnam 1965-1970], Margaret Clarke, who since died up in Abraham, Alabama. Her replacement came in and she was trying to establish herself and he was having a little trouble cutting up his meat that night. He loved to have people come over and eat supper, and so she insisted on cutting up his meat, which thoroughly infuriated him. "Now, let me cut that up for you."

(Laughter)

G: He didn't want to be babied.

N: We had a guy that lived with us named Fritz Freund, intelligence expert. Did you know him?

G: I know of him.

N: He and Westy were Eagle Scouts along the way and they were always arguing about who had the most merit badges and which camps they went to. One night they decided to have a knot-tying contest, and I had to be the umpire. So here I am a colonel, I've got this four-star general here and this one-star general here and then I'm calling out the knots and they're holding their hands above their heads and they tie it and then they accuse each other of anticipation and cheating.

(Laughter)

G: That's good.

N: The interesting thing about Westmoreland is that when he picked the people to live there with him, he wanted company and he didn't want to waste the cook and everything on just himself. Kitsy had been sent home by the President when they decided to escalate. So he

took an intelligence guy and then Fritz Freund was an image engineer. He was the public affairs, public relations go-between with President Ky and with the Vietnamese general staff. You know, they like to deal through an intermediary, they don't like to deal one-on-one, because it might be embarrassing. So Westy would say, "Suggest they consider so-and-so." And then Fritz would go across to the joint general staff and suggest it. Then he'd come back with was it going to fly or not and what they felt about it. Everybody had a way of backing out if something went wrong.

Then I was the surgeon, so looking back it's interesting because instead of having his operations guy, DePuy, come in there, or chief of staff or someone like that, he didn't pick the people that were going to win the war for him, because he was confident he was going to win the war. That didn't worry him a bit. He picked the three people that could lose the war for him, and he never did say it in so many words, but he had his intelligence guy, his image guy, that dealt with the press and everything, and then he had his surgeon.

G: Was that General Sidle?

N: No, it wasn't Sidle. The image guy was Fritz Freund. Now Sidle was public relations; he was there and Si handled the running of the thing. But the [inaudible] the guy pulling [inaudible] by the [inaudible] in the hotel lobby, you know, that sort of a go-between.

G: Oh, I see. Okay. What the intelligence people call a cutout.

N: Yes. Well, what he wanted I think was people that he could get information directly from that hadn't been through the screening of all of the criteria that set up. He'd say to Bill Crosson, who was the intelligence guy--now, McChristian was the J-2, but he didn't want

the J-2 there. The J-2 had to play by the rules. But he wanted the number-two guy there--and he said, "Do you believe the Viet Cong so-and-so regiment is up there at so-and-so town?" He said, "Well, I'm going to need two more sightings in order to confirm that." He said, "I don't have that kind of time. Do you think it's in there?" And he would have to give an opinion.

G: Who was this, now?

N: Bill Crosson, C-R-O-S-S-O-N.

G: It wasn't Rosson?

N: No, Rosson was the chief of staff, Bill, great guy.

And then he would ask me what I thought about the malaria, you know, about should I move the--well, he had a J-1, Stoneburg, who normally gives him his personnel information on the health of the command. He wanted the three of us there eating breakfast and supper with him, so that he would get his regular briefings after breakfast when he would go in at seven. But then he had gotten what he considered to be a technical, immediate real time, not subject to a whole lot of external, artificial screening. He wanted it quick and dirty, now, to try to get a week ahead instead of staying a month behind. Now, this is all things that I have rationalized since the experience. But it was something else.

He would invite me on Sunday maybe once a month to go with him up to greet a new battalion or brigade or something coming in. And I would invite him to come to church with me. And about once a month he would come to church with me, a little Episcopal service. And Ambassador Lodge was there, too. And then I got to thinking

maybe we should have gone up north, because he always had his two chase planes and everything. And in that church there, all the windows are open and here's the Ambassador and COMUSMACV in this little church there right off the main drag in Saigon. And if a grenade lobs through the window am I going to fall on it like I'm supposed to or like--but it never happened.

Then General Westmoreland would occasionally invite me to go with him to sit in on the morning briefing. The hacienda where we lived had three exits and he always used the same one. And the streets around there were one way. And he always left at the same time. I used to get anxious particularly when I was riding to work with him. (Laughter) "Were the claymores command detonated," and all like that. But his feeling was, "If I start worrying about personal safety and things like that, I'll never get any work done." But then I've seen him berate junior officers who went up and then they came back the same way and got ambushed. "Don't ever come back the same way you go." And I've seen him fly in helicopters where periodically he'd switch to the other side of the road and then switch back, because somebody's radioing ahead "He's on the right side of the--." But personally he had the same habit pattern the whole time I lived with him.

G: That's funny.

I want to try to persuade you to grant me a return engagement where we could really go into the living in the villa with Westmoreland and so on.

N: Sure. I can think of a lot more anecdotes as we go along.

G: Good. Let me ask you about the book, *The Lessons Learned in Vietnam*. If you were writing it today, what would you change or what postscript would you write, or would you write exactly the same way?

N: Probably the same way. I feel very badly about the current unpleasantness, you know, with the TV station and all like that, but then I'm not very objective about the whole thing, so this would color a lot of the things I would write or that I will be telling you as to Westmoreland the man, the man that I remember and his concern for truth, integrity, some of his impressions with the press, some of these things. But it's almost like I'm trying to help defend him at the trial.

G: No.

N: He is a remarkable guy. I was going to write a book, you know how you are when you are your age, you're going to write a book. Then time keeps going by and there's no deadline, and part of it was going to be "COMUSMACV and Me." I was going to write [about] 82nd Airborne, the Korea thing and more recently Vietnam. Then when I was deputy surgeon general, he was chief of staff.

G: Well, you ought to do that.

N: But now it would be something like *The Eagle Scout that Went to War*. Westy just never could understand why it didn't work out like it was supposed to. And when the presidential election was coming up and he was picked as the *Time* man of the year--this is my first tour--that's when I learned again don't ever go back in the military and try to do something over because it's never the same. So I asked him, "Why don't you--" you know, he didn't

know what he was going to do when he left that job, and I said, "How about commander-in-chief?" And he said, "Oh, I couldn't do that." I said, "Well, George Washington made it. Eisenhower made it." He said, "Yes, but they won their wars, and we're not out of this one yet." Then a couple of days later he said, "Do you really think I'd have any kind of a chance?" And I said, "Sure. In fact, my only problem is do I want to be the surgeon general of the Public Health Service." And he said, "But I can never run against the incumbent commander-in-chief." Then when Johnson came out and announced that he was not going to run and Westy was my beloved son in whom I'm well pleased, and I thought, "This settles it." Then everything turned to feces about that time, the war went down the drain.

Now, this thing that's going on now, I don't know that much about the intelligence exercise, but what I'm reading is that there was--how many of these irregular forces do we count, you know, the home guard, the RuffPuffs, the guys that used to ride the trains and things. Where do we have the hard-core armed, trained things. You can't count them all. He must have made some value judgments there that the intelligence community had some--he confused them because they like to have rules like doctors like to have rules. They don't like to have somebody that counts it this way this month and this way the next month.

G: Well, I think part of the problem is that the J-2 changed at a kind of important point in the development of our intelligence picture, and the one that came in had a very different way of doing things and that kind of juggled the picture.

N: Well, are you in a hurry?

G: No, sir. Let me undo us now.

End of Tape 1 of 1 and Interview I

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SPURGEON H. NEEL

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