If Navy Medicine had its own hall of fame there is little doubt that aviation pioneer Capt. Robert E. Mitchell would be among its enshrined legends. Through his work as a flight surgeon, principle investigator on the “Thousand Aviator” project, and commanding officer of the Naval Aviation Medical Research Laboratory, Mitchell helped shape the course of naval aviation. In 1973, Mitchell would pioneer a program for evaluating repatriated Vietnam prisoners of war—many of whom were aviators. His work with repatriated prisoners of war (RPWs) would serve as foundation for the Robert E. Mitchell Center (REMC) for Prisoner of War Studies, which today is the only DoD-sanctioned facility supported to conduct annual medical evaluations of former prisoners of war. In our cover story, authors Francine Segovia, Jeffrey Moore, Steven Linnville, John Albano, and Robert Hoyt look at Mitchell’s incredible legacy and unique role in Navy medical history.

For historians, the Ebola outbreak offers an opportunity to draw comparisons with epidemics of yesteryear. Over the last several months the internet has been full of articles and blog posts offering parallels between Ebola and everything from cholera, typhoid, and yellow fever. Throughout many of epidemics of yesteryear quarantine was often the standard practice for keeping outbreaks in check. In her article, archeologist Dr. Paola Schiappacasse’s looks back at the use of maritime quarantine procedures at the Lazareto de Isla de Cabras.

We follow these features with historical articles about: the Navy’s quarantine station at Widow’s Island, Maine; a Navy convalescent hospital in Coney Island; Navy Medicine’s role in the invasion of North Africa; and an age old mystery about Naval Hospital Chelsea’s cemetery.

As always we hope you enjoy this tour on the high seas of Navy Medicine’s past!
THE GROG
A JOURNAL OF NAVY MEDICAL HISTORY AND CULTURE

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tory and culture of the Navy Medical Department. Articles and in-
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reflect the present-day policy of the Navy Medical Department, U.S.
Navy, and/or the Department of Defense.
CAPT Robert E. Mitchell, MC, USN

A Navy Medical Pioneer


Courtesy of defense.gov
No one is more cherished in this world than someone who lightens the burden of another.”

--Unknown

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Capt. Robert E. Mitchell’s many honors include serving as Fellow of the Aerospace Medical Association in 1966; receiving the Theodore C. Lyster Award from the Aerospace Medical Association for his outstanding achievements in the field of aerospace medicine in 1980; being designated an Honorary Naval Aviator #21 by the Chief of Naval Operations; and being inducted into the Naval Aviation Hall of Honor in 2004. He has also served as inspiration for the Robert E. Mitchell Award established by the Society of U.S. Navy Flight Surgeons which is awarded annually to retired flight surgeons for their lifetime contributions to aerospace medicine. Throughout his career as a flight surgeon, Capt. Mitchell wrote and published numerous medical papers, and in 1955 became the principle physician involved in the follow-up studies of the “Thousand Aviator” project. There is little doubt that his operational work as a flight surgeon has helped shape the course of Naval Aviation. Capt. Mitchell's unwavering dedication to the care of Vietnam repatriated prisoners of war (largely aviation personnel) enabled an unbroken 41 years of dedicated service to those who suffered as a POW. He is the primary reason why today the Robert E. Mitchell Center (REMC) for Prisoner of War (POW) studies stands as the only Department of Defense (DoD) sanctioned facility conducting annual medical evaluations for American repatriated prisoners of war (RPW). This note outlines the development of the REMC for POW Studies and summarizes the pivotal role Capt. Mitchell played in its establishment.

~By the authors.
Before Capt. Robert Mitchell initiated a program for studying Vietnam repatriated prisoners of war in 1973, there was no long-term holistic study or data for forecasting the long-term impact of disease and psychological problems in such a group. POWs from past wars usually received one-time examinations with no follow-up. Systematic historical and scientific record keeping was lacking. The reasons for the lack of these repatriation reports following World War II are anyone’s guess.1 Perhaps the examination reports were never done, or the records were destroyed, or they have simply been lost to us. All are plausible.

When Operation Homecoming was in its planning stages, it was recognized that there was a lack of extensive longitudinal data from direct clinical examinations of repatriates in scientific settings. This realization prompted the Department of Defense to follow the Vietnam RPWs and plan for the Center for Prisoner of War Studies (CPOW) at Point Loma, California in 1971.2 The DoD funded a five-year charter for all the services to evaluate the effects of captivity among the repatriated POWs. To plan the program, a group of Army, Navy, and Air Force specialists met in San Diego during the summer of 1972. The services collaborated on designing uniform questionnaires and examination procedures for RPWs.

The pivotal role of the aerospace medicine community played in the return of the Vietnam POWs should be noted. Of great concern during Operation Homecoming was the availability of physicians for flying on air evacuation missions from Hanoi to Saigon to the Philippines and then from the Philippines to the United States. This concern was addressed by aerospace medical residents (Residents in Aerospace Medicine or RAMS) who underwent temporary duty to Clark Air Base exclusively for air evacuation missions.3,4

2. Ibid
Since the majority of American POWs were aviators and aircrew, the immediate rapport of the flight surgeon was critical.\(^5\)

The CPOW in San Diego conducted marriage and family research on repatriates’ families. The medical evaluations for each service were conducted at separate facilities. The medical evaluations for Air Force repatriates were conducted at Brooks Air Force Base in San Antonio while the Army repatriates were evaluated at Brooke Army Medical Center at Fort Sam Houston, San Antonio. At the time of repatriation, the Naval Aerospace Medical Institute (NAMI) had over thirty-five years of experience with a similar study, “The Thousand Aviators.” This program gave the Navy its first look at personal attributes of successful student aviators.\(^6\)

Since the majority of men were aviation personnel, the most logical place to conduct both the medical evaluations and research component for the Navy and Marine Corps repatriates was at NAMI in Pensacola, Florida.

In 1978, the CPOW charter ended and all services were required to archive and discontinue their studies. Doctor Mitchell refused to discontinue care to the Navy and Marine Corps repatriates was at NAMI in Pensacola, Florida.

In 1978, the CPOW charter ended and all services were required to archive and discontinue their studies. Doctor Mitchell refused to discontinue care to the Navy and Marine Corps repatriates was at NAMI in Pensacola, Florida.

In 1998, Building 3933, which stands adjacent to NAMI, and located at the Naval Air Station in Pensacola, Florida, was dedicated as the Robert E. Mitchell Center for Prisoner of War Studies. In this building the REMC continues its care of repatriates from all conflicts and is a special program of the Navy Medicine Operational Training Center (NMOTC).

Participants travel from all over the United States and different parts of the world to receive annual evaluations at REMC. To date, the Vietnam-era participants continue to be the largest and longest held repatriated prisoners of war group in this retrospective study.

The REMC is unique in conducting annual medical evaluations for all the service’s RPWs. As such, it is also the only existing longitudinal study of the long term medical and psychological effects of post-traumatic stress relating to the POW experience. The medical and psychological history of RPWs is stored in a secure database repository which, with their permission, can be used for research purposes.

**THE FINDINGS**

To date, the REMC data on POW health has supported high-quality research benefiting the following four groups: the current cohort of repatriated POWs, future groups of POWs, other military personnel, particularly those who suffer the trauma of war, and the larger population, especially those who suffer from severe trauma. Because of the larger percentage of aviation personnel in the Vietnam RPW cohort, the many lessons regarding the trauma of the POW experience have been especially relevant to operational communities such as the aviation communities and medical communities such as the aerospace medical and traumatic stress science and clinical communities. The high quality research conducted at the REMC has produced a better understanding of the following categories:

1. Mental health/psychology
2. Methods of survival
3. Physical health (today, former POWs are entitled to a presumption of several service-connected illnesses)
4. Policy, politics, and motives

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5. Ibid
The REMC has collected a number of lessons learned. Most recently the Office of Naval Research and the Bureau of Medicine and Surgery Clinical Naval Investigation Program provided grant support funding the center in examining optimism and resilience among the repatriates. During this time, researchers examined risk and protective factors for predicting resilience and determining applicability to current training. Several explorations of the data yielded the strongest association with resilience was a personality trait, optimism. In fact, optimism was a stronger predictor of resilience than experience type assessed through prolonged captivity, severe torture, and malnourishment across an extended period of time. It is the type of person rather than the type of experience which determines how one handles a traumatic/catastrophic experience. Thus, while there is considerable concern about the incidence of war-related post-traumatic stress disorder (PTSD) in military personnel with substantial research now asking how to diagnose and treat PTSD at the REMC, researchers have turned the question on its head by asking, who does not suffer ill effects of awful experiences? With over 40 years of longitudinal research collected from repatriated prisoners of war, REMC is the only center in possession of this unique data that is expertly qualified to answer such questions.

Today REMC subject matter expertise is recognized. The Executive Director serves as an advisor to the Congressionally-mandated Veteran’s Affairs (VA) Advisory Committee on Former Prisoners of War; and, works closely with the VA on POW-related matters including identifying medical and psychological conditions related to captivity. REMC’s recent work on bone density resulted in the VA adapting a new POW-specific service-connected presumptive diagnosis of osteoporosis for disability compensation. REMC provided the Navy and Air Force medical and psychological information for adjudicating applications for Combat-Related Special Compensation. Its research on optimism has also helped design the Emotional Fitness Training module of the Army’s Comprehensive Soldier & Family Fitness Program. Furthermore, REMC contributed to the new Department of Defense repatriation instructions and the Joint Personnel Recovery Agency’s plans for repatriation of future American POWs.

Presently, REMC continues its unwavering medical support of those selfless

yet distinguished RPWs. Current and past staff at REMC, a number of them themselves Fellows of the Aerospace Medical Association, continue to honor Dr. Mitchell’s efforts to provide unbroken dedicated service to this country’s RPWs.

Recently, REMC presented Capt. Mitchell with a commemorative challenge coin. The coin memorializes Capt. Mitchell, displaying a bas-relief image of him on the obverse side. The logo on the reverse side is highly symbolic in that the background is adopted from the ribbon of the POW Medal. The unchained bald eagle, an embodiment of the American POW spirit, stands with pride and dignity. Below the bald eagle is a yellow ribbon inscribed with “Never Forgotten.” Overlaying the yellow ribbon is a serpent entwined staff, the rod of Aesculapius, which is a symbol of medicine administered by a physician, in this case, a flight surgeon. The two together resemble a Caduceus, a winged staff with two entwined serpents, which is recognized to be a larger military health care system. In this larger setting the single serpent indicates REMC’s commitment and dedication to supporting the RPWs and providing lessons learned for future military training and operations.

America’s repatriated prisoners of war are an extraordinary example of the power of the human spirit to survive and even thrive in the face of trauma. The lessons learned from these heroes can be used to better screen and train military service members of this generation. None of these lessons would have been possible without Capt. Mitchell’s unwavering dedication. His singular vision and sheer audacity enabled REMC’s unbroken 41 years of dedicated service to those who suffered as a POW. ☞

ABOUT THE AUTHORS
Dr. Francine Segovia served as a Research Psychologist at the Robert E. Mitchell Center for Prisoner of War Studies from 2009-2012 before retraining as a Clinical Psychologist. She was recently accepted into Navy Medicine’s Clinical Psychology internship program and is serving in San Diego, CA. ☜

Jeffrey L. Moore, PhD, retired from active duty U.S. Naval service in 1997 at the rank of Commander. Dr. Moore has served as clinical neuropsychologist for the Robert E. Mitchell Center for Prisoner of War Studies in Pensacola, FL for 25 years. He is the current Executive Director for the center.

Steven E. Linnville, PhD, is an active duty Research Psychologist with 25 years of service who holds the rank of Commander. He is currently serving as the Deputy Director for Research at the Robert E. Mitchell Center for Prisoner of War Studies.

Robert E. Hoyt, MD, was in private practice for 15 years, followed by 20 years of active duty service as a Navy physician, retiring at the rank of Captain. He has served as a Clinical Research Consultant at the Robert E. Mitchell Center for the past seven years.

John P. Albano, MD, has served for the past two years as Deputy Director of Clinical Evaluations for the Robert E. Mitchell Center for Repatriated Prisoner of War Studies aboard the Naval Air Station in Pensacola, FL. He is a retired colonel in the U.S. Army.
WELCOME TO ISOLATION!

Aerial photograph showing the El Cañuelo (Fortín San Juan de la Cruz) at Isla de la Cabra, San Juan, Puerto Rico

Courtesy of the Library of Congress
Lazareto de Isla de Cabras
The First Permanent Maritime Quarantine Station in 19th Century Puerto Rico

By Paola A. Schiappacasse, PhD

The historical record indicates that Spain had first implemented maritime quarantine procedures in its colony of Puerto Rico as early as 1620. Although modest during its first three centuries of occupation, Spain’s practice of conducting sanitary inspections of ships reveals the role of health legislation in the colony. Throughout the eighteenth and nineteenth centuries inspections took place aboard incoming ships, on pontoons in San Juan Bay, as well as the military facilities of El Cañuelo (Fortín San Juan de la Cruz), Batería de San Francisco de Paula and the Batería de Santo Toribio. In the late 1870s, a permanent station was built on Isla de Cabras, a promontory separated from the mainland by a short stretch of water on the west side of San Juan Bay. This article addresses the nature and characteristics of operation of the maritime quarantine station, known as Lazareto de Isla de Cabras, through the examination of archival documentation, the archaeological record, and architecture (i.e. cartographic and photographic materials and architectural blueprints). It is through this line of research that we have been able to delineate the history of the quarantine station in terms of its evolution, operation and services.

HISTORY OF THE STATION

Construction of the original original permanent quarantine station at Isla de Cabras was completed on September 15, 1877. The history of this station can be divided into two periods: from 1878-1883, and from 1883-1898. During the first period, the station came under the jurisdiction of the San Juan City Council, who financed the construction of the maritime quarantine station, and the Municipal Board of Health, which was responsible for its administration. On February 12, 1878, the Lazareto de Isla de Cabras was officially signed over to the Board of Health. The original facilities consisted of an administration building, a convalescing ward (Hospital de Observación y Convalecencia), a sick ward (Hospital de Enfermos), a cemetery, and a dock.

In April 1878, the passengers from the ship Alicante reported the conditions of the place as “unsanitary.” A month later, the City Council secretary certified the agreement to close down the station, but it was reopened in June and again in late July 1878. Puerto Rico’s Governor-General Eulogio Despujols y Dussay (1834-1907) was informed of the abandonment of the station in a report stating two main causes: consecutive conflicts and annoyances caused by a lack of regulations, and not having sufficient resources to sustain it. The economic and administrative regulations would have been a key element to the operation of the station because it would have determined the daily fees and expenses, and the specifics on sanitation measures and rules to be applied to passengers, baggage, and cargo. Although the station only operated between April and August of 1878, a warden was retained to maintain the facilities until 1882.

In the second period, the station was under the control of the State. In Janu-

AUTHOR’S NOTE:
This article presents an overview of the history of the first permanent maritime quarantine station in Puerto Rico through three lines of research: history, architecture and archaeology. The station was located on Isla de Cabras, a small island at the entrance to the San Juan Bay, and operated under Spanish colonial rule between 1878 and 1898. The archival documents yielded information related to the establishment and operation of the station through operational budgets, expense accounts, board minutes, official government correspondence and blueprints. The architectural data sheds light on the physical layout by contrasting the site plans against the standing buildings, collapsed structures, structural remnants and features. A spatial analysis of the site provides an insight on the choices made behind the original location of the buildings, the conversion of permanent buildings, the construction of temporary buildings and the activity areas within the station. The archaeological record yielded tangible evidence by way of the material culture, to understand aspects of daily life at the quarantine station. Lastly, the discussion concentrates on the information provided by each discipline separately.
ary 1883, a transfer agreement for the Lazareto was certified based on the need of the insular government to establish a quarantine station. The first step was the preparation of an inventory of the buildings and their condition in order to assess the repairs needed.

The objective of maritime quarantine was the temporary isolation of passengers and/or crew members for a period of time to see if the suspected disease "flourished" among them. Throughout their stay the passengers were provided with the most basic services like clothing, lodging, daily meals, and the fumigation of their luggage. Following the social customs of the time, classes and sexes were separated. The services provided in the quarantine station were covered by the fare charged to the incoming passengers, based on the type of class under which they were traveling (1st, 2nd, 3rd, 4th). The employees were also treated but had to cover their expenses by a smaller fare.

The number of personnel employed at the facility varied based on the number of people being quarantined. In addition to the full-time warden who lived on the island, the Lazoreto would have employed a doctor/medical director, chaplain, doctor assistant, nurses, maids, boatmen, laundresses and a telegraphist. Some services like laundry, groceries, and filling prescriptions were done from San Juan.

It has been impossible to determine if a passenger journal was in fact maintained, even though Article 69 of the
Reglamento de Sanidad de la Isla de Puerto Rico (1854) clearly stated that the Diputación del Puerto (Port Deputation) had to keep an account of the quarantined vessel, number of individuals on board and days under quarantine. The minutes of the Municipal Board of Health sometimes include references to the sanitation visit paid to the incoming ships, providing the name of the ship, provenance, type of bill of health, and decisions pertaining to the imposition of quarantine. Among the goals of the archival research was to identify the people that were placed under quarantine because it would have been interesting to analyze if the maritime quarantine station was used as an "immigration filter." This would have been accomplished by establishing if the quarantined passengers were mainly Spanish military personnel, Spanish immigrants from the peninsula or other colonies, non-Spanish immigrants, or simply local citizens returning to Puerto Rico. Some of the information has been pieced together from the documents of the Royal Treasury which indicate that military personnel, a newly-appointed governor and a group of nuns were all sent to Isla de Cabras, showing that the quarantine process did not make social exceptions by filtering who was quarantined. Based on the information available, it is possible to establish that at least 39 ships were isolated between 1883 and 1897. Most likely, during the last decade of the nineteenth century the number of ships undergoing quarantine decreased due to a shift in public health management as a direct consequence of the scientific discoveries regarding diseases.

ARCHITECTURE

The architecture of the site was studied through the analysis of the physical layout, the identification of existing buildings and structural remnants. As the years progressed, the station expanded to accommodate the needs of the maritime station with the addition of kitchens, a pantry, laundry wash tubs, warehouses, a disinfection shed, a telegraph station and a shed for third-class passengers. Archival documentation delineated the expansion of the station chronologically, while the location of the buildings and auxiliary structures was linked to the types of activities undertaken at the station. From the archival data, four main areas within the station were established:

1. The arrival, processing and storage area was composed of the dock, a luggage warehouse, a cargo warehouse, a disinfection shed, and wagons.
2. The administration area was composed of the administration building and the telegraph station.
3. The convalescing area consisted of the convalescing ward, the third-class shed, and service areas including a kitchen, wash basin area, cistern and latrine.
4. The sick ward area included the sick ward and associated service areas including the kitchen, wash basin area, cistern, latrine and the cemetery.

The presence of standing buildings, collapsed structures, and structural remnants aided in understanding the physical layout of the station. Through the archaeology program it was possible to corroborate the masonry structures that were part of the quarantine station (the administration building, the convalescing ward, the sick ward, the laundry wash tubs, the latrines and the cisterns); and the absence of the non-masonry structures (the warehouse, disinfection shed, third-class shed and the telegraph station). Lastly, graphic documentation by way of detailed drawings and photographs of the unrecorded auxiliary structural remnants (latrines and wash basin tubs) was done. A spatial analysis of the site provided an insight on the choices made behind the location of the buildings, and the appropriate use of the space according to the sanitary demands of the time.

ARCHAEOLOGY

The archival research produced information on incoming ships that were inspected, the discussion of specific quarantine cases, personnel employed, services provided, and the construction and reconstruction projects of the station. Questions regarding specifics on

<table>
<thead>
<tr>
<th>Vessel Name</th>
<th>Port of Provenance</th>
<th>Date of Arrival</th>
<th>Quarantined Passengers</th>
<th>Days in Quarantine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alicante</td>
<td>La Habana, Cuba</td>
<td>April 21, 1878</td>
<td>18</td>
<td>10</td>
</tr>
<tr>
<td>Alfonso XII</td>
<td>Cadiz, Spain</td>
<td>June 12, 1878</td>
<td>10</td>
<td>17</td>
</tr>
<tr>
<td>Marsella</td>
<td>La Habana, Cuba</td>
<td>July 24, 1878</td>
<td>6</td>
<td>6</td>
</tr>
</tbody>
</table>

Quarantined vessels during the first period of the station, 1878
the daily operation of the station including diet, garbage disposal, and the use of quotidian artifacts remained unanswered. After examining the documentation relating to the Lazareto we anticipated the types of artifacts to be expected in association to the convalescing ward and the sick ward as follows: (1) artifacts associated to kitchen activities such as food preparation, food serving and storage of food and supplies, (2) refuse deposited on garbage pits that could shed light on the dietary elements of the quarantine station and the processing techniques, and (3) refuse associated to discarded medicinal artifacts.

Systematic fieldwork carried out at Isla de Cabras in three seasons brought forth undocumented elements and generated a collection of material culture that provides a better understanding of the operation of a specific quarantine facility. In some instances the archeological record can corroborate or refute the archival data, and in other occasions, there are questions that cannot be answered with the archival and architectural documentation. A single cultural deposit denominated Locus 1 was located north of the Convalescing ward. The cultural materials consist of an extensive amount of kitchen and tablewares as well as domestic refuse that can be linked to kitchen activities, diet and medicinal artifacts. Therefore, the deposit could be a trash midden, or the result of the collapse of the kitchen pantry where crockery, tableware, cutlery, and provisions were stored.

In order to understand the types of artifacts used for kitchen activities, we turned to the 1885-1886 proposed budget for the quarantine station, and the request for bids for the meal service from 1886. The budget estimated having fifty people for a period of 120 days, divided into 20 first-class place settings, 10 second-class place settings, and 20 third-class place settings. The information from Locus 1 sheds light on kitchen activities by way of the artifacts used and the foods that were prepared. Artifacts related to food preparation recovered from Locus 1 include evidence of kitchen wares and storage.
containers. The tableware pieces include fragments of saucers, small plates, shallow dishes, deep dishes and tureens while the drinking vessels consist of coffee cups, tumblers, and goblets.

As soon as the Lazareto was opened in 1878, efforts were made by the Municipal Board of Health to establish a service that would provide meals to the quarantined passenger. Eventually two kitchens were added to the station, one adjacent to the convalescing ward and the other adjacent to the sick ward but regardless of these additions, bids for the meal service at the Lazareto de Isla de Cabras were requested on 1886. The archaeological evidence from Locus 1 indicates the presence of faunal remains and shells that can be related to the diet of the personnel at the quarantine station—78% of the sample consisted of invertebrate species while the remaining 22% corresponded to vertebrate species. The vertebrate species are represented by various anatomical parts of cow, pig, chicken, turkey, horse, turtle and fish. In the case of fishes, only four species were identified from eight fragments corresponding to a minimum of six individuals. Although the 1839 regulations of the Hospital de San Juan Bautista de Puerto Rico, which is being used as a comparative element, do not mention the consumption of fish or seafood, its presence indicates that it could have been used as a supplement to the basic diet or incorporated later on. The invertebrates are species whose habitats include terrestrial (crustaceans), estuary-coastal (marine mollusks), banks and reefs (marine mollusks) and multiple habitats which are consistent with what was available both in San Juan and at Isla de Cabras. These species could have been used for soups, stews and paella. The expenses associated to the operation of the quarantine station show that the groceries and other items needed for the passengers of the quarantined ships were brought over from San Juan. The fact that no complete examples were found for the terrestrial species supports the fact that there were no existing animal pens within the station; and the meat was supplied by a butcher shop.

The purpose of the maritime quarantine station can be divided into two categories: suspect and non-suspect passengers. The objective of the suspect quarantine was to isolate the passengers aboard a ship because of the suspicion that they could have been exposed to a contagious disease. This observation period was dictated by the board of health to allow time for the suspected passengers to show symptoms of a disease. This observation period was dictated by the board of health to allow time for the suspected passengers to show symptoms of a disease. After the confirmation by a doctor that the passenger manifested symptoms, additional quarantine days were imposed. The non-suspect quarantine was to isolate passengers exhibiting symptoms of a disease or already sick with a potentially contagious disease.

This differentiation is crucial to understanding the type of medicines and treatments that would have been available to the passengers. The first group would have not received any medicines since at the time there were no preventive treatments (Rigau Pérez 2009, pers. comm.). The types of treatment commonly used during the nineteenth century for cholera, small-pox and yellow fever included bleeding, the use of purges, emetics and poultices. The use of ingredients like mustard, arsenic, sulphur, ipecacuanha, magnesia, quinine, and senna, as well as castor oil was common. The use of purges and emetics were done to cleanse the body while poultices were used to alleviate irritated skin.

The small sample of medicinal artifacts from Locus 1 consists of a few bottles, fragments of glass ampoules and a dropper, which could be indicative that:
(1) medicines or treatment-related artifacts were not used at the convalescing ward in large quantities, after all it was a convalescence and observation ward, (2) the ward did not have a fully-stocked pharmacy because the medicines were purchased for each quarantine period as reflected in the expense accounts of the station, and (3) the medicinal artifacts were reused and discarded only if broken.

FINAL REMARKS

In 1898, the quarantine station was closed down and transferred to the Miraflores Ward of San Juan. The facilities at Isla de Cabras were converted into a leper colony that operated until 1926. Additional use of the buildings took place during the Second World War when Isla de Cabras and the Islote del Cañuelo were consolidated, and the area was converted into a military camp. Since the 1960s, Isla de Cabras has been converted into a recreational park. Over the years, the buildings fell into disuse, becoming the dilapidated ruins that can be seen today.

ABOUT THE AUTHOR

Paola Schiappacasse, PhD, is a historical archaeologist with research interests in the Caribbean. She is currently teaching in Department of Sociology and Anthropology at the University of Puerto Rico, and the Graduate Program in Archaeology at the Centro de Estudios Avanzados de Puerto Rico y el Caribe, where she also serves as a Graduate Coordinator.
For many thousands living in American port cities in the eighteenth and nineteenth centuries, yellow fever was a nightmare come true—killing many thousands of people each year. Even though the fever was endemic in tropical and sub-tropical areas of the globe, increased shipping and naval presence in southern waters helped to spread the purveyor (i.e., the mosquito) of this disease into northern latitudes. In the summer months (AKA, the “sickly season”), the mosquitoes’ expansive territory of fevered death could make even Alexander the Great’s many conquests look paltry.

Before the mosquito was acknowledged as the purveyor of disease, naval hospitals along the eastern seaboard had to contend with great public outcry against transporting and treating yellow fever victims to stateside hospitals. Within this milieu of apprehension, the Navy Medical Department established Naval Hospital Widow’s Island, a secluded quarantine station nestled off the coast of Maine in Penobscot Bay specifically designed for treating yellow fever patients.

Even though major ports in Norfolk, Va., Philadelphia, Penn., New York, N.Y. and Portsmouth, N.H. maintained “disinfection facilities,” the prevailing medical opinion of the day was that patients with yellow fever could be treated best if they were isolated in a sparsely settled “cool environment.” Remoteness was Widow’s Island’s prime feature. In 1884, after inspecting the 12-acre property, Surgeon General Francis Gunnell deemed the island “ideally suited as a quarantine site,” and procured $5,000 to construct a small “temporary” pavilion hospital, a wharf and to dig a well to supply fresh water. Under the guidance of Navy Surgeon A.C. Heffenger the temporary facility was completed in June 1885, complete with furnishings. Doctors from Naval Hospital Portsmouth, N.H. were ready to report and even a watchman was hired at the cost of two dollars a day, including Sundays. The only thing missing were actual patients. To rectify this, a larger hospital sanitarium was planned to accommodate 20 patients in a 94-foot by 25-foot main ward. Workmen laid out walking paths and planted spruce, fir and other evergreen trees on the grounds. The original temporary structure was relocated below the hospital terrace for use as barracks for men of infected vessels who did not require treatment. By 1888, the new facility was complete and ready to accommodate 50 patients in the main ward. Of the 11 yellow fever patients admitted to naval installations that year, not one came to Widow’s; this was a trend that would continue throughout its existence.

When the new Surgeon General (J. Rufus Tryon) took the helm in 1894, he decided to disestablish the hospital and get rid of the Island altogether. He deemed hospitals in Portsmouth, N.H. and New York as more “adequate” for the quarantine of yellow fever victims despite some public outcry from people in these communities fearful of contagion. On March 2, 1903, an act of Congress gave the Navy authority to cede the island to the state of Maine. Formal control over the island passed on January 1, 1904. According to the Reports of the Surgeons General, throughout its eighteen-year history, not one patient was ever admitted to the hospital.

In later years the old hospital became a summer retreat to “convalescent insane” and in the 1930s, the hospital was razed as part of a WPA project. Today, the island is privately owned.
Art therapy session at Naval Hospital Sea Gate, N.Y.
Brooklyn Eagle Collection
Courtesy of Brooklyn Public Library
Navy Medicine in Coney Island: A Short History of Naval Hospital Sea Gate

Built in 1927 as a luxury resort, the Half-Moon Hotel¹ was located just 10 blocks away from Coney Island’s famous amusements in an area called “Sea Gate.” The hotel offered visitors a bit of class along a boardwalk dominated by kitsch and cotton candy. Designed in the Spanish Colonial style in the shape of a half-moon, it featured relief busts of Henry Hudson, a luxurious “Isabella” lounge, murals depicting life in a seventeenth century Spanish port and a tower crowned with half-moon weather vane. Early visitors included Governor Al Smith who used the building as his unofficial headquarters, when not in Albany.

As the fortunes of the Half-Moon began to wane² the Navy was bolstering its wartime rehabilitation program and looking for resorts to turn into convalescent facilities. The Half-Moon was seen as a prime site due to the local amenities it could offer patients and the Navy contracted to lease the property for $70,000 per year. On August 30, 1944, the hotel was commissioned U.S. Naval Convalescent Hospital Sea Gate (designated “U.S Naval Special Hospital, Sea Gate, N.Y.” on July 1945).

As part of the Navy’s massive rehabilitation program, Sea Gate was one of several hospitals commissioned for the strict purpose of taking care of Sailors and Marines no longer in need of general hospitalization, but not yet able to return to duty or be discharged from service. The Navy’s convalescent facilities were rehabilitation havens where occupation and physical therapists applied their trades and explored new paths to recovery through physical education, hydrotherapy, light and heat therapy, massages, corrective exercises, and recreational services. Most of Sea Gate’s patients fell into one of two categories—those suffering from short-term illnesses like pneumonia or appendicitis and those deemed “chronic.” Many of the latter came from other hospitals with stays from months to several years. Surgical services were

¹ Named after the ship “Halve Meen” (Half Moon) used by Henry Hudson to explore North America. The hotel was purportedly located on a spot the famed navigator landed in the seventeenth century.
² In the 1930s it became infamous as the site where mobster stool-pigeon Abe “Kid Twist” Reles came to roost before “falling” out of a sixth floor window. Lucky Luciano would later state that the police guarding Reles were paid $50,000 to push the witness out of the window.
limited to minor conditions and non-operative orthopedic services. Most patients needing surgery had received it before entering Sea Gate.

As a former resort, the hotel offered patients an open-air sun-deck with reclining Lounger chairs, a ballroom, banquet halls, a large auditorium with stage and orchestra booth for visiting entertainers, lounge rooms brightly lighted dining hall with ample window spaces facing the boardwalk and beach. The facility also offered a gymnasium, pool-tables, a library, shuffle boards and recreational facilities stocked by benevolent societies like B’Nai B’rith.

Like many of the Navy rehabilitative facilities in World War II, Sea Gate offered patients various occupational and vocational training courses. Patients could learn photography, leather-working, wood-working, printing and typesetting, and automotive repair. Red Cross personnel frequented the hospital providing classes in painting and sculpture. The New York City Teachers’ Voluntary Service Organization offered various academic classes.

At its peak the facilities was staffed by seven Navy medical officers, one dental officer, eleven nurses, two chaplains, one supply officer, four line officers (serving as ship’s service, education, physical rehabilitation, and welfare and recreation), two WAVE officers for physical and occupational therapy, 106 enlisted personnel, eight Hospital Corps Officers, 17 civilians and 65 contractors for commissary services. From October 4, 1944 to June 1946, Sea Gate treated some 4,832 officers and enlisted.

Naval Hospital Sea Gate was decommissioned on June 15, 1946. It later served as a hospital (1949) and beginning in 1954, home to the Metropolitan Jewish Geriatric Center Nursing Home until 1989 when it was demolished.

References:

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The Navy’s First Convalescent Hospital (excerpted from article published in The Hospital Corps Quarterly, 1944)
By Francis Doty and J.L. Heckendorn

Perched majestically on the summit of East Mountain, like a mighty bird watching over her young, the U.S. Convalescent Hospital Harriman, N.Y. proudly surveys the rolling wooded vales, hills, plateaus, grassy-green meadows, and mountain lakes for many miles around.

This naval hospital, formerly known as Arden House, is located in the Ramapo Mountains at an elevation of 1,380 feet above sea level, and is the highest inhabited point in this vicinity. The Harriman estate itself, of which the convalescent hospital is part, is surrounded by Bear Mountain, Palisades Interstate Park. It is about 50 miles from New York City, on the west side of the Hudson River.

On August 6, 1942, Mr. William Averell Harriman (railroad heir and later New York governor) offered this beautiful 100 acre estate for use by the medical department of the Navy. This hospital is intended solely for male officer patients who, in a large majority of the cases, come for a much needed rest from military routine. Many have been wounded in the various theatres of war and are in need of rest and quiet. Others need a convalescent period following fractures and post-operative treatment.

An open patio, surrounded by the administration office, the organ room, and the glass enclosed corridor facing
Throughout World War II, the Navy operated special medical facilities for Sailors and Marines who no longer needed general hospitalization, but were not yet able to return to duty or be discharged from service. Patients sent to these "convalescent hospitals" required little treatment other than rest, psychotherapy, physical therapy and oftentimes "salubrious climate" and a good diet before being discharged or returned to duty. Oftentimes located in luxury resorts and hotels, the Navy convalescent facilities were havens of rehabilitation where occupation and physical therapists applied their trades and explored new paths to recovery through physical education, hydrotherapy, light and heat therapy, massage, corrective exercises, and recreational services.

**Location (in order of commission date):**
- Harriman, N.Y. – November 16, 1942-November 1, 1945 (Former home of politician W. Averell Harriman, 1891-1986)
- Santa Cruz, Calif.—March 8, 1942-April 1, 1946 (Formerly the Casa Del Ray, beach hotel)
- Asheville, N.C.—May 24, 1943-April 10, 1946 (Formerly the Kennelworth Park Hotel or Appalachian Hall)
- Yosemite, Calif.—June 25, 1943-December 15, 1945 (Formerly the Ahwahnee Hotel, Yosemite National Park)
- Sun Valley, Idaho—July 1, 1943-December 1, 1945 (Formerly the Sun Valley Lodge and Resort)
- Glenwood Springs, Colo.—July 5, 1943-April 1, 1946 (Formerly the Colorado Hotel)
- Arrowhead Springs, Calif.—May 23, 1944-April 15, 1946 (Formerly the Arrowhead Springs Hotel)
- Sea Gate, Brooklyn, N.Y.—August 30, 1944- June 1946 (Formerly the Half Moon Hotel, Coney Island)
- Springfield, Mass.—September 8, 1944- March 1, 1946 (Formerly the International YMCA College)
- Banning, Calif.—October 2, 1944-December 31, 1945 (Formerly the 297th Headquarters Army Field Hospital)
- Beaumont, Calif.—October 2, 1944-October 15, 1945
- Asbury Park, N.Y.—April 10, 1945-April 1, 1946 (Formerly the Berkeley-Carteret and Monterey Hotels)
- Palm Beach, Fla.—May 21, 1945-February 20, 1946 (Formerly the Palm Beach Biltmore Hotel)
- Camp White, Ore. (Medford) —August 31, 1945-1946
- Camp Wallace, Texas (Galveston)—September 5, 1945-1946 (Former Army hospital)

the reception room, is distinguished by a series of five fountains. The large center fountain is surmounted by a legendary stone figure of a man, a lion, and a turtle. Evergreens, shrubs, and flowers complete the arrangement of this court.

Far from the seething crowds of the metropolis where Mr. Harriman built his financial empire, the stone towers of Arden House rise through the dense mass of blue spruce maples and oaks as a welcoming sentinel to the fatigued Navy patients coming to its sheltered walls.
Several years ago while placing flags on World War I graves at the Woodlawn cemetery for Memorial Day, I overheard a discussion about a Sailor who was purportedly buried there. He had died at the Chelsea Naval Hospital and was supposedly buried in the hospital’s cemetery in 1888. It was believed that his remains were then reinterred and reburied in Woodlawn in 1920. Every year the cemetery receives many queries about him. With my curiosity getting the better of me, I asked who this Sailor was and why he garnered so much interest. I would soon learn the name “Thomas Joseph Kersey.” And little did I know this name would send me on a quest that continues to this day.

In July 1876, while serving aboard the USS Plymouth, Ordinary Seaman Thomas Kersey saved a fellow Sailor from drowning. For his bravery and keen presence of mind, Kersey would be awarded a rare peacetime Medal of Honor in August 1876. Just twelve years later, at the age of 41, Kersey would be dead from kidney failure. Although Woodlawn has a letter attesting to Kersey’s re-internment at the cemetery, to this day no one knows where his remains are located. While trying to look into this mystery I soon learned that Kersey was not the only missing Sailor.

I discovered that remains of Sailors from the Chelsea Mariners’ Hospital and Charlestown Marine Hospital were transferred to the Chelsea Naval Hospital cemetery before the Civil War. The earliest headstones at Chelsea were originally from the Charlestown Marine Hospital cemetery. There seems to be little information about it. In the 1830s, after the hospital closed down, the remains were exhumed and buried at the naval hospital. Many of these burials included Sailors and Marines from the early nineteenth centuries through the end of World War I. And what tales these dead might tell if only we could inter-

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1. One of the first permanent medical facilities in the Navy, Naval Hospital Chelsea, Mass. was established in 1836. It was decommissioned in 1974.
2. Woodlawn Cemetery in Everett, Mass. is currently home to six Medal of Honor recipients, not including Thomas J. Kersey.
view them. What adventures at sea might they recall. Men who served in the War of 1812, including several British and possibly American Sailors from the crews who took part in the battle between USS Constitution and HMS Guerriere in 1812. Another burial contained the remains of a Marine killed in a duel of honor in 1819.

Sailors and Marines continued to be buried at Chelsea Naval Hospital cemetery until 1918 when all burials were ordered ceased on account of the deplorable conditions in the cemetery. Water was leaking from the harbor into the newly dug graves even before the caskets were dropped into place.

In the early twentieth century, the Navy purchased a parcel of land within Woodlawn Cemetery, and in 1920, preparations were made to transfer the remains and headstones to the cemetery. Work began in June, but once again trouble would arise.

When the first plots were opened workers were shocked to find not a single human remain. Capt. Norman Blackwood, the hospital’s commanding officer, assisted in solving the mystery. He discovered that in 1898 contractors were hired to transfer the graves from an older cemetery at Chelsea Naval Hospital. The headstones had been moved but bodies were left untouched. Blackwood set forth locating the missing bodies. Workers found 42 sets of remains to match the 42 empty grave sites. As they worked through the older cemetery they found an additional 60 unmarked graves. It is believed that among these unknown remains is Medal of Honor recipient Thomas Joseph Kersey. Between June and August 1920, all the headstones and some 290 remains were transferred to Woodlawn Cemetery.

These last few years I have tried to locate records that would enable us to identify the 66 “unknowns” now buried at Woodlawn Cemetery. Presently, I have been successful indentifying several of these unknowns. In some cases, a few of these poor souls have been buried three times. I have gone through the National Archives and Records Administration, the Bureau of Medicine and Surgery, Charlestown Navy Yard, City of Chelsea Clerks Office, Woodlawn Cemetery records, archival newspapers and, of course, Google, but to no avail.

It seems to me that an important part of United States Navy and Marine Corps History is missing. Somewhere burial records must exist. These records need to be found so that these unknown Sailors and Marines may be given the recognition that they deserve.

No one wants to be forgotten. It seems tragic that so many men who served their country and died doing so are simply to be remembered as “unknown seaman.” Might we at least find out who they were?

If you are interested learning more or joining me on this quest to uncover this mystery, please contact me at: babysullivan1@comcast.net

ABOUT THE AUTHOR
Mr. Ernie Sullivan is a retired history teacher with 35 years at Chelsea High School, Chelsea, Mass.
NAVY MEDICINE IN THE NORTH AFRICAN CAMPAIGN, 1942

"LST and Half Truck, North Africa"
by Albert Murray, Watercolor, 1944
Courtesy of Navy Art Gallery
88-195-EP
Throughout the allied invasion of French North Africa (November 8-16, 1942), Navy Medical personnel played a crucial role overseeing medical evacuations, working with Army and Allied colleagues in providing medical care at newly established shore based facilities, and shaping sanitary practices and precautions. As a result, casualties were kept to a minimum. The practices would later be utilized during the invasion of Sicily in July 1943.

The following history, excerpted from BUMED’s unpublished U.S. Navy Medical Department Administrative History, 1941-1945, offers a glimpse of this often-overlooked medical activities during the North African campaign.

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President Roosevelt’s announcement on November 8, 1942 that United States forces had landed that day on the Mediterranean and Atlantic coasts of North Africa brought to the realization of the American people that the war was being fought in earnest on the fringes and approaches to Europe. The long months of planning, preparation, and training were now to be tested in battle. The successful outcome of this first real thrust against the power of Germany and Italy was imperative if final victory was to be effected.

Simultaneous assaults were made on Casablanca, Oran, and Algiers in the regions of Morocco and Algeria, leading to the complete occupation of French North Africa on November 11, 1942. The United States Navy was a key factor in the final outcome, particularly in Morocco, largely because of the amphibious nature of the landings and necessary naval attacks on coastal fortifications and units of the French fleet. By the same token, the Navy Medical Department assumed its combat role and responsibilities immediately.

The invasions of North Africa were successful, both militarily and medically. In spite of the large scale of operations, loss of personnel was relatively slight. The estimated total of casualties amounted to little more than 2,000 of which one-half were wounded and the remainder killed or missing. Many of those missing, prisoners of the French, were subsequently returned to their respective units.

Much of the success of the North Africa operations may be traced to careful planning before the invasions, full cooperation between the forces entailed, adequate establishment and use of ship and shore facilities, and proper preventive medicine precautions and practices to keep casualties at a minimum. The U.S. Navy Medical Department played an important part in all of these phases. Full use of ship facilities was contemplated by the Navy Medical Department in the invasions of North Africa. For example, in the Safi area of Morocco, plans called for Navy responsibility for the medical care of personnel of all services between the port of embarkation and the high water mark on overseas beaches, including evacuation and hospitalization afloat. As visualized, transports (AP’s) were to serve for
Specific instructions provided that: (1) wounded were not to be evacuated until assault troops had been landed, except that men wounded in landing craft enroute to the beach were to be returned to transports; (2) transport beachmasters attached to shore parties would be responsible for removing the wounded from beach evacuation stations and placing them in boats assisted by medical action of shore parties; (3) the evacuation of wounded was to begin with the second trip of the boats, unless it became necessary to make rapid landing of vehicles, in which case the beachmaster was to be notified; (4) boats would return the wounded to the transports from which they were working, unless otherwise directed; (5) advantage was to be taken of placing wounded directly on ships at docks in Safi Harbor to the limit of the capacity afloat to care for the wounded; (6) boats with wounded aboard, on return to the transport, would be hoisted to the rail on the side davits for disembarkation; (7) the exchange of litters, blankets, etc., with beach evacuation stations was to be carried out; (8) reports as to the number of wounded aboard transports and remaining accommodations would be made every two hours; and (9) the commander of the transport group was to be informed every two hours by the regimental beachmaster as to the number of casualties ready for evacuation, with similar reports to be made to the regimental beachmaster by the battalion beachmaster.

As finally organized under this plan, the USS Harris (APA-2), for example, was prepared to receive 200 beds and 1,000 ambulatory casualties. Her medical unit, composed of a beach party
of one medical officer and 11 enlisted men, a main battle dressing station of two medical officers, a dental officer, and 15 Hospital Corpsmen, a forward battle station of two medical officers and eight Corpsmen, and an after battle station of one medical officer and six Corpsmen, was ready to meet all battle contingencies.

The use of hospital ships, in addition to transports, was planned for the Algiers area, where several were to arrive on D plus three days. One hospital ship was to be retained at Gibraltar until D plus four days for severe casualties.

Naval medical plans, contemplating the maximum use of shore facilities, were also completely formulated prior to the landings on November 8th. The premises on which this mission was based were: (1) the assault, landing, and seizure of the base were to be accomplished by the Army; (2) the first group of Navy personnel would land shortly after the assault troops; (3) some opposition would be encountered by Navy personnel and casualties might be expected; (4) the area occupied was to be available for establishing a naval base by the time the Baker party of naval personnel arrived; and (5) the sanitation and health conditions in the area of employment were such that certain precautions and preventive measures would have to be taken to safeguard the health and the care for any sickness that might be expected.

The methods of accomplishing the mission included: (1) preliminary preparations, which stressed instructions on personnel selection, preventive measures, identification tags, health records, health and sanitary conditions to be expected, and training; (2) procedures enroute, including preventive measures to be completed and training to be continued; and (3) procedures during and subsequent to landing.

The plan further provided for the logistics of medical personnel and supplies. Three medical officers, one dental officer, and twelve Hospital Corpsmen were provided—two medical officers and four Hospital Corpsmen to accompany D-day convoy; one medical officer and one dental officer, in addition to eight Hospital Corpsmen, to accompany D plus three convoy. Each was to carry appropriate field medical kits, and a brassard was to be worn by each of the medical personnel. Medical supplies were to include medical supplies and equipment of the Navy standard 20-25 bed dispensary unit. Water was to be obtained from the Army Medical Supply Depot, or Base Two, as circumstances warranted.

So far as the Army was concerned, it was known that provision had been made during the landing for the Army to provide first aid and to establish battalion first-aid stations. These were to be followed by division medical battalions and medical personnel to furnish collection facilities and clearing stations. At D plus four hours one surgical hospital of 250 beds was to be set up shore to care for casualties. At D plus
eight hours one evacuation hospital of 750 beds were to be set up to care for casualties. After the occupation, by D plus 13, there was to be one general hospital of 1,000 beds. Later, a medical field laboratory and a medical supply depot were to be established.

THE ASSAULT

When the landings began, American armed might face a test which could easily have meant a great national disaster if it had failed. The long ocean voyage necessary deprived our forces of nearby bases from which to recoup and draw reinforcements. This fact made the responsibilities of the medical department of utmost importance. Should heavy casualties result, as was expected in many quarters, the effectiveness of the medical department in returning casualties to duty would be a significant factor in recouping American losses. As events transpired, it was the good fortune of American arms that casualties were light—this despite heavy seas developing at the time of the landings which wrecked many of the landing craft, especially in the Morocco area, as they hit the beach.

Ship-based medical facilities did, however, play their part in the invasion. Besides handling routine work aboard, they formed at times, effective liaison units with the shore. An example was the USS Barnegut (AVP-10), which had anchored in the Sebou River in the Port Lyautey area of Morocco, and had furnished medical aid there during the landings. Beach parties from transports also gave substantial aid. Going ashore in various types of landing craft, including LCP (L)’s and LCP (R)’s, LCS (L)’s and LCM’s, both personnel and supplies were adequate to meet medical needs.

A report of the USS Harris indicated that about one-half hour after the landing at Safi, the general care of casualties had begun. The Corpsmen in the early waves treated and evacuated about five casualties from the Blue Beach as soon as the assault waves were in and before they had been joined by the medical officer. Communications had been established on D plus one day between the medical beachmaster and the ship and regimental beachmaster. At that time a battalion aid station was established on the shore end of a phosphate dock; henceforth casualties were moved to that station. When casualties were ready to be evacuated, they were transferred from the battalion station to the medical beach party for transportation to the ship. The regimental surgeon at this time ordered all casualties to be transferred to ships even though their apparent morbidity was less than 30 days.

Continuing, the report of the USS Harris pointed out that the treatment of casualties during the first day consisted of the applications of powdered sulfonamides to wounds, of splints to fractures, and the administration of morphine by syrette. In one case, plasma was administered after the casualty had been removed to the boat. Twenty-five casualties in all were treated and evacuated. Distribution of the casualties to the ships was entirely on the initiative of the medical officer and the Corpsman on D-day. On D plus one day, orders were received to evacuate the remaining casualties to USS Lyon (AP-71) and USS Calvert (APA-32). A few men were placed in returning boats, thus reducing the delay. The rigging installed for tiering patients in the boats was not utilized in this phase of the operations. The transfer from boat to boat was accomplished by means of a double litter lift raised by the single whip boom. All casualties were placed on the port or starboard quarter-deck and were later moved to the main battle station. Of the casualties, two of the Army [soldiers] died and were transferred to the Army field hospital ashore for disposition. Twelve casualties and two sick were transferred to the Army field hospital just prior to sailing; 10 were retained on board. Despite little rest for about 80 hours on the part of the crew of the USS Harris, all evacuation was accomplished without incident.

The experience of the USS Thomas Stone (APA-29) was unique in the North African invasions. Early in the engagement this transport was beached at approximately 100 yards from the exposed sandy beach at Algiers. Deprived of flotation and means of propulsion because of torpedo and bomb casualties before and after the invasion, the ship was in other respects in perfect condition. While in this condition, she was able to shoot down at least two planes, and was used extensively as a berthing and receiving ship. Her excellent sick bay proved to be a helpful supplement to the U.S. Naval Dispensary established shortly after the capitulation of Algiers particularly with respect to surgery, dentistry, laboratory work, and roentgenology. Although work was hampered at times by rough weather and resultant high waves which made it difficult to approach the ship, a reporting officer stated that “from all evidence
at his disposal, the medical department functioned during battle in accordance with the best tradition of the Navy.”

Land-based facilities had become well-established shortly after the invasion had taken place. A memorandum of November 21, 1942 from Capt. J.W. Vann, MC, USN, indicated that medical facilities (largely Army installations) in the Oran area included the 77th Evacuation Hospital of 750 beds, which was to be moved to Senia, about six kilometers from Oran. It was to be replaced by the 7th Station Hospital in Oran, having 650 beds in addition to 100 beds for sick officers and nurses. The 38th Evacuation Hospital of 750 beds was functioning under canvas at St. Cloud, about 20 kilometers from Oran. Furthermore, the 48th Surgical Hospital was functioning in the French Army barracks at Arzeu; the 9th Evacuation Hospital of 750 beds was to be established at Sainte Barbe du Tlelat about 25-kilometers from Oran; and one or two general hospitals of 1,000 beds to be established in or near Oran. A medical supply depot had also been established in Oran, from which the Navy was to draw its supplies. In addition, sufficient ambulances were to be provided for the Navy; burials were to be made in the American Cemetery at Oran; the water supply was sufficient, although in need of boiling or chlorination; and the naval dispensary in Iran was sufficient to supply prophylaxis for naval personnel.

A subsequent memorandum of November 28, 1942 from Captain Vann indicated that the medical plan had been carried out in most of its details. Medical supplies had arrived safely and were put to use, and the Army had succeeded in landing and had established its own medical facilities, which were available to U.S. naval forces. Certain local conditions had not been anticipated: (1) the unexpected working arrangements of the port of Oran; (2) the resultant distribution, billeting, messing and employment of U.S. naval personnel; (3) the medical care of Royal Navy personnel; and (4) the medical care of Armed Guard and Merchant Marine personnel.
during their stay in port. Sick bays with ample supplies and medical personnel had been established for the U.S. Navy at Mers-el-Kebir and Arzeu; and a dispensary, at Oran. Recommendations were listed for the handling of Royal Navy personnel, ships of the Merchant Marine, provision for ambulances, and evacuation of patients to facilities in the Zone of the Interior (under cognizance of the surgeon of the Second Corps, U.S. Army) and then direct to the United Kingdom and the United States.

Meanwhile, medical facilities were also established in Morocco. In the Casablanca area, the first medical personnel destined to establish permanent shore establishments debarked at Fedala on November 10, 1942. Consisting of three medical officers and eight Hospital Corpsmen, they established a temporary barracks and a small sick bay in a camel barn on the dock. Supplies, slow in coming ashore, consisted for the most part of the medical packs of these personnel, as well as material which could be gathered from other sources. On the night of November 10th, transport sinkings from submarine action resulted in several days’ work in which the Army and the Navy fully cooperated to care for the survivors who reached shore. Subsequently, a dispensary was established at Fedala.

Other facilities were forthcoming with the establishment of a first-aid station in the port area of Safi on November 9th and a sick bay at Casablanca on November 12th. On November 18th, a group of medical and dental officers arrived to establish the first dispensary at Casablanca. A permanent dispensary was established on December 7th, 1942 in a clinic formerly operated by a French physician and surgeon. In this building there was room for 54 beds, a good surgery ready for occupancy, X-ray equipment, etc., which permitted the medical and surgical units to start functioning at once. To meet increasing needs, several neighboring villas were occupied until space for 210 beds became available.

A permanent dispensary was established on January 1, 1943 at Safi in the building of the Regie Tobacco Company. At Port Lyautey, a naval dispensary was opened February 1, 1943—previous needs having been met by medical beach parties during the invasion, by medical units of the USS Barnegut anchored in the Sebou River and by VP-73, which had arrived from Iceland on November 15th to set up a sick bay.
Navy Base Hospital 9 in Oran, Algeria, 1943

BUMED Archives
Memories of Base Hospital 9:
Excerpt of Oral History with CAPT James Miller, MC, USNR

Navy Base Hospital # 9 (Glen-57) was a 500 bed facility placed in operation during the North African Campaign of 1943. Capt. James Miller, MC, USNR served as Chief of Surgery at the hospital from 1943 until its decommissioning on September 30, 1945. Years later, theBUMED History Office caught up with Dr. Miller and captures some of his memories this facility.1 The following is an excerpt of that session.

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In 1942, I was ordered to join a group called “Glen-57.” We weren’t told where we were going. When we finally got to New York after about two weeks of waiting around in Norfolk, they put us on a barge and took us down the Hudson River. We were just sitting on our gear on the barge. Then we went on down to Bayonne and were put aboard a Navy supply ship, the Tarazed (AF-13),2 which took us across the Atlantic in what was said to be one of the biggest convoys that had gone across. There were four of us in the cabin I was assigned. There were bunks. The first three of us got in the cabin and put our steamer trunks under the bunks and we thought we had plenty of room until the fourth one showed up with a great big trunk. After that we could hardly move. All the personnel for our whole hospital were on this one ship, which included about 300 Corpsmen. We officers had the cabins to sleep in; the others had to string up their hammocks. I remember feeling pretty sorry for some of them being so crowded.

We woke up the morning after the ship got underway and right in front of us was this great, big battleship. I don’t recall the name, but it was big. We thought, “Gee, we’re safe enough.” But, then we realized that battleships weren’t really that good at taking care of submarines. So, we weren’t quite as easy about it as we had first thought. We had one or two days with rough seas but for the most part, the weather was beautiful and the water was smooth. On the outside of the convoy were the destroyers. We moved down the Atlantic coast. We knew we were still close to the coast even though we couldn’t see it because we were covered by airplanes looking for submarines. After the crossing we began seeing planes flying out from the African coast to cover us.

This convoy had a lot of Army personnel that were being transported across for the invasion of Italy. That was 1943. We landed September 3, 1943 in Oran.

We were assigned to other Navy receiving stations, small craft landing stations and what-not. Our hospital had not even been started when we landed. We heard that the Seabees and Italian prisoners were starting to build the hospital in a wheatfield about five miles out of Oran, but, until that was set up, we were parceled out to various hospitals. I was sent to a 105th station Army hospital that was set up in Oran in a girls’ school. I was there with a group of doctors, medical staff, that had come over from Atlanta in the same convoy in which we came. They had also been going to set up a Navy hospital.

The hospital had some specialists. I was chief of surgery. We had, of course, a man trained in X-ray. We had a medical internist from Philadelphia. I must say that the group they put together was easy to work with and we thought quite efficient.

We pulled into Oran, actually Mers el Kebir, just a little outside of Oran, on the second of September. Right beside our pier, they were loading soldiers to go to Italy. The thing that impressed us was how tough these fellows looked. It looked to us, as we’d see them going up the gangway, that anyone that got in front of them was going to catch it. Of course, it turned out that they were a tough organization.3

We were assigned to other Navy receiving stations, small craft landing stations and what-not. Our hospital had not even been started when we landed. We heard that the Seabees and Italian prisoners were starting to build the hospital in a wheatfield about five miles out of Oran, but, until that was set up, we were parceled out to various hospitals. I was sent to a 105th station Army hospital that was set up in Oran in a girls’ school. I was there with a group of doctors, medical staff, that had come over from Atlanta in the same convoy in which we came. They had also been

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1. Oral history session with Capt. James Miller, MC, USNR conducted by Mr. Jan K. Herman, BUMED Historian, February 12, 1990.
2. On August, 21, 1943, Tarazed weighed anchor departed Norfolk for North Africa, arriving at Mers el Kebir on September 2nd. After calling at Bizerte and Algiers, she returned to the U.S.
3. Seventh United States Army
pushed into this station hospital just temporarily until they were set up. So, I got acquainted with a good many of the Atlanta doctors. We'd play poker and spend the time.

CAPT [George] B. Tyler⁴ would come by and pick me up at this hospital and take me out to the site of the new hospital so I could see it as they put up the quonset huts.⁵

It was really quite comical. Here it was, in the middle of a wheat field. The roads had not been treated; they were just mud. The Seabees were trying to finish up this hut. They knew we were supposed to move in. It was raining; it was cold; it was sleeting. I think it was the worst day, weatherwise, that we had. The Seabees were working, trying to wire the hut and put up the stove. The painters were trying to paint the interior. And we moved in, four of us, with all our gear. But, I recall that we had a real good night sleep on those cots. We really enjoyed it. This was in the early part of November. We commissioned the hospital on 19 November 1943. We took 30 patients the day the hospital was commissioned.

[The first patients came] from Army hospitals. There must have been a dozen Army hospitals in the Oran area at that time. So why did we need a Navy hospital? The Navy was sending their patients to the Army. When an Army hospital would get orders to go to Italy or Sicily, or wherever, they'd take the Navy boys with them. They said that it was a very difficult task keeping track of the Navy boys who were in the Army hospitals. That was probably the main reason. Another reason was they anticipated that the Army would be less and less in that area and that the Navy would still be there. The port was considered to be one of the best ports in the Mediterranean.

The object of our hospital was to treat patients who could recover in four to six weeks and that would not have to be sent back to the States. I thought we had unusually good Corpsmen assigned to our hospital. It was sort of fun helping to set it up. I wrote to my wife in one of the letters saying, "I learned more about hospital equipment in those few weeks than I had ever had before."

I recall that dust storms were pretty bad. But, somehow the Seabees were able to seal those operating room huts tight enough that, as far as I can remember, the dust was not a great problem inside. But it was in other places.

The patients that came in were so happy. To begin with, they were in a hut instead of a tent. It was beginning to get cold at night. The winter was rough in the tents of the Army hospitals. For us, in the quonset huts, with a stove—with a space heater—it was very pleasant. The patients that came from these Army hospitals were just tickled to death with the set-up.

We handled all kinds of acute cases, like acute appendicitis or trauma cases. Some of the worst cases we had to handle were not war casualties but were due to accidents. A Navy truck loaded with boys, going to a movie or something. They'd be spilled out down into a ravine or something. We had three of those situations, with as many as 40 injured people. Some of them were pretty badly injured. We had a few deaths from head injuries on account of these accidents. But, getting back to the type of surgical cases we had, it was more or less whatever would be at a station hospital or community hospital in the States. Some of the things that looked liked they were going to take a long recovery period, we would try to get them transported back to the States.

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4. Commanding Tyler, MC, USN served as the Commanding Officer of Base Hospital 9, Oran Algeria (1942-1945)
5. The hospital consisted of 110 prefabricated Quonset huts.
Halsey's Typhoon

The True Story of a Fighting Admiral, an Epic Storm, and an Untold Rescue

Bob Drury

Tom Clavin
Some books are meant to be movies. *Halsey's Typhoon* is definitely one of them. *Halsey's Typhoon* is a spell-binding World War II account of a super-storm that decimated the Third U.S. fleet in December 1944. The characters include the legendary Adm. William “Bull” Halsey, the fleet commander, and its task force commander, Vice Adm. John S. McCain, Sr., whose son, John II, a celebrated Navy veteran, is today a U.S. Senator. The story line of this tragedy includes heroism, mistakes, shipwrecks, terror, carnage, and a remarkable rescue mission.

Halsey’s task was to support General Douglas MacArthur’s invasion of the Philippines with bombing missions flown from his carriers against Japanese airfields and ships. From the 14th to the 16th of December, 78 planes destroyed 270 enemy aircraft and sank eighteen ships, crippling another 327. On the 16th the fleet was some 300 miles east of Luzon and was encountering squalls as they steamed toward the Philippines. Cmdr. George Kosco, the fleet’s meteorologist (an aerologist in those days) on Halsey’s staff aboard the carrier New Jersey, had access to the primitive weather forecasting radar of the time, but this was not much improved beyond the classic trio of barometer, thermometer, and a “seasoned weather nose”. Early on December 17th, the pilot of a scout plane reported a tropical disturbance 225 miles south east of Luzon, but through a variety of snafus his report failed to reach Kosco for a day and half. It was a classic case of “the dog that didn’t bark.” Although Kosco warned Halsey of strong weather ahead, he could not predict that a vicious storm was brewing in their path, and the fleet remained on a course that would take it squarely into the typhoon at the peak of its strength.

By the morning of the 18th, the fleet was encountering the full strength of the storm. The ships’ fuel tanks were becoming dangerously low on fuel, which also made them more top heavy and less stable, but in spite of the increasingly intense weather, Halsey ordered the fleet into formation to refuel with oilers. However, refueling became impossible as the ships were mercilessly pummeled with winds howling at over 140 miles an hour and gusts much higher. Kosco’s anemometer on the New Jersey was torn from its support and blown into the sea. The smaller ships, especially the destroyers and destroyer escorts, were especially subject to dreadful rolling and capsizing, and there were reports of seventy degree rolls. Conditions aboard the ships were nightmarish. Three destroyers were lost; the USS Hull capsized, USS Spence broke in half, and USS Monaghan imploded, taking ninety percent of its crew to the bottom. The typhoon destroyed 146 planes. The casualty toll was 793 dead with many others injured.

Survivors found themselves in shark-infested waters as Halsey ordered the fleet to rendezvous and steam away. However, Lieutenant Commander Henry Plage, skipper of the destroyer escort USS Taberrer, which was heavily damaged but still operational, intentionally disregarded the order and continued a careful, methodical search, plucking survivors from the water. Other ships eventually joined in the search, and 98 men were saved. Of that number, 55 were rescued by the Tabby, and there have been efforts in recent years to award Plage the Medal of Honor for his epic rescue mission.

A court of inquiry found Halsey responsible for the tragedy through his errors in judgment by sailing the fleet into the heart of a typhoon, but did not recommend sanctions. According to the authors, Halsey would never speak or write about the inquiry for the rest of his life. Strangely enough, in June 1945, Halsey’s fleet encountered another typhoon east of Okinawa that killed six sailors. The inquiry in that case also recommended no action against the admiral.

In this case, the absence of a fully effective warning system for an impending threat at sea, along with the hubris of a leader committed to a goal that would override the safety of his command, resulted in dreadful suffering and death. Yet, *Halsey's Typhoon* would accelerate advances in weather forecasting at sea, especially the use of aircraft dedicated to this mission. And as is so often the case in disasters, survivors told stories of heroism and presence of mind in the face of dreadful odds, such as was the case with Henry Plage.

~Review by Col. (ret.) Richard Ginn, MSC, USA