The Vietnam Archive
Oral History Project
Interview with William G. Meffert
Conducted by Jason Stewart
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Transcribed by Sarah Tapia

NOTE: Any text included in brackets [ ] is information that was added by the narrator after reviewing the original transcript. Therefore, this information is not included in the audio version of the interview.

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Jason Stewart: This is Jason Stewart with the Vietnam Archive at Texas University conducting an Oral History interview with Dr. William Meffert. Today is April 29, 2011, and we are in Herndon, Virginia. Alright, why don't we begin, sir, if we could, if you could tell me a little bit of information about yourself. First of all, when and where were you born?

William Meffert: I was born in 1936 in Iowa City, Iowa.

JS: Alright. Could you tell me a little bit about your parents? What were their names and what did they do for a living?

WM: My father, his name was Clyde. He was a doctor in Cedar Rapids, Iowa. A surgeon. Served in World War II with Patton's Army. Participated in Baston and the Battle of the Bulge, that sort of thing. My mother—maiden—my mother's first name was Elsie. She left Iowa to get her master's degree at Columbia University. They both met earlier in college, and they decided to live their life in Cedar Rapids, Iowa. That's where I grew up.

JS: Where did you go to high school there?

WM: To Franklin High School in Cedar Rapids.

JS: Let's see, what year did you graduate?

WM: 1954.

JS: Was it directly off to college at that point?

WM: Yes, that next fall.

JS: Where did you go to college?

WM: Duke University.

JS: Could you tell me a little about your experience at Duke? What that was like for you.

WM: Well, I was pre-med. So, I was taking quite a heavy load of science. Including zoology and biochemistry, analytical chemistry eventually. Qualitative and quantitative chemistry. It involved about five labs a week, which made for a fairly heavy load. Eighteen hours plus five labs (clapping in the background). I wrestled a lot in high school. I wrestled a lot for Duke, too. I was on their team, and we traveled a lot up and down the east coast. I guess that's what kept me sane with all the studying. Because I probably wouldn't have enjoyed it as much if I hadn't done that. We had good times.

JS: Did you know all along that you wanted to go to med school and become a doctor?

WM: You know, I think probably wasn't too realistic because it's the only thing I ever considered. It was very competitive at Duke. Took pre-medical courses at—we were heavily booked and crowded. I think they really didn't want everyone to be pre-med who was. So, there was a lot of competition. It wasn't always pleasant because of that. I should have probably had some alternatives, but I just never did.

JS: What about the med school itself? Where did you go?

WM: I went to Yale. I really had a great time at Yale. It was one of the few times I was treated like an adult. Had a responsibility of their own for learning and didn't have to be tested every single step. We had two main examinations in four years. But other than that, the examinations were voluntary. I so appreciated being treated like an adult. I found it quite a pleasant experience. I mean, you didn't have time to do a lot of the things that you might have enjoyed. Like traveling or taking time off for various things that you might have enjoyed. You studied; you know. Every night and every weekend. But they trusted us to learn. We had oral examinations perhaps every week. There'd be about four or five of us in a professor's office. Must have spent a lot of time with those students because they'd test you in a congenial way. You know, talk with you like we're talking

sort of. They had a pretty good idea of what you knew and what you didn't know. What your concerns were. I just really liked the atmosphere there a lot.

JS: Well, what about after that? Was it on to a residency at that point?

WM: I did six years of residency. I stayed at Yale for that. General surgery first, and then thoracic and vascular. Then a chief residency in cardiac surgery.

JS: How did you get involved with the Army? How did all of that come about?

WM: Well, it was a competitive system, again. When you're a resident we started out with eighteen interns. They call them first-year residents now. We ended up with two chief residents at the end of six years—or, at the end of four years. Before you're appointed for the final two. Every year several people got dropped out of the program. If you couldn't guarantee you wouldn't be drafted in the Army, they probably wouldn't keep you. Because they hated to invest that time in your training and then have you suddenly leave the program. So, it wasn't a patriotic thing. We all just volunteered out of the compe—because of the competition. We all volunteered for the Berry Plan.

JS: Could you, for possible future listeners that don't know exactly what the Berry Plan is, could you tell me a little about what the Berry Plan was?

WM: The Berry Plan was set up to allow people who were specializing in their training, such as surgery or the subspecialties of surgery, to finish their training before they were taken in the Army. You volunteered to go in the Army if they'd let you finish your training rather than take you out in the middle of your training. Which was quite disruptive. Not only personally, but to be drafted out of a competitive program when you're in pretty heavy competition would be hard to get back in the program. So, we all volunteered for that reason. Not particularly out of patriotism. Although back then I guess I believed that we had a place in Vietnam.

JS: Timeline wise, as far as this is concerned, when you were going through residency, when would this have been?

WM: Well, I finished up in 1968—late '68.

JS: You mentioned at the time feeling that America belonged in Vietnam. Had you paid close attention to what was going on, though? Did you follow it through the media?

WM: No, I really never watched television. I might read a newspaper now and then. I knew we were getting more involved right along. It seemed like, from what I'd read, that it was probably a good thing to do to prevent the domino effect, you know? But I didn't have time or the inclination to really study the different reasons.

JS: Did you see much of the war protests on the campus there?

WM: No, I spent my life in the hospital. Anybody who was protesting would be downtown somewhere and I never went there. I just lived the life of a medical monk, more or less.

JS: Since you had volunteered and once you were finished with the residency, was it on to the Army at that point?

WM: Yes. I had orders—when I graduated, just before I finished residency, I got orders for Camp Zama in Japan. So, we sold our car. We sent all of our household belongings, all of winter clothing, all of my medical books to study for boards, to Japan. Then my wife stayed and waited, expecting to go to Japan. She stayed with my family in Iowa while I went down to Ft. Sam Houston for training.

JS: Could you tell me a little bit about what the training was like?

WM: We learned what a high velocity gunshot would do. One that was—a bullet that was traveling 2,500 feet a second as opposed to a .45, for example. An M16 or an AK compared with a .45. That was quite dramatic. We operated on sheep that had been shot there. We looked at what the bullet did when it went through gelatin and hit a glass rod at a distance. The shockwave would break the glass rod. Which happened in Vietnam. A lot of bone would break that wasn't actually struck by the bullet because of the shockwave. The bullet would be a quarter of an inch in diameter, perhaps, plus or minus. But the shockwave would be a foot in diameter that went through a person's leg, for example. It wasn't unusual to have a little entrance wound, like you saw tonight, and a big exit wound. But the main thing was not the destruction that the bullet did particularly, but the shockwave. It would just rip things apart and many times damage things that were quite some distance away. You had to be very careful and take out all the dead tissue that the shockwave caused, as well as the bullet. Which sometimes would break up and cause multiple shockwaves in the tissues of the body. So, I learned that down there. The rest of it was not—I mean, we played toy soldier with the compass at

night. People trying to find us, and we crawled under gunfire, and this sort of thing. But it was sort of taken as a joke by us. Although, I did see the need to get in really good shape. It was back then I think I first started to jog seriously and take my conditioning seriously. Because I figured it just might be really smart before you went to a warzone to be in fairly decent shape. So, that started then too.

JS: Any particularly memorable moments or funny moments? Anything like that from that training that sticks out in your mind?

WM: Well, one of the things I'll always remember is going through a line to have the medical people—the people that worked in the office, examine your orders—(third person speaks in the background). They looked at my order and said, "Camp Zama, three-year commitment." I said, "Well, our orders only say two years. I have other commitments after two years." They said, "Well, Captain, if you don't sign up for the third year, we'll change your orders." I had already—you know, they'd already had me ship—sold our car, sent our clothing, all the books, all of our household things—my wife's sewing machine, all this over to Camp Zama where I had orders. To me, it seemed like blackmail. I'll never forget that. That was the first time I really began to dislike the Army and to distrust some of the people in the Army. I thought it was really a very poor thing to do. I called my wife—they did change my orders, actually. After we'd been in training there for a couple weeks, I got orders for Vietnam. I told my wife. She came down to San Antonio to be with me. Left the two kids in Iowa. We faced it. I didn't think that signing up for a third year was a wise thing to do. Particularly since it had been handled that way. Because I thought if they're gonna do that, they'll send you to Vietnam anyway after two years. So, I just didn't do that and sure enough, the orders got changed. Well, she was pretty upset. I had planned to probably go into academic medicine. But we got to—she got to know Iowa where we grew up over that year and it really changed the rest of our lives. I ended up practicing in Iowa. It might have been traced back to that change of orders. It seems rather strange. But anyway, I had a pretty unfavorable impression of that in the first introduction to the Army.

(Editor's Note: there is a lot of noise from people in the background. The interviewer comments on it, but it is not relevant to the interview)

JS: This is getting a little loud over here, I'm not sure what is going on. So, once the orders were changed—I'm not sure this is gonna work. Let me pause this for a minute.

(Editor's Note: background noise continues, interviewer briefly stops the interview to relocate)

JS: So, once the orders were changed, were you then at that point sent to Vietnam pretty soon afterwards?

WM: In about three weeks.

JS: Oh, wow. So, not much time to prepare then.

WM: Once through basic training, such as it was.

JS: Oh, okay. So, that was before the basic then. Okay.

WM: Well, we got down to Ft. Sam and it wasn't—it was in the first week that they reviewed all of our orders. So, then we had, as I recall, it must have been three or four weeks of basic training. That was the first week and we had three more after that.

JS: Tell me, I guess, a little about the trip over to Vietnam and what that was like for you.

WM: Well, I'll never forget that either. I waited in Oakland at the Naval terminal for several days for a plane. I was rooming with two Vietnam veterans that had come back. They went out every night and partied all night and drank, you know, and so forth. Of course, I was just entering, and they were just leaving. Their attitude was almost psychotic exuberant. I was scared out of my mind. So, I was actually—as it was the first time, I really didn't have anything to do. I mean, I had been going through this rigid training thing for twelve years—yeah, twelve years after college. I still never watched a football game. Everybody was drinking beer and I couldn't quite believe the life and the exuberance of these people. I was actually glad to leave. But we left at midnight and took a bus out to—what's that air base out there near Sacramento? I can't remember. Anyway, they bussed us out. Everyone very quiet. On big—several busses. We loaded on a 707, flying Tiger Airlines. I think they had their full gear on at that time. Everybody very quiet and with their uniform. I think they had their guns, as I recall. Upright seats. Very hard to sit. The plane was really loaded. We took off and—Travis was the name of that air base. We flew over San Francisco, and I remember looking down at those lights and seeing

them disappear underneath the right wing. I thought, “My god, I may never see those again.” That was a pretty tough feeling. Then we landed in the middle of the night in Honolulu. We met a group of soldiers coming back from Vietnam. They were hollering and shouting and drinking beer. They’d see you and know you were going over by your clean fatigues and probably by the look on your face. They say, “Oh, you’re the fucking new guys? You watch out. You’re gonna get your asses shot off.” You know, all this sort of thing. Every time you’d go in the john you’d run into a bunch of these people. So, then we got back on the airplane, and we flew to Guam. We landed in Guam, which is up on a high cliff. It’s a pretty traumatic entrance. We went for the john, the same thing happened again. We ran into more planes coming back. They said, “Fucking new guys. You won’t be thinking this was a picnic, you know? Watch out. Keep your head down,” all this sort of thing. Then we landed at Tan Son Nhut. The doors opened and there was this humid, hot air. This heavy air that smelled like diesel fuel and charcoal and rotten fish. These people running around—the Vietnamese with their hats. You realize, “My god, this isn’t National Geographic. This is real.” You heard the phantom jets taking off. This huge noise right beside where we were parked. We all got herded over and sat down in chairs and somebody told us what we had to do the rest of the day. Check our money in. Get a haircut. Be sure to not to try to sleep in. If there was any noise, run for the rocket shelter and this sort of thing. Because people were killed there last week, and they did not. That all happened in one day, basically. So, that’s kinda my memory of going over there. It was pretty rough. I thought, “Well, I’ll probably never make it out of here.” You sort of thought of your wife, your family, you parents. At that point, you still sort of believe that you—that America had a good cause, as I did at that point.

JS: Did you already know at that point that you were going to the 95th Evac?

WM: No, we got that—I think the next day we got our assignments. They took us over to the headquarters. I Corps—I’m not sure what it—it may have been the headquarters of all the different Corps; 1st, 2nd, 3rd and 4th Corps. Then I got my assignment then. I think later that day we flew up in a C-130 and landed at Da Nang. I was met there by an ambulance and got into the 95th just after they had moved into their new quarters.

JS: Could you tell me a little bit about your first impressions of the 95th? Of the hospital itself, some of the staff, that type of thing.

WM: Well, it was very clean. I thought it was well staffed. I met a surgeon the next morning. Introduced myself. He said, "Well, why don't you"—he said, "I've got two weeks left. Why don't you follow me along and see what we're up against and see how we deal with different things?" I thought that was quite helpful. I operated with him and talked with him about cases. I don't remember his name. I didn't particularly have much to do with the administration at the hospital at that time. Because we sort of melded into the surgical personnel and just started working. I met them as time went on. But I was impressed with the facility. It was just new, of course. They had a pretty good laboratory. They could run arterial blood gasses and chemistries. They had respirators in the ICU (Intensive Care Unit). We had plenty of blood. We only ran out about two days in the whole year I was there. I thought the people in the A&D (Admission & Disposition) room, or the emergency room, were all well trained and mainly by experience. And very helpful. The nurses knew what to do. I was quite impressed right after training to go there. I was inexperienced, of course.

JS: As you begin to settle into your work and the job, I guess, could you talk a little bit about what you—your daily schedule. What your routine or your daily schedule would have been like.

WM: At the hospital?

JS: Yes, sir.

WM: Well, I would get up in the morning. I don't know, can't remember—probably six or so. It was usually that time. Make rounds. Check on the patients we'd operated on the day before. Set up the operating schedule for closing the wounds that we had left open for a few days. Check on the—especially the really ill people in the intensive care unit. I'd usually see them first before anything. Then we'd go to surgery and close the wounds up. Oh, this would be assuming it was a quiet day. A lot of the fighting was at night so a lot of times you got called to A&D at night. You didn't get up in the morning because you're already up. One day blurred into the next. You slept when you could. You slept on the floor or on a gurney somewhere when it was really busy. You just made it up as went along. You kept track of the sick patients you'd operate on.

Got ‘em ready as soon as you could for evacuation. You took care of the acutely ill. Tried to close up the older wounds when you had time between the major cases. It was a very fast learning curve. You learned that the training that you had of being very meticulous just didn’t work until you got control of the blood loss. If you tried to be meticulous at the beginning, you’d lose the patient. So, you had to be what people in academic medicine might think would be a very rough surgeon. Very gross surgeon. I mean, sometimes scooping the blood out of the abdomen with your hands. Big blood clots. Running blood, blood clots. You’d spill, the nurse would try to catch what she could with a basin and a sucker. But most of it would roll right over the side onto the floor. You could feel the clots between your toes. We were in shorts with sandals because it was so hot. Sweat was running off your glasses into the wound. You had to get the blood out of the abdomen. Assuming we’re talking about intraabdominal injuries. Had to get the blood out of the abdomen so you could see where the bright blood was coming from. You had to jam a sponge in there as quickly as you could. Maybe you had a minute or thirty seconds. So, your opening would be very fast. Sometimes—and I’m talking about critically ill patients. The patient might not even be quite asleep, but unconscious because of the severity of the wound. They would never remember anything. I talked to lots of ‘em. But you had to get in there fast to stop the blood loss. Then, kept your hand over the part where the blood was coming from, and you transfused the patient. You got things under control. Got some more help. Got some blood hung up. Three or four units brought in and ready. One or two running. Then you went after the injury. That’s the way you save those soldiers. Then once you’ve got control of the bleeding you could be meticulous like you were trained. But you couldn’t be—you had to learn not to be meticulous at first. That was hard for freshly trained surgeons, you know. But very critical. Very critical.

JS: Could talk, I guess, a little bit about—I’m not sure what role you would play in this, but as far as the triage system. Determining who would be operated on. How did that work?

WM: We had—we always had one or two emergency room doctors, A&D doctors. They got quite good at triaging. We very rarely had what they call nowadays as an expectant category. Where you thought somebody was gonna die. So, you put them

over in a corner somewhere and let them die. That happened in World War II and Korea, I guess. But I don't remember that happening in our hospital. Very rarely. I mean, somebody with a terrible head injury and brains sort of running out. Or other severe multiple wounds, maybe. But that was rare. Usually, we took the worst wounded patient right to surgery and tried our best to save their life. We lost some in surgery that way. But a lot of times we saved them. Especially if you were quick with the blood loss and stopping that.

JS: I guess, I know it would depend on the day, but if you could estimate. About how many surgeries would you be doing per day?

WM: When it was quiet, I went to the ARVN (Army of the Republic of Vietnam) hospital. The Vietnamese Army hospital and to the civilian hospital across town and I worked with a Dr. Phouc there. P-H-O-U-C, who happens to be in Houston. He came over for a training session with the American College of Surgeons and while he was gone, I think, Saigon fell. I've never spoken with him about the details, so I don't know what happened. But anyway, he's in Houston. We worked a lot together. Dr. Polit, who you may have—well, you didn't meet him. He gave his dictation last night. But Dr. Polit is a cardiologist. We would work—we'd make rounds over at the Vietnamese civilian hospital together quite often. We had a particular interesting rheumatic fever. He could—by listening, he was a very skilled diagno—

(Editor's Note: Audio abruptly ends and continues with session two)

Interview with
Session [2] of [2]
Date: 26 May 2011

JS: This is Jason Stewart with the Vietnam Archive at Texas Tech University continuing an Oral History interview with Dr. Bill Meffert. Today is May 26, 2011. I'm in Lubbock, Texas in the Special Collections Library on the campus of Texas Tech. Dr. Meffert is joining me by phone from California. This is interview session number two. Okay, I wanted to begin, if we could, first, I know last time you were talking about—you mentioned that your father was with Patton's Army in World War II and had participated in the Battle of the Bulge. Did he ever talk with you much about those experiences?

WM: A little bit. He sort of had to be prodded a little bit. It didn't involuntarily come up in our conversation. But I know that at one point they lost their hospital. They got the patients out and all the personnel got out, but they lost their physical hospital during the Battle of the Bulge. Then, I think after that they turned north—Patton's Army turned north and managed to break through the German line to get to Baston. The weather cleared that helped a great deal.

JS: I just remember that you had mentioned that last time. I just wanted to ask you had he mentioned it. But did his experiences, I guess, have any impact—his career as a doctor have any impact on your decision to become a doctor as well?

WM: It was really about the only thing I wanted to be after about eight or so. I used to go around with him all the time to the hospital. Later on, in college and medical school, I'd spend free time with him too. Going into the operating rooms, at least, as an observer. Meeting patients with him and talking about things. I'd been interested in medicine since way before college.

JS: Well, I guess, jumping now back to about where we left off the last time that we did an interview session. I wanna ask you a little bit about the operating room and the staff there where you guys would perform the surgeries. Could you talk a little bit about the—like, how large the staff was and what some of the different jobs were there.

WM: As I recall, we had at least six operating rooms. It may have been eight, but I think it was six. It was just opposite the intensive care unit and opposite the blood bank and the lab. It was quite an efficient set up. We would often run four or five operating rooms at a time, sometimes six when the casualties were very abundant. We had—we

didn't have as many anesthesiologists as we needed, but the people that—the techs were very good at giving the anesthetic and intubating these critically ill patients. They did an excellent job. The nurses also were very competent. You tended to work with certain ones because of the specialty. I mean, I was in general—doing general surgery. But also, chest and vascular. So, I tended to work with just a few nurses rather than everyone. They were very good. I was very impressed with them.

JS: What would some of the other specialties be besides chest and vascular?

WM: We had orthopedic surgeons, several of the orthopedic surgeons. We had ENT (Ear, nose, and throat) surgeons. Neural surgeons. Urologic surgeons. We had dentists. One or two dentists were there. I may be leaving one or two out. But we pretty much shared the patient load. Oftentimes, if a patient were severely injured, more than one system would be involved. So, you might find yourself operating on a patient who had an abdominal or chest problem. Someone else would be operating on the same patient with taking care of a head injury or fixing a shattered leg. So, we had multiple teams on lots of patients.

JS: I know that I asked you this question last time, but this is one of the parts of the audio that was a bit distorted. Could you talk a little bit about—I guess some memorable patients that stick out in your mind that you operated on?

WM: I guess the most memorable one was the last one. A patient—a thin soldier—a thin boy who lived in Iowa, I found out afterward. Not far from where I grew up. He was brought in in shock. Had an entry point of shrapnel, I think. Or perhaps it was a bullet in the upper abdomen. His blood pressure was about 60/40, something like that. We took him to surgery, had a lot of blood in the abdomen. The spleen was shattered. There were holes in the stomach and small bowel. We were able to take the spleen out fairly rapidly. It was bleeding. We closed the openings in the rest of the injury. Closed the bowel opening. Noticed when we were sort of halfway through the surgery that there was a small opening in the diaphragm. When the anesthesiologist would inflate the lung, a small bit of blood would come through the hole into the abdominal cavity from the chest cavity. So, we opened that. Opened the diaphragm and I could see that there was a hole in the sac around the heart and around the pericardium. So, we opened the sac, the pericardium, and there was a wound of the left ventricle. Every time the heartbeat, blood

would shoot out of this hole. Of course, we just had the small incision in the abdomen—in the upper abdomen, a midline vertical incision. But he was thin enough that we could fix that hole in the heart through the abdomen. So, he ended up with the repair of his left ventricle, repair of the diaphragm. The spleen removed. Multiple perforations of the stomach and small bowels, through a little short incision. That was sort of typical of the unusual situations you found yourself in. Where the usual approach would have been to split the sternum, if you knew he had a cardiac wound, and get a more direct approach. But many of these soldiers were thin enough and we had room enough to do some unusual things through unorthodox incisions. We did that fairly often, actually.

JS: Any other memorable patients as well that you could mention?

WM: Well, I suppose the most troubling cases were the ones that had multiple injuries. Such as a head injury and leg amputation, loss of vision, all in the same patient. Sort of wondered if you were really doing them a service to save their life. Really, I mean what kind of life would they have? It couldn't help but cross your mind. We didn't make that decision for them. I mean, we did the best to save all their lives. It troubled me at the time and subsequently what kind of life they would have. I'm sure it hasn't been the most pleasant, in many cases, though probably better than you might think. You know, there's kind of a moral question that came up again and again of exactly what we were doing there. I'd say maybe even more so in the Vietnamese. Where the same thing happened but they would have less support after they recovered.

JS: Once a wounded soldier had been operated on by you all, what would happen at that point to them?

WM: Depended on the injury. Usually, the orthopedic cases were sent out fairly rapidly to Japan or Okinawa, or even back to the States in a few days. If we could only complete part of the operation, we would keep the patient around until they recovered enough to go back and finish the operation or finish the repair. By that I would mean severely injured abdominal—a patient with a severely injured abdomen would have the intestines closed and the damaged part—the most damaged part removed. But perhaps there would be a lot of bleeding from the liver. In that case, after the patient's temperature was going down to a level that blood clotting would be insufficient, we sometimes would put a pack in the liver wound and take the patient to the intensive care

unit. Then go back the next day or the day after that to take the pack out of the liver and remove any tissue that wasn't alive. Or stop any bleeding that was still occurring.

JS: Would you ever hear of the fate of soldiers that you had operated on and been sent on, say to another hospital or back to the States? Would you ever hear about what happened to them?

WM: You know, I never did. That was one thing that I really missed, too. Because I would have really liked to have had a follow up. I guess you could always get a follow up on patients in general simply by going to the VA (Veteran's Administration) hospital. They have a big VA hospital here in Palo Alto. But it wouldn't be your patient. I just haven't done that. Maybe I'm just reluctant to. I'm curious but I don't ever follow through. Nobody's actually presented my particular cases to me. I'm aware of the general results from surgery in Vietnam and the comparison of surgery there with World War II and then subsequent wars such as Iraq and Afghanistan.

JS: In the 95th operating room and when you worked there, I know you talked last time about also volunteering at some of the Vietnamese hospitals. But when you were working in the 95th, did you only treat—did you guys only treat Americans? Or would casualties from other countries come in as well?

WM: We treated everybody who came in. Lots of civilians. Quite a few Vietnamese Army personnel who were wounded, and a fair number of Viet Cong. We never really neglected anybody. They were—as far as I was concerned, they were treated the same. So, I think the treatment was almost equal. There were two night I recall of the whole year that we ran out of blood for transfusing. In that case we just operated on the Americans till we got more blood. But that was the only time that we ever really showed any difference in treatment. A severely wounded Vietnamese who might die was taken before a lot of Americans who were pretty stable. Taken to surgery.

JS: You mentioned operating on the Viet Cong soldiers. Was there any sort of special rules or procedures for working on them regarding safety and that type of thing?

WM: I personally was not aware of any difference. Usually, when they're severely wounded, they're just—everybody's the same, you know? The war's essentially over and everyone has this human need. It wasn't very often that we had any incident related to what side they were on. I don't think that we had any special guarding or

anything like that. Maybe that did happen occasionally. I know that the Vietnamese Army Hospital had a separate area where the prisoners were behind bars. I'm not sure whether they operated on the Viet Cong or not. I think they must have, though. We did occasionally.

JS: Did you ever detect any sort of resentment towards you guys working on them? Say regarding other patients—American soldiers that were in the hospital? That type of thing. Did you ever see anything like that?

WM: No, I never did. No, I didn't see that.

JS: You mentioned a moment ago about a couple of nights of running out of blood. Outside of that, was the hospital well equipped? Did you guys always have the equipment and the supplies and things that you needed?

WM: Oh, I think we did. I mean, we had all the supplies you could reasonably expect in a warzone. I thought the lab did an excellent job with blood tests. The intensive care unit had respirators that were good for the time. They're outmoded now, of course. The blood bank was very aggressive in providing blood rapidly. Usually just type specific if the need were immediate. We saw a fair number of rashes from the blood not being cross matched really carefully in that situation. But that was not a big thing compared with loss of life if you'd waited for the very careful match. There were some things. I mean, they didn't have a heart lung machine. We could have used it to operate on Vietnamese civilians with more severe heart problems than just the mitral stenosis that we worked on. But I don't think you can expect that in a warzone. We certainly didn't.

JS: Where would the blood come from? Was it donated from soldiers? Or where would the blood come from?

WM: You know, I'm not really sure of that, Jason. I think it—the Red Cross collected it but maybe the Army did too. I never really looked into that. We had an ample supply.

JS: I know last time you also talked about on your off days sometimes you would go to the Vietnamese hospitals. Could you talk a little bit more about those experiences? Was this something you decided to do on your own? Was it a volunteer thing or was this encourage? How did that work?

WM: It was encouraged but you didn't have to do it. I happened to meet some Vietnamese doctors that I respected and were hard-working and pleasant to spend time with. So, one of them was a Dr. Phouc. I guess I told you he's in Houston, at least the last time I knew. He would come over to the 95th, oh once or twice a week. We'd make some rounds and talk about things. At least once or twice a week I'd go over there if things were quiet. If it were—if you were on third call and it was pretty quiet, usually we could go spend the day at either the Vietnamese Army or the civilian hospital. He and I would operate together over there. Their conditions were quite primitive. They lacked lots of things that we took for granted. Such as chest tubes that you use fairly frequently in a combat situation to drain blood out of the chest. We had a special plastic receptacle that we could apply suction to and so forth. They just used coke bottles filled halfway up with water. Had the tube drain into that. They didn't—the nurses didn't provide any particular care for the patient. The linen changes and the washing of the patient, and the meals were all supplied by the family's relatives. There was an intense overcrowding. There were, I think, 800 patients in 400 beds in the civilian hospital, as I recall.

JS: How about with the Vietnamese—with the military hospitals? Was there much difference in the facilities and the equipment and things that they had there between—when comparing the military and civilian hospitals?

WM: The military and the civilian hospitals were very similar in their equipment. There were lots of patients that hadn't been attended to in the emergency rooms of those hospital. The number of Vietnamese physicians was inadequate. It seemed like you could go by rows and rows of people that had been admitted to the emergency room but not treated yet. There wasn't much ability to take care of big burns or complex injuries. They just didn't have the personnel or the expertise. So, that was upsetting. But I thought the Vietnamese doctors tried to do the best they could. They weren't completely trained, lots of 'em. But Dr. Phouc, for example, and several other doctors would come to the evacuation hospital and make rounds. Ask a lot of questions and I think they learned quite a bit from us. They learned about our equipment too.

JS: I know the last time that you talked quite a bit about your impressions of Dr. Phouc. Unfortunately, that was one of those parts that was a little difficult to hear as well,

I believe. Could you talk a little bit more, I guess, about Dr. Phouc and your impressions of him?

WM: Actually, I didn't myself initiate that. He came to the 95th Evacuation Hospital to make rounds with surgeons. He was a partially trained surgeon. I think he'd had a year or two of training in France and then some more training in Vietnam. He was very eager to learn. He came on his own initiative on his motorbike and just showed up in the emergency room. Either I was there, or they called me to come and talk to him. We made rounds and he asked me to come and make rounds at the Vietnamese civilian and the Vietnamese Army hospital. He was the Vietnamese—he was in the Vietnamese Army. So, we spent time at both the Vietnamese hospitals together and made rounds. Talked about the different patients and what could be done. What couldn't be done. Then we agreed to find patients that couldn't be treated very well or couldn't be treated at all with surgical problems that were too complicated for their hospitals. We sorted through the ones that we thought we could help. They set up a fairly large tent outside of our hospital. The patients that needed surgery were transferred there with their families. They set up sort of their own little community right outside of our hospital. Then Dr. Phouc would come over and we'd operate on those patients. Sometimes when he wasn't around, we'd operate on 'em ourselves when it was a fairly slow period. So, we took care of quite a few Vietnamese patients with interesting wounds or complex wounds by just transferring them to our hospital and waiting for a time that it was quiet and safe to take care of 'em. We gradually got to know each other as well as can in that situation. He brought his fiancée over one night for me to meet. She was just a lovely person. We went out for a times and had some beers and so forth. Just had a quite an interesting congenial time together that year.

JS: What was your impress, I guess, if you wouldn't mind, of Vietnamese civilians? Just your impression of them.

WM: Well, the people that had a little something material wise were in much better condition than the people that were living in the country. Da Nang was not a particularly sophisticated city. When we were there, it was more of a rural city. Most of the people—err, very rarely could they speak English. They didn't have really much in the way of material things. They rode bicycles. A few of the better off people rode

motorbikes and a few motorcycles. Pedicabs were used. Lots of 'em didn't—they wore sandals and very ordinary clothing. I suppose most of our patients were rural and not used to any luxuries. They seemed confused and dazed. Of course, they were worried. They were usually injured. It was a very awful time for them. But you couldn't help but like them. I mean, they weren't lazy. They weren't antagonistic. They seemed to trust you and care for what you tried to do for them. I suppose, you know, civilian injuries in a city might have been a little different experience. Didn't have too many that were injured in Da Nang itself. Didn't have any that were injured from Saigon either.

JS: Did you ever—err, were ever able to, I guess, get away from the hospital and see a little bit of Da Nang or Vietnam outside of the hospital? Or was your time completely spent there?

WM: We went down to Saigon to take a written board exam after about six months. Saw a little bit of Saigon but there really wasn't—Da Nang wasn't a place where you wanted to poke around and go in back alleys and that sort of thing. It wasn't particularly safe. I was always a little uneasy about driving a Jeep around. Usually, we had someone that drove it for us. But you just felt exposed. Quite a few times we would take an ambulance because it seemed safer. You close the doors and roll up the windows and nobody could throw a grenade inside. I guess they could throw it underneath, but it just seemed like you were in a safer situation. In Saigon we just landed at Tan Son Nhut, as I remember. Stayed overnight in the main hospital there—the main Army hospital. Took the written exam the next morning and then flew back to Da Nang. So, I didn't see much of Saigon. Just a little bit walking some of the streets. The main streets. It seemed quite a bit more of a mature metropolis than Da Nang.

JS: You mentioned the dangers there around Da Nang. Was the hospital ever mortared or did it ever come under attack while you were there?

WM: Not intently, I don't think—intentionally. We were near a Marine base called Tan Chau. Some of the rockets came right near us that were meant for the Marines, I think. We had one night when we thought people—we thought the enemy was trying to get through our barbed wire. Some helicopters come over and that sort of thing. We had one of the guards was shot. Just a minor injury one night. There wasn't any concentrated attack. We were quite exposed to attacks from the ocean. I mean, that was pretty much

unguarded except for several rows of barbed wire and some sentry posts. So, we could have been. But I think that the Viet Cong and the North Vietnamese sort of looked upon hospitals with some favor because after all we took care of a lot of those people too. Maybe that was the reason why they didn't really bother us too much.

JS: Well, I know we've talked about your time in surgery and also volunteering at the Vietnamese hospitals. But how else would you spend your free time if you had any? What types of things would you do if you had any free time?

WM: I didn't have a whole lot of free time because if we weren't doing much at our hospital, I'd usually go find Dr. Phouc and we'd do something at one of his hospitals. Used to write quite a few letters home. Make some tapes for the kids telling stories. We'd go—there was a little store there where you could buy things like cookies and soft drinks. We'd do that. We had an Officer's Club in evenings you could go to if you wanted to. I didn't hang out too much there. I read quite a bit getting ready to take surgical boards. I went through major texts and all these other specialties just to get ready for the board exam. So, no, I wasn't aware I had a whole lot of time. I mean, I wasn't just sitting around watching the hours go by hoping to get out of there. It went pretty fast, really.

JS: Did you have an R&R (Rest and Recuperation)?

WM: Yes. Went to Hawaii. Also, I left the hospital I think about five times taking prisoners—err, taking patients to Japan. Usually severely wounded patients. Then you'd spend that day and the next day in Japan and then come back to the hospital after that. So, that was a little relief. I suppose it added some safety to have a physician on the plane with some of these badly wounded patients.

JS: Anything else—any other memorable moments or anything else we should cover about your time incountry before talking about coming home?

WM: You know, I suppose my attitude changed towards the war. Maybe we've talked about that before, but it's not that I'm anti-authority but it's caused me to question political and military moves more than I used to. I mean, I used to—being from the Midwest we're pretty trusting people to politicians and military personnel, we tend to take them at their word. At least when I was growing up. But then after seeing some of the repeated injuries, taking the same land and giving it up. There was one hill near the hospital that was taken and then given back to the enemy three times in one year. At least

two dozen soldiers, I think, were killed each time it was taken. That really changed my attitude. It's one thing to list on a piece of paper twenty-four soldiers were lost. But it's quite another to see forty-eight or fifty boots in the emergency room and the dead soldiers there too. It really made me upset and somewhat angry, and distrustful of authority. At least suspicious. I'd be much more apt to investigate what motivates some of the decisions now than I did. So, I guess in that respect it changed my thought process. Another thing that I was a little surprised about is how it's sometimes odd circumstance, whether you're not hurt or whether you're hurt badly or killed. It just sort of mattered where you were at a certain time whether you were in trouble or not. That was probably one of the most upsetting things of all because I think we all—or, at least most of us were reasonably cautious. But sometimes it just didn't make any difference. It's just that you were in the wrong place. I guess at the time it didn't bother particularly but when I think back about it—looking at—talking with some of the people that were there and looking at some of the photographs. You realize that it's an isolated decision that can spell the difference between life and death sometimes. It's a little shocking.

JS: Did this, I guess, evolution or change in your views on the war—this change on your thinking, did it happen early on in your tour or was it something that happened late in your tour? Do you remember?

WM: I think it was about halfway through. At first, you're really not paying attention to the war. You're trying to learn how to take care of these huge injuries. A lot of your training—I think I'd mentioned it to be very meticulous and precise. There was no emphasis on speed particularly when you were in training. I think that's the way it should be. But in a combat situation, unless you can stop the bleeding you don't have a patient to operate on with your meticulous technique. So, you have to do whatever you can to stop the bleeding just as quickly as you can if it's a major bleed. So, that was new, and it took a while to learn that. Took a while to relearn anatomy when you were coming at organs from a different approach than usual. It wasn't the usual planned incision lots of times. It got to be pretty amazing what you could do through unplanned and atypical approaches after a while. You learned all that. That took a few months, but then after a while you saw some of these repetitive situations. It really made you wonder. I mean, especially when they would make all these aggressive patrols to retake these hills and

interdict the supplies coming down from the north. But then because there weren't enough Army personnel to cover all the country—I mean, there never are enough. Then the supply train would start up again. And a lot of the rules for combat were decided in Washington. Even down to what type of bullets that plans could use—err, the bombs. For instance, I had quite a few pilots that told me that they couldn't bomb trucks that they saw because they were parked in North Vietnamese villages. They only drove at night. Back then they couldn't see 'em very well with whatever gear they had. You know, it just seemed like we were fighting with one arm behind our back. But our casualties were real and awful. And could have been prevented by stopping the inflow of goods by just destroying the North. But then, of course, you realize that China probably would have intervened and I'm sure that the military commanders were concerned about that. It was frustrating to be in a war that you could see the problems were not—the basic problems were not being controlled. Maybe they just couldn't have been. But in that case then we shouldn't have been there, I don't think.

JS: Did you talk about, I guess, your views—did you and some of the other surgeons every, I guess, sit around and talk about these things?

WM: Oh, all the time. You know, we used to talk about—oh, sometimes at night, usually. I mean, we'd usually be fairly busy during the day. But it was a pretty common topic about the casualties and repetitive nature of taking the same hill or going on the same patrol all the time. Instead of being able to stop the infiltration.

JS: Did most everyone seem to be of the same mindset as you about the war?

WM: I think so. I suppose the RA (Regular Army) people, like the CO (commanding officer) of the hospital would not agree. But, you know, you wouldn't expect him to, I guess. But we were just civilians there for a year. It seemed pretty obvious to us what was going on.

JS: Well, I know you talked about the surgery being a little—well, being quite a bit different as far as not being meticulous at first. Just having to focus on stopping the blood and just the differences there in dealing with some of those very traumatic type injuries. What type of impact, I guess, would that—did that have on your later career as a surgeon? Did it have a positive impact?

WM: I think so. I got a lot faster in my surgery. My overall times for certain operations declined markedly. It wasn't that I was hurrying, it was just sort of a tempo you picked up after a while. I don't think I was passing over the fine points. But in order to be efficient you sort of—I would after lots of cases I would think about the case and think about where I could have saved time and not lost any carefulness. Or, any precision, I should say. That happened in the civilian work afterwards too. I would think about combining steps or eliminating things that were not helpful. Using different instruments that could do the job better. A little different approach. I think the analysis of the cases started in the Army. Much more so than in my training. I was able to streamline the procedures quite a bit.

JS: Anything else regarding this time period before we talk about coming home?

WM: You want me to talk about going home?

JS: No, I was asking was there anything else about Vietnam that we haven't covered yet before coming home?

WM: No, I don't—there's all kinds of things but I can't think of anything else really major. I mean, I really appreciated the skill of some of the other doctors there. One of them in particular was Lenny Polit's ability to pick out patients with mitral stenosis just using a stethoscope. I mean, we were all taught to do that but, in our training, of course, we never would operate on anybody just on the basis of listening to them. Over there we didn't have any more sophisticated diagnostic equipment except for Lenny's ear. He could pick up a narrowed mitral valve that wasn't leaking backwards. We operated on—I don't know, I can't remember. Five or six of those patients during the latter part of the year. I thought that was pretty amazing that he was so accurate.

JS: Well, for possible future listeners, including myself, that may not know what mitral stenosis is. Would you talk a little bit about what that ailment actually is?

WM: With rheumatic fever, sometimes there's an inflammation of the valves of the heart. The valves that go between the upper chambers and the lowers chambers on each side, the atriums and the ventricles. The left atrium and ventricle, and the right atrium and ventricle. Those valves, when they're inflamed, get swollen and they tend to fuse together in their healing and get narrow. The very flexible, pliable valve tissue gets thickened and curled up. So, sometimes it gets to be very narrow. The valve on the left

side of the heart, between the upper and lower chambers, should admit two fingers of every size. Sometimes he valves would be narrowed to a pencil point—err, to the size of a pencil. That would keep blood from going through the heart the way it needed to. It would backup in the lungs and result in shortness of breath and heart fail—

(Editor's note: Audio momentarily cuts out)

WM: Are you still there?

JS: Yes, sir. I am.

WM: Okay. If that couldn't be opened up, then the patient would eventually die from heart failure. So, if you could be sure that just the narrow valve existed, you could open that with your fingers through the upper chamber without a heart lung machine. That's what we did.

JS: Well, guess now if you could talk a little bit about the end of your tour and coming home. Did you continue surgeries all the way up until your last days there? Or was there a cutoff point?

WM: The last patient was the one I told you about. I don't think I operated on the last day I was there. It was the next to the last day that I operated on him. Usually at that time, at that stage of the war, people were leaving Vietnam by going down to Cam Ranh Bay. Then they waited there sometimes for three, four, five, six, seven days even to get out. The CO of the 95th asked me if I wanted to fly out with the patient who had a wound of the heart. He asked me if I wanted to leave the next day. I was within about two days of my full year tour. So, I said, "Sure, that'd be fine." So, that's how I left. I flew out with him and some other patients aboard a C-141 and we flew to Okinawa. Then the next day to San Francisco and Letterman. I dropped him off with some surgeons in Letterman. Of course, in Vietnam, we didn't have lengthy operative notes. We didn't have any dictation. Nobody will type it if we have dictations. So, you might say, "Severely wounded GI (Ground Infantry). Abdominal incision. Spleen removed after found to be fractured. Multiple perforations sewn up. Diaphragm open. Heart found to be bleeding from the left ventricle. Wounds closed. Patient taken to the intensive care unit." That'd be the—that might be the equivalent of a four- or five-page operative note in the states. So, they looked at that at Letterman and they looked at the short incision in the abdomen and it was a little hard, I think, for them to believe that you could do all that through that type of

an incision. But it wasn't intentional. It's just that we kept discovering things. We could see—okay—so we'd then lengthen it. It was kind of an interesting thing to have them look at.

JS: Once you returned to the States, were you done with your Army time at this point? Or did you still have some more—still have part of your commitment to go?

WM: I had another year. We spent that at Fort Ord in Monterey.

JS: Would you still have been operating on Vietnam casualties there at Ft. Ord? Were some coming in there?

WM: It was mainly civilian. Well, there were soldiers, but not wounded soldiers. That had other things—other surgical problems that we took care of. Hernias and woman had thyroid problems and breast masses. It was sort of a typical general surgical practice there. Then, I don't think we did too much vascular or chest surgeries I recall.

JS: Once you were back in the States, did you follow the war at all through the newspapers or through any type of media after you returned?

WM: Yes, I did. Once you were there, you knew it couldn't end well. I was quite interested in how it wound down and what finally happened. I mean, it wasn't a surprise at all because we really weren't conducting the war in a way it could be won.

JS: What was your reaction to the way the war wound down and the way it ended with the fall of Saigon?

WM: You know, when you see these eighteen and nineteen and twenty-year-old kids torn apart or dead, I mean, it affects you in a way that seeing their names on black marble at the memorial doesn't. At least to me. I mean, it's much more real. You saw it with your own two eyes. It's not represented at some memorial. I just thought it was a huge waste. I guess I started out believing what the politicians said about the domino effect and the stuff they did to stop communism and all that sort of thing. I suppose they believed it too. But, you know, the consequences of acting on that and fighting to win would have been another huge World War. I don't know how they thought they could win without doing that. I mean, I just couldn't see of another way that the—that our goals could be accomplished other than wiping out North Vietnam. And precipitating, probably, another huge World War.

JS: Right.

WM: So, the ending wasn't surprising to me. Maybe they knew or thought they knew something that I never did, but it wasn't a surprise to me. It's kind of like fighting in Afghanistan without controlling the inflow of weapons from Iran. I mean, I don't know how you win those situations. I thought they would have—or somebody would have learned that before.

JS: Well, before wrapping the interview up, would you mind, I guess, talking a little bit about your career after the military? What you did afterwards.

WM: Well, first of all, I got my boards out of the way. My general surgical boards and my thoracic boards. Then I started looking for a job. I wasn't sure whether I wanted to be in academic medicine or in private practice. So, I looked at quite a few places. I went back to Yale and looked at a job there. I looked at Cleveland Clinic and looked at smaller clinics in the Midwest. I looked at Stanford out here and at the Palo Alto Medical Clinic. But it seemed to me that a lot of these places would take a while to get in position of responsibility such that you could operate on the cases that you wanted to operate on. Do the things you wanted to do. I just decided to set my own system up in the Midwest and set up an open-heart program—a big vascular program. That's what we did. I started out alone and hired another chest and cardiac surgeon. Then we hired a couple more and then a couple more. We ended up with thirteen. Now we joined other specialists, we have over 200 people—200 physicians that are surgeons in the group. It worked—I enjoyed it. It was a tough goal, but an interesting one. I thought we were well supported by the community. I guess I would do it again. There's no—there's never just one way to go. I mean, I think academic medicine would have been interesting too, but quite different.

JS: Is there anything else you'd like to say? Anything else we haven't covered before wrapping the interview up?

WM: I've got lots of fragments in my mind of things that happened. I never took notes over there, which I wish I would have. On the other hand, I think a lot of people that take the notes don't end up using them. I can remember lots of little bits of things that happened. I do write some stories about those as well. I'm trying not to write just on war stories—just war stories. But some things about Vietnam—I've written a few, I guess. Did you get the one about the red box?

JS: Yes, sir.

WM: I guess I gave you that one, didn't I?

JS: Yes, sir, you did.

WM: I don't know whether you'd be interested in keeping that for the Archives or not.

JS: Absolutely.

WM: Well, I guess I should sign the same papers when you get around to it.

JS: Right. Yes, sir, I will have one of our archivists send those out to you.

WM: Okay, I guess that short story to me is just a little bit crude in the language. I guess to say the least. But I was trying to capture what the average soldier thought, you know? And what the average soldier did. So, that's the reason it ended up like that. I can write some more stories that aren't quite so shocking (both laugh). Anyway, I'm thankful for the memories. I think sometimes you can explain what happened better with fiction than you can with the facts. But anyway, that's why intended to do some more of.

JS: Well, we'd certainly love to have them whenever you write. So, if you wouldn't mind, we would certainly love to have them as part of our collection as well.

WM: Well, thank you, Jason. It's very gracious of you. I'm sort of on a kick now of writing civilian stories. So, it may take me a while to get back. But I'm sure I—I sort of forget about it after a while. In some ways it's not too comfortable calling up the themes again, but I can certainly do that. I appreciate that—all the time you've spent. All the care.

JS: Well, I certainly appreciate you taking the time to do this. To tell your story and for sending us those stories that you write as well. We certainly appreciate it. Let me go ahead and bring the interview to a close now. But I'd like to talk to you for a few more minutes if I could.

WM: Sure, Jason. That's fine.