Notes on the Establishment of the United States Army Special Warfare Center (Airborne) Surgeon’s Office

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ABSTRACT

In the early 1960s, LTC Richard L. Coppedge, Medical Corps, expanded the functions of the Office of the Surgeon for the Special Warfare Center at Fort Bragg, North Carolina. He drew upon the then recent Special Forces experience in Laos and the beginnings of Special Forces experience in Vietnam to reorient the Special Forces medical mission from guerilla warfare to counterinsurgency. With improved training, development of new equipment, coordination with civilian and military medical agencies, collection of medical intelligence data, and an increase of key staff within his office, he left a huge legacy for other Special Forces Surgeons to emulate.

ESTABLISHING THE CENTER SURGEON’S OFFICE

Since the 1952 relocation to Fort Bragg, North Carolina, the United States Army Special Warfare Center (Airborne) (hereinafter SWC) lacked the authorization for a full time Surgeon to direct its medical activities. Over eight years later, a physician was finally given the function merely as an additional duty. Captain (CPT) David Paulsrud, Medical Corps (MC), the Surgeon of the 7th Special Forces Group (Airborne), was assigned those perfunctory duties on 2 December 1960. Outside of the title, the functions of the position were undefined. The duties of the 7th Special Forces Group; however, were real and CPT Paulsrud recalled that his additional duties as the Special Warfare Center Surgeon rarely exceeded that of recruiting enlisted personnel at Fort Sam Houston in Texas or proselytizing medical officers from the 82nd Airborne Division. The position of the SWC Surgeon was now placed under the SWC G-3 for staff supervision, predicated on the realities of needed medical involvement in virtually every phase of operations and training.

THE COPPEDGE ERA

Lieutenant Colonel (LTC) Richard L. Coppedge, MC, brought about a new era in Special Forces (SF) medical support.

CHART 1—Organization Chart of the Special Warfare Center (Airborne)
LTC Coppedge was an energetic, as well as articulate, salesman for upgrading the medical posture within SF. A medical degree from the University of Pennsylvania, a post doctoral fellowship at the National Cancer Institute, a previous commission as an Infantry officer, an internal medicine and physiology background, as well as his previous association with training SF aidmen at Fort Sam Houston, were all positive factors for Coppedge in addressing future training needs at the SWC. Assigned on 2 August 1962 from his position as Division Surgeon of the 82nd Airborne Division to replace CPT Paulsrud, he found a small office with an NCO, a clerk and an MSC officer. Barely able to acclimatize himself with the current parameters of his job, Coppedge faced his first crisis. Two medical officers were sent from the Office of The Surgeon General (OTSG) on 21-22 August 1962 to shed light on the rumors that reached OTSG from Laos and Vietnam about SF aidmen practicing medical procedures considered to be solely within the realm of trained physicians. “These rumors included statements to the effect that SF aidmen were being trained to do and were doing bowel surgery, appendectomies, craniotomies, thoracotomies, and obstetrics, including pre and post natal care.”

Additionally, the OTSG visitors were inquiring into possible adjustment problems of highly trained aidmen being suited for subsequent hospital assignments since “Doubts had been raised that the SF aidmen would fit into the less responsible and relatively subservient hospital role after his training and experience on SF missions.”

A visit to the training laboratory, as well as interviews with veteran aidmen returning from Laos and Vietnam, vindicated the SF medical training program. None of the allegations of illicit surgery were sustained. It was noted however; that at various hospitals on the job training (OJT) experience in obstetrics was offered for SF aidmen. The primary benefit of the visit was familiarizing the OTSG representatives with the SF medical training requirements. The visiting officers also offered recommendations to assist the program. They espoused more dispensary level training for aidmen for sharpening their diagnostic capabilities, as well as increased coordination with OJT facilities to assist those facilities in becoming familiar with the unusual nature of SF medical training. They felt that a thorough understanding by the professional medical personnel at each OJT facility would enhance acceptance of the training program.

LTC Coppedge’s interest in expanding the SF medical role was based on an acute appreciation of the changing patterns of medical support requirements for a counterinsurgency, versus solely a guerrilla environment that existed in Laos and Vietnam. His efforts at first were limited only by the lack of sufficient staff to tackle the myriad projects he generated. Coppedge established immediate liaison with appropriate military and civilian medical authorities for assistance in focusing on the very real medical problems encountered by SF personnel on overseas missions. Arrangements were made to evacuate wounded or ill SF personnel to Womack Army Hospital at Fort Bragg (if not medically contraindicated or objectionable to the individual concerned) to facilitate medical follow up, as well as collection of medical data/intelligence.

Subsequently, in November, the SWC hosted the fall meeting of the Armed Forces Epidemiological Board (AFEB). Coppedge’s emphasis on this area rapidly led to a positive program for medically debriefing all pre- and post-mission SF personnel. Actively seeking suitable lightweight field medical equipment for SF Tables of Organization (TOEs), Coppedge was responsible for a wide ranging program in design and field testing of potential equipment in cooperation with the U.S. Army Special Warfare Combat Development Agency, the Limited War Laboratory and other similar organizations.

His office published a semi-official monthly Medical Information Letter. It became a useful medium for communications with overseas SF units and though designed primarily to disseminate technical/administrative information; it no doubt served admirably to publicize the SF medical role. During Exercise “Devil Arrow”, conducted during September-October 1962, new insight was gained by the SWC via design of realistic casualty play regarding treatment and evacuation of casualties in a counterinsurgency environment. Experience gained in Southeast Asia was used to recommend a revision and increase within the SF Group TOE. Commensurately, Coppedge requested an increase in his own staff. Approval of nine additional personnel spaces in 1963 provided the necessary manpower to accomplish the medical mission. Recommended medical personnel increases at the SF Group level were also approved. An OTSG sanctioned recruiting trip to Fort Sam Houston produced the requisite increase in physician volunteers. Formal mission changes now incorporated the concept of collection, evaluation, and dissemination of medical information pertaining to the areas of Special Warfare operations, as well as the remainder of the programs recommended by Coppedge.

Liaison with the civilian, Federal, and the military medical community, as well as the American Medical Association, was further enhanced by two seminars held at the SWC in April.
1964 and January 1966. The seminars explored the complexities and the common trends within the medical aspects of counterinsurgency. Comparison of government overseas medical programs with the military medical efforts in Southeast Asia focused on the inherent difficulties of exporting Western medicine to underdeveloped countries, especially those facing local insurgencies.

Coppedge was also an avid proponent of increased hospital training for his medics with the specific proviso that training be more doctor than nurse-oriented. He saw the need for physician substitutes. This was a logical reflection of the Laos and Vietnam experience, wherein independent action by the SF aidman was the rule, not the exception. This operational reality juxtaposed the SF aidman against the nurse-oriented programs conducted at Fort Sam Houston.

Accordingly, he set up an OJT program at Womack Army Hospital. Under the supervision of physicians, selected SF aidmen received three to six weeks of training in a variety of areas that Coppedge felt was necessary for those expected to serve in Vietnam, namely pediatrics, dermatology, orthopedics, and laboratory procedures.

Coppedge’s views on increased clinical training for the aidmen were properly balanced by his acute awareness of its limitations. With the encouragement of Major General William Yarborough, he formulated a guidance code entitled the Special Forces Aidman’s Pledge. Of particular significance was the wording of the third tenet in the Pledge “I confess the limitations of my skill and knowledge in caring for the sick and injured.” Coppedge also maintained a close relationship with academia in exploring the need for a physician assistance concept. This led to support of the development of a formal Physician’s Assistant (PA) program at Duke University, patterned to a great extent on the SF experience.

Under Coppedge’s direction, the SF medical program expanded. Most of the projects were directly or peripherally related to the growing SF presence in Vietnam. The assignment of the first veterinarian to SF added a welcome dimension to SF medical support. LTC Bjoune Folling, Veterinary Corps (VC), undertook a pilot program to revive training in the use and care of pack animals and published a local manual on the subject. More directly related to the Vietnam needs of SF, he began to examine ramifications of dealing with locally procured foods and the feasibility of animal husbandry programs, both useful to the growing counterinsurgency efforts.

With the addition of a SWC psychiatrist position, Major (MAJ) Karl A. Zener, MC, assumed a rather unusual military role as a “tactical anthropologist”, focusing on the proper methods of dealing with primitive societies and cultures. Awareness of this area was often the key to proper introduction of Western medicine. His studies on the psychological stresses of isolated and hazardous operational areas allowed him to instruct A Team commanders on recognizing and coping with interpersonal problems likely to be encountered.

**Additional Enlisted Medical Training**

The SWC Surgeon was a proponent of additional training for the aidmen. As the TO&E was being revised, authorization for some ancillary medical skills for aidmen, such as pharmacy, X-ray, laboratory, preventive medicine, veterinary, medical records, and medical supply were added for the first time. Since the Surgeon’s Office also developed a TO&E for an air-droppable/porable guerilla hospital, these medical skills were added. There was no new demand for initiation of courses to provide the necessary training for most of these skills, since the Medical Field Service School in Texas already had appropriate training courses and the overall authorization within SF for these positions was limited. Despite this, there was a chronic shortage of personnel within these Military Occupational Specialties (MOSs) in Vietnam SF units. The gaps were generally filled by SF aidmen with MOS 91B, thereby training available assets within those ranks. Perhaps the most successful MOS addition was that of preventive medicine (91S), wherein those aidmen who failed the advanced SF medical training could be retrained as preventive medicine specialists.

Coppedge interviewed SF veterans who served in Laos and responded to their recommendations, as well as those found in after action reports from Laos. He was instrumental in the design of a field laboratory kit being made available to SF medics. With the addition of MOS 93B (Laboratory Specialist) positions to the SF TOE and the introduction in late 1964 of the prototype Portable Medical Laboratory Equipment and Supply Set (Civic Action), there arose an obvious need to further sharpen the laboratory skills of SF aidmen. The set was now expected to be issued to each A Team.

The ultimate result was the initiation of a new, but informal laboratory course by two enterprising SF medical NCOs, Sergeants Edward Palow and Johnnie Wills. Another highly qualified laboratory NCO, MSG J.V. Hickman took over the course soon after its inception. The four-week long course opened in October of 1966. It offered intensive training in diagnostic medical laboratory procedures, supplementing any limited laboratory training received in the basic SF 300F1 Course at Fort Sam Houston.

**Training of the SF AMEDD Officers**

The SWC Surgeon’s Office accelerated the recruitment of Army Medical Department (AMEDD) officers. The existing training requirements for qualifying AMEDD officers for SF duty were on the average far shorter than those for the enlisted aidmen. This was due to the AMEDD officer career patterns in the 1960s, which made it prohibitive for extended or multiple SF tours. There appeared to be a major reluctance at OTSG level to provide MC and MSC officers for more than one SF tour of duty. Additionally, the low authorized grade structure, as well as the limited availability of openings or positions, created assignment problems for AMEDD officers. In contrast, enlisted personnel could legitimately expect multiple assignments to SF units.

Under Coppedge, the AMEDD officer (regardless of Branch) once he was selected for SF, was expected to complete airborne training either en route to his assignment or shortly thereafter. His next hurdle was attendance at the Special Forces Officer Course or the Counterinsurgency Officer Course. Either
of these twelve week courses was similarly required for Combat Arms officers – a necessity for awarding the Special Forces designator Prefix-3 to their Military Occupational Specialties, signifying completion of the above courses. For AMEDD officers, the Prefix-3 could only be awarded by OTSG. Many AMEDD officers also volunteered for further training that was not medically oriented, such as Ranger School, Jungle Operations, HALO (High Altitude Low Opening) and SCUBA.13

Later there were a number of AMEDD officers who were able to obtain their SF Prefix-3 without direct attendance at resident courses of instruction at Fort Bragg. As to further medical training, the physicians could attend a variety of courses offered by OTSG. Of significant value to Vietnam-bound SF doctors was the Tropical Medicine Course offered at Walter Reed Army Institute of Research (WRAIR).

SF AMEDD officer replacements for the 5th Special Forces Group (Airborne) in Vietnam were generally selected and recommended to OTSG by the SWC Surgeon’s Office. Many of these officers left Fort Bragg for Vietnam right after completion of their SF training, while others remained at Fort Bragg awaiting openings within the 5th SFG. If possible, pre-mission and language training were attended by these AMEDD officers along with other Combat Arms officers. There were a number of exceptions to the above, wherein physicians transferred from units already in Vietnam or were assigned by United States Army Vietnam (USARV).

THE CENTRAL MEDICAL EXAMINING FACILITY

The integrated surveillance of the medical experience of SF personnel in overseas operational areas is rooted in the Laotian experience. The rudimentary post-mission medical procedures performed on White Star Mobile Training Team personnel toward the latter stage of the U.S. involvement in Laos showed possibilities for systemic collection of medical intelligence. The very fact that deployed personnel returned to Fort Bragg upon completion of their overseas mission, presented an unusual opportunity to observe the results of exposure to medical problems in operational areas of SF. This surveillance was beneficial not only towards protection of returning troops, but also dependents and civilians.

LTC Coppedge greatly expanded on the fledgling program that was in effect upon his arrival.

With the Laotian involvement still underway, LTC Coppedge wasted no time in drafting a staff study in September 1962, seeking command approval to develop a broad program for collection of medical information/intelligence. The program was to utilize the medical expertise of Walter Reed Army Institute of Research (WRAIR) to help analyze the data acquired by SF aidmen returning from missions, as well as the post-mission debriefing to be conducted on each SF returnee, in accordance with a set protocol. Coppedge also went with Major General William P. Yarborough on a number of fact finding tours to other countries, including South Vietnam.14

Coppedge recognized that the SF efforts in Vietnam were confronted with a medical situation calling for a critical examination and an unorthodox response. In his own words “The very nature of the counterinsurgency operation places the Soldier in intimate contact with a primitive environment; in some instances without benefit to the preventive measures that are available to conventional forces. At times, he may be required to eat native foods with local villagers, exposing himself to dysentery, hepatitis, cholera, and parasitic infections; may be required to participate in daily operational patrols which necessitate immersion in swamp paddy water, resulting in exposure to such diseases as leptospirosis and melioidosis; at all times, must live and work in intimate contact with animal and human reservoirs in infection for that particular area. Like the conventional Soldier, the SF Soldier arrives in the operational area without the advantage of natural immunity to many of the diseases endemic to the area. He may in truth, be described as an immunologic virgin.”15

Consulting with experts from WRAIR, Coppedge issued a regulation by March of the following year, standardizing the policy and procedural aspects of pre- and post-mission medical examinations. Under the technical guidance of the SWC Surgeon, baseline medical data were to be obtained prior to mission departure, with the assumption that any acute symptoms occurring in the zone of operations resulted from exposure to the area. The SF Group Surgeons were to be responsible for the conduct of the pre-mission physical examinations and the necessary laboratory tests for their assigned personnel. Urinalysis, white blood cell counts, as well as blood differential counts, serology, chest X-ray, hemoglobin and three consecutive stool examinations were required. Additionally, 50cc of post-mission serum from each man was sent to the serum bank at Fort Bragg and made available to WRAIR in Washington, DC for more sophisticated studies, in correlation with additional disease history obtained from unit members operating in the same geographical vicinity.16

The SWC Surgeon conducted an extensive pre-mission briefing for medical personnel scheduled for overseas deployments, providing the necessary direction for collection of data. As a result, the aidman’s abilities were enhanced to look for and observe significant factors related to disease and its transmission in each specific operational area. A compact pocket-sized document entitled “Medical Guide for Special Forces Aidmen” was developed. It incorporated the medical Essential Elements of Information (EEI) and established a standard guide for collection of medical and medically related data in operational areas. The Department of Biostatistics, WRAIR, assisted in developing standard encoding methods on IBM cards for the acquired data. Essentially, the same studies were repeated in post-mission physicals upon the return of SF personnel. Post-mission sera were examined at WRAIR for a battery of diseases. For example, the British military medical experience in Malaya and the French experience in Indochina suggested a strong need for comparable studies on leptospirosis in Vietnam, while examinations for suspected drug resistant strains were performed at the University of Chicago. Returning medical personnel also underwent a detailed medical intelligence debriefing. Synthesis of all the gathered data was expected “over a period of time … (to) suggest areas where on-the-spot epidemiologic investigations are appropriate, should the etiology, the mode of transmission, ecology of an operationally significant disease remain obscure.”17

By 1964, voluminous data had been collected, revealing the potential for extensive morbidity if large numbers of Ameri-
can troops were to be introduced into certain areas of Vietnam. Preliminary findings were formally discussed at a medical seminar on counterinsurgency held by the SWC Surgeon at Fort Bragg in April of 1964. Key military, Federal, and civilian medical leaders were briefed on the medical experiences of SF. With over a year and a half’s accumulation of collected data, certain trends emerged. Diarrheal diseases and hepatitis were found to be the most significant cause of morbidity and non-effectiveness. Diarrhea caused evacuation from the operational area for 4.8% of those affected. Of the first 902 personnel sent to Vietnam from Fort Bragg, 510 recalled having diarrhea sometime during their six-month tour. 16

Recurring symptoms of high fever were found in over 25% and bloody stools in 11.9% of those suffering attacks. Infectious hepatitis was found to be localized in the Delta area of Vietnam, with an attack rate of 4.1 per 100. The administration of 0.05 cc/lb of body weight of gamma globulin gave indication of effective prophylaxis, though a second re-immunization was indicated five months after the initial administration. This was deemed to be of great importance among SF troops, since their tours at that time were six months long and the potential for bringing hepatitis back to the Continental United States (CONUS) increased towards the latter part of their tours.

In a joint paper presented at the seminar, LTC Coppedge and his Preventive Medicine Officer, MAJ Llewellyn J. Legters, MC, cited the evident increase in drug resistant strains of malaria, though at the time, malaria was not felt to be as militarily important as in subsequent years. Also tropical sprue (malabsorption syndrome) was found in enough returning SF personnel to give rise to concern. 19

A variety of serologic tests confirmed that antibody titers on returnees showed scattered exposure to many militarily significant diseases. Positive antibody responses to cholera, plague, rickettsial organisms, dengue and Pseudomonas pseudomallei, indicated a need for more sophisticated studies of their impact. Acquired intestinal parasitic infections were common.

LTC Coppedge and MAJ Legters entertained few illusions about the acquired data. They realized that their efforts needed far more sophisticated assistance. Through Legters’ perseverance, WRAIR backed and funded a field epidemiologic survey team composed entirely of SF medical personnel. Conceived originally by Legters, the team was formed in the fall of 1965 and after extensive training, deployed to Vietnam in September of the following year. 20

By early 1966, the SWC Surgeon realized that, as conducted, the pre- and post mission medical examinations were not completely satisfactory. SF Groups were far too short of personnel to maintain effective administrative and clinical standards. The permanent change of station (PCS) requirements versus the previous temporary duty (TDY) assignments changed workloads as well as screening requirements. SF troops were no longer routinely returning to Fort Bragg, so post-mission physicals and tests could not be conducted with any regularity. The previously utilized facilities at Womack Army Hospital were now not available, since Vietnam was no longer considered to be an “area with limited medical facilities” in accordance with Army Regulation 40-501. No one bothered, regretfully, to ask the SF troops in remote Vietnam locations whether they had adequate medical facilities and routine and adequate medical care available.

In June of that year, all previous procedures were standardized under the direct control of the SWC Surgeon with the creation of the Central Medical Examining Facility (CMEF). A suitable building was acquired in the process. The CMEF quickly proved its worth by demonstrating that under previous procedures, as many as a quarter of the examinees required further follow up examinations at specialty clinics at Womack Army Hospital. 21

The formalization of data collection by the SWC was not effected until the Commander of the SWC requested from Continental Army Command (CONARC) a revision of the mission statement to include “operation of a medical examining facility which both monitors the health of the personnel deployed to remote areas of the world and serves as a collection agency for vital medical intelligence data.” 22

Command backing of the CMEF generated a new flurry of activities. A number of new procedures were tried. Post-mission psychological interviews by the SWC Psychiatrist became an integral part of CMEF testing procedures. The objectives were to determine the effects of psychological stresses peculiar to SF operations in remote areas, as well as appropriate preventative psychological measures. A secondary expectation was the collection of data for the development of improved criteria in the selection of SF personnel. Special immunodiagnostic studies determined by geographical exposures, nature and length of deployment, medical history and physical examinations were performed at the discretion of the CMEF. The outdated, as well as the impractical initial manual encoding system available at the CMEF was scheduled for replacement via linkup with the more sophisticated computer facilities at Fitzsimons General Hospital in Denver, Colorado. After a promising start, however, the transfer was never satisfactorily completed. 23

EPILOGUE

LTC Coppedge was reassigned from the USA John F. Kennedy Special Warfare Center (Airborne) in 1967. He received a Legion of Merit for his work and left behind a tremendous legacy of activism and a refocus of the SF medical mission from guerrilla warfare to counterinsurgency. He was responsible for the definition of the SWC Surgeon’s role and the expansion of the Surgeon’s Office to properly support SF medical efforts. His focus on the problems initially encountered by SF medics in Laos and Vietnam resulted in a systemic approach to medically debriefing overseas returnees and linking those findings to a more successful preventive medicine effort. His visionary efforts, leadership and accomplishments raised the bar for all future SF training and medical support in the years to come.

REFERENCES

1. Para 2, Special Orders 224, Headquarters, USA Special Warfare Center, Fort Bragg, NC, 2 December 1960. Also see personal communication of Dr. Paulsrud to Author, 1 November 1976.

2. In late 1962 and early 1962, the SWC was under the operational control of the 18th Airborne Corps at Fort Bragg. This created obvious problems for the Corps Surgeon, as the SWC lacked its own medical administrative capabilities without a full-time Surgeon.
3. Interview with Colonel (COL) Helmer W. Thompson, MSC, by Author on 17 December 1976, p. 2.
4. Though legitimately functional, the position of the Surgeon under G-3 supervision was a radical departure from the standard Army doctrine of the time. Field Manual 101-5 Staff Officers’ Field Manual: Staff Organization and Procedure, listed the Surgeon in roughly similar organizations under the G-4.
6. Ibid, p 2
13. While the U.S. Army Special Warfare Center and later the U.S. Army John F. Kennedy Center for Military Assistance were authorized to award the Prefix-3 to all Combat Arms officers completing SF training, only the Office of The Surgeon General had the same award authority for AMEDD officers. See AR 611-101.
17. Ibid., paragraph 1c(5), Inclosure II, p.1.
19. Between January 1962 and March 1963, SF returnees experienced only 41 cases of malaria. Of these, 39 were vivax, one falciparum, while one patient was infected by both parasites. At that time, prophylaxis consisted of chloroquine, not the later chloroquine-primaquine combination. See LTC Richard L. Coppedge, MC, Medical Information Letter #3, Malaria Prophylaxis and Treatment, HQ, USA JFK Center for Special Warfare, Office of the Surgeon, Fort Bragg, NC, 15 March 1966.
21. Regulation Number 40-5, The Special Warfare Central Medical Examination Facility (CMEF), HQ, USAJFK Center for Special Warfare (Airborne), Fort Bragg, NC, 3 June 1966.
22. Letter by COL Albert E. Milloy, INF, Subject: Request for Mission Clarification, DA, HQ USAJFK Center for Special Warfare (Airborne), Fort Bragg, NC, 12 October 1966. WRAIR also strongly supported the establishment of the proposed facility via a letter through The Surgeon General and CONARC. See letter by COL William S. Gochenauer, VC, Subject: Operation of a Special Force Central Medical Examining Facility, HQ, Walter Reed Army Institute of Research, WRAMC, Washington, DC, 14 December 1966.

Louis T. Dorogi, LTC, MSC (USAR Ret) received a BA in history from Bowdoin College and an MAPA in public administration from the University of Oklahoma. He entered active duty in 1963 with a Regular Army Commission through ROTC. Among others, his military assignments included the 82nd Airborne Division, 7th Special Forces Group (Abn), the U.S. Army Special Forces-Walter Reed Army Institute of Research Field Epidemiological Survey Team (Abn), service in Vietnam attached to the 5th Special Forces Group (Abn), USA JFK Center for Military Assistance, XVIII Airborne Corps, and Medical History Division of the USA Center for Military History. In 1978 he became a Reserve officer, retiring from the military in 1990 as the Director of Officer Instruction for the 1033rd U.S Army Reserve Forces School. As a civilian, he served as the Assistant Director Health Programs for the Passamaquoddy Indian Tribe, then as Director of Licensing and Medicare/Medicaid Certification for the State of Maine, retiring in 2007. He was an instructor on the Vietnam War for Southern New Hampshire University during 1992-95. His publications include articles in Special Warfare and the Journal of Special Operations Medicine.