STEPHEN MAXNER: This is Steve Maxner, conducting an oral history interview with Ms. Lynne Hudson at the Southwest Collections/Special Collections Library interview room on the 18th of May at 3:30 in the afternoon. Would you please begin by giving us a brief biographical sketch of yourself?

LYNNE HUDSON: I was born the oldest daughter of a military family. My father is a naval officer and he grew up really all over the country, primarily up and down the Eastern Seaboard. I’m the oldest of six brothers and sisters, and I attended, after high school, I attended a three year nursing school program in Washington D.C. After that I went about the business of joining and joined the Army Nurse Corps and was in the Army for a couple of years. Since my Army days I’ve had multiple jobs in a professional, I think upward, direction. I’ve been in Texas primarily in the last probably 25 years of my life living and working in Austin, Texas and I came here to the Health Science Center two years ago to work at the Health Science Center. I think it made interesting for a professional and personal life. I am the mother of two daughters that are adult women now, and that’s primarily it.

SM: How much interaction, how long have you been involved with the Vietnam Center activities?

LH: You know, Steve, exactly a year. About a year ago I heard of the Vietnam Center through, I met Dr. Walker and he mentioned then that there was a Vietnam Center and he actually I think he was on the board of it and that they would be interested in
having perhaps me consider being on the board because they didn’t have very many
women and then after that I kind of sought out an opportunity to meet Dr. Reckner and
then I had an opportunity to join the delegation that was led by the chancellor last year to
go back to Vietnam and I represented the Health Science Center on that trip. I began my
interaction about a year ago finding out about the center and then seeking out being on
the board probably a year, too.

SM: Now your nursing training that you received; how relevant and how well did
that prepare you for what you would eventually encounter in the Army generally and
more specifically in Vietnam?

LH: You know, I think I had a splendid, splendid training experience. I went to
what they call a three-year hospital program, diploma program, and they don’t exist
anymore, but you actually lived in a hospital environment and you’re working there
solidly for three years. You have some academic classes. In my school it was fairly
forward thinking that so long ago and I actually did get a year's worth of academic
classes from American University. You work probably four or five days of the week
actually on the ward doing nursing work and then you have one or two days of classes. I
think that there’s no time in my life that I’ve had a job that I didn’t think I wasn’t well
prepared because of that particular training experience. It was more training probably
than the academics pursuit you see now when nurses get a baccalaureate degree program.
I have gone back and gotten baccalaureate and then a Masters in Public Health, but that
three year nursing school program was intense, it was almost like joining a convent
because you line in very enclosed hospital environment. My hospital was in the inner
city of Washington D.C. so I was exposed to a lot of trauma, a lot of violence in terms of
the injuries incurred by violence, you know, shot guns and things like that, and I had
always been fairly interested in intensive care environment so I worked primarily in the
emergency room and intensive care unit. That was the area that I most focused on when I
was in the school. I felt that perhaps I was better prepared than if I had done something
like public health nursing. Ironically, I left that intensive role in nursing and now do
things that are community based, population based health care rather than individual one
on one care.
SM: Now in the emergency room as a student nurse, did you get involved or witness much of the triage process?

LH: Yes, you really do, you really do. I mean, you’re not responsible for it, but you’re responsible for responding to the instructions given by people that are conducting the triage. At least it offered some familiarity to the fact that in very tense conditions, you can’t do everything to everyone, so you often had to make decisions that were on the triage nature or I was at least very familiar with that.

SM: Now, based on the training in the civilian world, what was triage? What was it based on as far as the system? How did it work?

LH: Well basically someone would show up in the emergency room and there’d be a quick review by whatever intake personnel was. I mean, if somebody showed up in an ambulance, or brought in on a stretcher, then the ambulance people would give you information and you would make a quick decision what kind of teams of people you needed available to respond. I’ve worked in a lot of emergency rooms where people would just walk in with a child or with a bleeding hand and you quickly ascertained what kind of response, whether they could wait a few minutes or whether you needed to see them immediately, whether it was life threatening, so that concept was there.

SM: What about multiple patient scenarios where you have like three or four or five or even more people? Did that happen much?

LH: This was a large inner city emergency room and in the civilian world, also that hospital was fairly intense, fairly busy. I don’t think that there was as often that you had a huge array of 20 or 30 seriously injured casualties showing up like you would see in a war environment. You did have competing priorities. We had to make a decision.

SM: And did that particular aspect of your training, was that perhaps rather helpful when you had to go to Vietnam because you were in that emergency room environment, the high stress?

LH: Right, right, right. Well, I think, yes. The atmosphere of it being in an intensive environment where people were critically ill was the best preparation. The area that I worked in in [?] evacuation hospital, I really was rarely on the front end of the triage. I was on the end after someone had been triaged, had been in surgery, and then they were sent to this area called [?] which was really an intensive care environment.
Every casualty kind of went through some surgical procedure. There was nobody that I
could think of that didn’t have to have some kind of surgical procedure; at least some
manipulation like orthopedics or something like that. So, it was very rare that we were
pulled out of where we were working to help a triage. You had another unit of people,
and a lot of times, because in an evacuation hospital most people had received basic first
aid in some cases in a really forward first aid area, and a lot of times they had almost
been triaged and then you knew exactly from when they got to your hospital what the
next step was. There were, sometimes, when fresh casualties came directly to us because
there was not a field hospital that they went to. That’s happened, particularly more
during Tet, but a lot of times the triage had been done and the next piece of intervention,
in most cases, was surgery; removing shrapnel or debleeding a wound or something like
that, amputation, but it was usually a surgical intervention and then they stay with us and
stabilized until they were really able to go be Air-evaced. That’s what it was called in an
evacuation hospital. They were Air-evaced from us, sometimes not even Air-evaced but
they may just be returning from more of an...Some were sent back to Saigon where there
was a hospital they could stay longer, even to Cam Ranh Bay. Most of the casualties
were Air-evaced out of our hospital to then the next level and that would either be Japan
or Hawaii, sometimes Europe to the next before they even came back to the United
States.

SM: And your intensive care unit training, did you find that to be particularly
similar to what you would have to do in Vietnam?

LH: Well, probably much more sophisticated; much better equipment, probably
better staffing ratios.

SM: In training or in Vietnam?

LH: In training Vietnam was certainly not as lavish and our materials or
sometimes there were shortages of things. It was much more primitive. There’s no time
in my civilian training where I ever had to throw people on the floor and cover them up
with a mattress when they had chest tubes and broken wounds and splints and things like
that, so it was a far more primitive and dramatic environment, but I still was better
prepared I think if I hadn’t had that kind of nursing experience.
SM: So it sounds like you had kind of a clinical experience at your nursing program.

LH: Well, it was a three year intensive program and so I had one clinical experience when I had gone through a traditional [?] and then I’d had probably six or seven months of working in small hospitals; again, most of the time around the emergency rooms and those were not intense, but I had [?] responsibility.

SM: Now what made you decide to go in the Army?

LH: Well I was really going to join the Peace Corps when I left nursing school, but I think the concept of service and contribution was a strong family ethic in our family and it was something that I predicted that I would probably do. My dad was a naval officer, so he was really astounded that I wanted to do Army nursing. The problem with the Navy was I never felt like if I joined the Navy that I would do the direct, on sight work that I wanted to do, and that was probably the strongest case. Other than that, as I said, I had been married at the time to my husband who was a Westpoint graduate and knew he’d be going over to Vietnam and he would be joining the Army, so sharing that experience with him was more convenient than joining another service branch. I was going, I mean, it was kind of part of my life plan to have done that when I left school.

SM: So when you made that decision, Vietnam had been going on for several years or a couple of years. What were your concerns? What was your knowledge of Vietnam? How much had you heard about news, things like that?

LH: I was woefully ignorant about the political environment that created Vietnam and I was probably a good American citizen, but not studying the history. I did not know, really, why we were there. It just was kind of blindly knew that the United States had engaged in an involvement with a country in Southeast Asia because of that sort of domino theory and the fear of communism but I didn’t really understand the political borders or the history of the country. That kind of was just kind of blind ignorance that we had a need, we were involved in a war, there was a great deal….there was terrible things happening in that country and terrible things happening to American GI’s that were there, so it was more to go offer comfort in nursing to the soldiers that our country had sent, but there was no understanding of politically why they were there. I’d grown up in an era was a little bit ahead of the time frame of the political protesting, and
because I was a child of a military family I was not really kind of missed that age group of protesting and so I had a lot of pride in the fact that to serve the country and serve in the military force. But, I was really popular in nursing school. Friends knew that, you know, being in the draft, avoiding the draft, what have you for not going to Vietnam, was a big part of our social fabric for just common friends, boyfriends, girlfriends, that I had. So, there was a part of me that knew people were frightened and didn’t want to go to Vietnam and would do anything they could to avoid going. Then, there was a part of me that was aware that a lot of people were going and so what could I do to help?

SM: So this was something discussed amongst your fellow nursing students, Vietnam and what was going on?

LH: Not really. It was more strongly felt by me, I think because I guess the military background. What was discussed with people, friends, guys you might date who might be asking you, “Gosh, do you know a medicine I can take that makes my blood pressure go up so when I have my draft physical?” or “What can I do? Can I run in place so I look like I’m going to have a stroke?” The fear of so many young people, particularly if it looked like they may be college, dropping out, would they be drafted to go to Vietnam. Men certainly, the military academy, that was just kind of the feeding ground for every young officer who’s going to have to spend his time there, too. There was a lot of fear in Vietnam, but I think in serving there, but I think a great deal of...I had a sense of for the honor of it rather than the dishonor of it.

SM: How old were you when you graduated from nursing school and you made this decision?  
LH: I was 21.

SM: You were 21? Okay. What did your parents think?  
LH: I think that they were proud. My father actually swore me in so I have all these wonderful pictures of my dad, a naval officer, swearing me in. One of the fun things, my dad was a Naval pilot and none his children had never been able to fly in the plane with him and then [Bob] and I had a military uniform and I was able to actually go on a – not a mission – to fly around with daddy. So, there was a lot of kind of being part of a fraternity of acceptance. They had some pride in it and I think they had a lot of fear
about me going, and a lot of my lotters were trying to reassure them that I’m really okay, that I’m fine, but I think it was mostly pride.

SM: And what did your husband think about your decision to go to Vietnam with him; to go to Vietnam and be with him?

LH: I think he thought it was just great and we took a lot of pride in sort of manipulating the environment so that we could manage to go, when I finished my basic training, as quickly as possible and not have a long time in States; a lot of pride in finding, you can find some wonderful E5 enlisted person who loved sort of saying, “I’m going to do anything I can to keep this couple together,” so our orders were processed always with a lot of personal efficiency and a lot of support. We were quite a notoriety, you know, going together and being stationed together, and got kind of a lot of publicity because it was weird to see a couple. We weren’t totally rare, I had some colleagues who were married, but very rarely did they have a chance to be in the same area where their husbands were. A couple of nurses were married to pilots, but they weren’t stationed there, so we took a lot of pride in sort of being able to twist the system around so that it would work for us.

SM: Where did you go; you spent a year before going into the Army where you had to wait for the cycle to go through?

LH: Uh-huh.

SM: What did you do in that intern after graduating from nursing school?

LH: I basically graduated from nursing school, worked for a while, and then joined my husband in different Army rotations as he went through flight school, and then as I said I left in the summer, probably the late spring and then attended basic training at Fort Sam Houston in San Antonio. Then I had a month of leave, or actually he was completing his final flight school program and then we actually left then from San Francisco that fall so I had not been out of school…I graduated in June of ’66 and I went in fall of ’67 – a little over a year.

SM: And was this hospital work that you were doing in that time frame?

LH: Uh-huh.

SM: Anything notable or memorable?
LH: No, really not. They were small communities. They were very little and very backwards. No, not at all. I stayed in my own hospital for about five or six months after I graduated working there, but the other small military towns, but they were not good nursing experiences. They weren’t bad, but they weren’t enriching.

SM: What was the course at Fort Sam Houston like? Six weeks?

LH: It was a lot of fun. I really enjoyed it. I’d been out of school long enough to realize that school was fun again, and I loved the military history classes we took. I loved understanding the battalions and companies and platoons. I loved the orderliness of the military and how it all kind of made sense. I was always very impressed with the Army and I’m sure the other services were that way, but they moved so many people and materials and things from one place to another and in most cases it was all accurate; your paper work did arrive, you did get your stuff shipped, things did happen in a very predictable, organized way. This school, basic medical program at Fort Sam Houston is made up of all medical professionals; the dentists, the veterinarians, the nurses, the physicians all in through that program, so its very very soft and in no way was it a very strong hardship program. We had some few exercises where we had to take some cross country maneuvers with compasses and find our way back, some practicing on the artillery range where we learned to handle some weapons, the marching in order, a lot of marching, a lot of learning how to do that, and a lot of getting uniforms fit, but the classes I really enjoyed. Some of the classes even in triage where you actually would have to be…in the military there’s a whole kind of framework that if so and so, if there’s not a doctor, then the next person in charge will be a vet and if the vets not there, then the next person in charge would be a dentist and then if that person is not there then it would be a nurse, so you kind of triaged down and kind of priorities. We learned how to do wound debreadment. We actually had a clinical lab where they would anesthetize animals, and then shoot them, you know, create a wound, and you’d practice suturing and cleaning, things like that. A lot of that work, a nurse would not normally do but in a triage, a world of where resources might be different and you would be responsible for a level of expertise you wouldn’t normally have, like wound repair rather than just wound treatment. But I loved the basic training. I thought it was fun; I didn’t mind it. I just
thought it was an interesting experience. The worst part was probably marching to get
your immunizations in a hot tent and fainting as you walked out of that tent.

SM: Really? People fainted?
LH: Oh yes, I mean, they’re coming at you with shotguns?
SM: Oh, the air, okay.
LH: So even the most traumatic of all was overseas because you get a whole
boat load of those terrible...and if you weren’t viciously sick, the immunizations, too.
SM: Wound debreadment?
LH: Debreadment is cleaning a wound.
SM: Oh, okay. What animals, what kind of animals would they injure?
LH: Goats.
SM: Goats? Were they chosen specifically because of their anatomical
similarity?
LH: I don’t think so. They were just accessible. I don’t think there was
anything. I don’t know but the goats I remember.
SM: And your training with cleaning and handling gun shot wounds to animals;
did that include removing bullets and shrapnel and stuff like that?
LH: Yes, right, it was mostly cleaning it and opening it up. Yeah. The typical
way of treatment of the wounds in Vietnam is very different than what you would see
classically in civilian life because of the incredible rate of infection because everything
happened in such a dirty environment that there was really no way to really be assured
that you were cleaning and taking away any kind of foreign objects, so in surgical
procedures, in most cases in Vietnam for fresh wounds, was to open up the wound in
what we called debreadment; clean it, open it up, but we let most wounds heal with what
they call secondary healing where you did not close it up and hope that it would just heal
that way. You kind of left wounds open. You were constantly irrigated with peroxide or
normal saline trying to always keep it clean and then after a period of time when the
soldiers or casualties were on heavy doses of antibiotics, and usually during the time that
after they were evacuated to the next hospital in more or less primitive environment,
that’s when they would go in for follow up surgery to close the wound. We did a lot of
open, and that’s probably why you probably had more scarring because the wounds were
not closed sufficiently like you would in a clean environment. The use of antibiotics was massive because the biggest problem was infection.

SM: And was keeping the wound open, that was part of keeping it from getting infected?

LH: You were constantly cleaning it and irrigating it, so that was a different part of nursing that I’d never seen before. Most of the time someone with an injury goes to surgery, you clean it out, you know, fix it and stitch it up, but in most cases except for abdominal injuries, most cases wound injuries, shrapnel injuries, napalm burns were all left open.

SM: The triage system that you were exposed to at Fort Sam Houston, was this different from triages you understood in the civilian hospital?

LH: Well, only in the fact that they spent more time sort of explaining the hierarchy; taking over and being responsible for an environment and that never came up in the civilian world. I mean, that just intrigued me that there was a stepping level of expertise and it included vets and dentists and things like that.

SM: And vets would come before dentists?

LH: I actually can’t remember. I can’t remember. I think it was physicians, vets, then dentists, and then the next level would be nurses. The other part about the nursing in Vietnam that was extraordinary was that skill level and the ability and the dedication of the trained corpsmen that work with you. We may have had less ratio of nurses to critically ill patients, but the support that we have in the absolute marvelous ability of the corpsmen assigned; also to have a ward sergeant and you have your corpsman morale directed and the administration of your work sergeant and those guys were really well trained and incredible veterans, and were amazing patients who deal with a 21 year old 2\textsuperscript{nd} lieutenant right out of school, their amount of respect they paid you, the support they give you. If you had a good ward sergeant, you could get anything done, but I think most fondly of the incredible ability we had with the corpsmen, and then the other thing that was different in terms of civilian life is that I had never known there were male nurses and there were more male nurses probably chose that as a way to serve in the military and had not ever seen before nurse anesthetics and in the military you use a lot of allied health professionals, so a lot of the anesthesia was not provided by
anesthesiologists physicians but by trained nurses anesthetics. A lot of times those were
male nurses and that was just a new set of colleagues that I never had in the civilian
world.

SM: Now what about weapons training? Do you remember what weapons you
received training on?

LH: Only the M-16 and then we had some pistols; I don’t remember even the
name of them. That was very rudimentary training. I don’t think there was many
expectations that the health care professions would actually be bearing arms or would
need to defend the environment. During Tet, they did defend some pistols out to the
males; whether they were male nurses or the male physicians, the doctors. They didn’t
just hand out the pistols, the weapons, at that time, to the females. When it looked like
that our place of residence was probably more vulnerable and we might be more
vulnerable going back and forth to the airbase, they did do a distribution of weapons then,
but I remember I didn’t get one.

SM: Did that concern you or bother you in any way?

LH: No, no. It would have felt inappropriate because I didn’t feel like I had
been trained well enough to have done it. I totally trusted the professional soldiers to
take care of this and you had all these professional health care providers and that was the
limit of my expertise.

SM: You didn’t actually have to qualify with the weapon?

LH: You did, but it was very, very simple; very simple. I mean, they weren’t
going to ever not let anybody join the military in the medical field because they didn’t
qualify. It was very...a lot of sustenance but not much form.

SM: Did they talk much about Vietnam?

LH: No, not at all, and I truly regret that the training that we had, the basic
training, did not talk about any of our overseas kind of investment and involvement.
Everyone knew they were probably going to go to Vietnam in some period of time, but
there was no preparation, and of all the regrets I have I think this country ill served a lot
of its draftees or its volunteers by not preparing them with some basic kind of
understanding of the core culture of the country, the core political structure and what was
creating, you know, what was the background to this war, where were the leaders? You
may hear about Diem but you didn’t have any understanding of who was in control. We
knew nothing about the religions or nothing, and we didn’t know one word of
Vietnamese, nothing about their culture, what was appropriate in terms of how to greet
somebody, how to call on somebody. To them we were ugly Americans in that respect
and in going to Vietnam, my first impression about Vietnam led me to have incredible
almost distaste for the Vietnamese people and that’s tragic. I wasted a lot of time being
an ugly American. The first thing happens when you land in Saigon in Ton Son Nhut in
Saigon is you’re absolutely overwhelmed and assaulted by hundreds of thousands of
people on motorcycles and motorbikes and I was looking out of the bus that’s
transporting you somewhere and all these young men were riding motorcycle and they
weren’t in uniform and they Vietnamese and it sort of struck with, “Why aren’t they in
the Army and why aren’t they fighting?” Then it took a very long time to just…because I
didn’t understand the culture and the values system; the way the children were raised, the
way the women worked, the way the men didn’t work in some cases. It was almost an
assault to a very immature psyche that I had at that time, and I’m just sorry that I didn’t
know more about that country and more about the people. I’ve often wanted to go back
and do that year again with a broader understanding and I think I would have been a
better human being during that year. A lot of almost being revolted by just some of
the hygiene habits just because you didn’t…you weren’t exposed to it and you weren’t
comfortable with understanding the very Asian country. Whether you’re spitting or
coughing or blowing your nose or whatever, there’s a lot of very…the Vietnamese use
life with gusto. There’s a lot of culture that we didn’t understand and I think that was sad
that we went so ill prepared. It wasn’t until I took care of many more civilians, women,
and children that were injured after Tet that I think that my sensitivity and maturity began
to develop in terms of realizing that there were other ways to do things than the
performance and behaviors that I saw in America. That took a while.

SM: Was there anything in particular that you remember, particular things that
you saw that bothered you more than others?

LH: Well it took me a little while to get used to the fact that little kids don’t wear
pants, and when they need to be potty trained its real easy because they just squat on the
roadside. Squatting on the roadside, using teams of people [?], I mean they’re slightly
offended but not grossly offended, but through the coughing, spitting, expectorating that
a Vietnamese person will do just anywhere without looking for a container took me a
while to get used to. Some of the very first casualties I took care of were Vietnamese
soldiers, ARVN soldiers, and again they didn’t speak a word of English; I mean, they
couldn’t speak English. It’s very hard to even care for them, to console them, to comfort
them, to explain anything to them, what was happening. One of my favorite stories is a
Vietnamese soldier waking up and speaking in kind of that pigeon language, “Me die, me
die,” and I thought he was saying, “I’m going to die,” and I was trying to reassure him
and all he wanted to do was urinate. The word for urinate is mi dai so anyway, that was a
good language when I realized that all he wanted was a urinal. It seems like that we
should have been much better equipped because…and perhaps the thought was when
they sent those personnel and military, medical personnel, we knew we’d only be taking
care of American soldiers or English speaking soldiers and then in Vung Tau particularly
our perimeter of defense was provided by Australian soldiers but we had Royal Korean
Army there and you had a lot of ARVN soldiers and then we also had some Northern
Vietnamese soldiers too, so we had a hodgepodge of different cultures, totally different
cultures. I actually, for a long time, saw more foreign soldiers than I did GI’s just
because that happened to be the perimeter of defense and that’s where a lot of different
other Army’s were kind of stationed. After Tet that changed and we began to see a lot
more fresh casualties that were American GI’s.

SM: And your arrival was October ’67?
LH: ’67, uh-huh.
SM: Okay, stationed exclusively at Vung Tau?
LH: Uh-huh.
SM: For your four years?
LH: We went through processing for probably about eight or nine days, you
know, in Long Binh, I can’t remember anything other than staying there and a trailer
where they processed the paperwork...
SM: Did they give you an indoctrination, anything?
LH: No, nothing, absolutely; just kind of blindly trying to find your way and I
remember that we had to manufacture our own transportation even to get to Vung Tau.
You had to wait for a certain amount of orders to be cut to be able to send you if you
were going to be flying in a military plane, so it seemed very, of all the disorganized
types, it was after you got there and they had your paperwork, then after that no one quite
seemed to know what to do with you or where to send you for a little while. That was
disorganized, but then yes, the only assignment I had was at Vung Tau at the 36th
evacuation hospital, and there was an airfield there which was appropriate because you
needed to evacuate and bring in fresh casualties and then you would evacuate the
casualties out after they were stabilized so that the main business of this assignment in
Vung Tau was the air station had been built primarily by the Americans; I don’t think it
was an airfield before the Americans took it over. In about probably two or three
kilometers outside of the air station, the military medical folks were stationed and they
were kind of like a large group almost like an apartment building that had a compound. It
was walled off with the barbed wire and sandbags, but it had its own little compound and
it was just where all the medical people stayed and even pilots who flew the Air-evaced
helicopters stayed there also and up until Tet you could kind of get back and forth
whether someone had a jeep and you could drive a jeep or you could sometimes
hitchhike, sometimes you could take the little pedicabs or there was kind of like a regular
bus going back and forth and would take you by the airfield. After Tet, that totally closed
down and the only way we were transported back and forth was an armed guard, you
know, the 2x4s or 2x2s, the number of these…

SM: Oh, deuce and a half?

LH: Deuce and a half, thank you, deuce and a half, and then they’d have armed
guards with you, too so you never freely moved any place outside of being on the base
where the hospital was and then the...they called it the villa but really where your quarters
were and you stayed there. The villa was actually quite self-contained, in fact, that it had
a little hut kind of happy hour club hut that was a lot like MASH where they had beer,
soft drinks, and people would relax and you’d talk. In case you might be working all
hours, any time of the day or night there’d be somebody kind of relaxing probably in the
hut. They had a big water tank out front and that’s the only place that they had potable
water so you had to get your allotment portable…what’s the word?

SM: Potable?
LH: Potable, thank you, take it into where your room was and you couldn’t use any of the water that was in the rooms there. There was no cooking facility or anything like that so anytime you ate, they…it was not primitive, but it was not easy for me to get comfortable. The smell of the villa, the first floor of the villa is really located over a huge sewage pit, and the fresh sewage would be collected in that and every week or so the Vietnamese people would show up with a huge tank and they’d suck out the material out of the pit and unfortunately that was right outside the door so I think one of the most unpleasant parts of Vietnam for me was the smell. All my letters home are asking for room freshener. I used to carry, literally, in my pocket, a little piece of material that had cloves in it just to try and deter the odor that was around. Your clothes would mildew, too, but mildew [?]. I can get those smells back by going some places. What I noticed about Vietnam this time going back is that the smells were not so bad; its not the rotting garbage or it was amazing to me the smells were really almost gone. I do remember the smell.

SM: The base area in which you lived, was it heavily segregated as far as men and women?

LH: No, it wasn’t. The nurses mostly were on the second and the third floor and the first floor was more of a transient bachelor place because the pilots staying there temporarily, but it wasn’t really terribly segregated at all. There were different floors, but there was a lot of…on the first floor there were a couple of other married couples that were living there, too, so the couples were on the first floor too plus the single bachelors.

SM: Okay. How many people actually worked in this evacuation hospital?

LH: You know, I don’t know the numbers; I should know that. I could figure it out.

SM: Approximate?

LH: I’d say probably 80 to 90, probably. Maybe not that many, maybe not that many. Certainly not more than like 50 to 90.

SM: What was morale like there?

LH: It was good. I think that the best part about the military is that in the medical world, everyone had basically volunteered or was there because a lot of the physicians had gone through and gotten their military training, excuse me, their medical
training, through the military where they were paying back getting their medical school paid for. There was a lot of…it was not just like fresh draftees; they had no sensitivity about why they were there but they were paying back an obligation. A lot of the nurses had gotten nursing school, nursing training, paid for by the military. The military is very good about offering to pay your education and then you owe time back. A lot of people were doing that. I don’t think the morale was bad. It would rise and fall. There were long hours, we’d work 12 hour shifts, the conditions we lived in were, in some cases, very difficult because in the daytime they would turn off the generators so you wouldn’t have any electricity so there’s be no fans, so if you had to work nights and were trying to sleep in the daytime it could be oppressively hot. The cleanliness was a problem; there were inconveniences, but they don’t seem to me like they were morale killers. Everybody looked forward to R&R, everybody looked forward to their leave, and everybody really counted days to go home. There were not a lot of people that I saw extend.

SM: How was food?

LH: Food was terrible. It was military. We ate at the hospital had our mess hall and a lot of the people on the base would come to the hospital mess hall because it was supposed to be better than the other place. It was mostly dehydrated food. We didn’t get a lot of fresh things. The only time I anything good is when the Australians would invite you to their camp and Australians are wonderful on how they would treat their soldiers because they would bring in wonderful fresh food; the only time I had ice cream or cream or anything. They would bring things over in a refrigerated plane. That would be a treat, sometimes they would invite the nurses out for tea but food was just basically military. We didn’t have C-rations, we didn’t have that. It was mostly dehydrated, you longed for things like fresh salad and so for a little while, before Tet we could actually eat in a village but I never had any Vietnamese food that I liked and it never was appealing because the village was really quite poor and it just…I didn’t know enough, but about pho, the soup was a delicacy. They had a couple of [?] restaurants that was cheap imitations of continental food, but you really had some high suspicion that you were eating that were probably pretty rustic and I do believe I’ve probably had a dog in my life, but it would be in the village only, on the economy.
SM: You couldn’t eat on the economy in Vietnam after Tet?

LH: No, because literally your approval access to anything beyond working and sleeping was totally cut down just because [?]. It was just too dangerous. Before Tet, we were able to use the beach, you know, Vung Tau was on R&R Center South Vietnamese, North Vietnamese, Australians, the Koreans, and GI’s, and the beach facilities were wonderful with a lot of water toys and treats and things like that. The beach was a wonderful treat, but then it was shut down and you couldn’t go there anymore either.

SM: Your first experience with casualties, you mentioned that ARVN soldiers were brought in?

LH: Uh-huh.

SM: That was your actual first hospital experience with casualties?

LH: No, I don’t, I don’t…it’s one of the impacts that I remember. I don’t remember who was the first fresh casualties. You know, there would be days all bleed together, the first months I said when I worked on a large ward that was mostly made up with American GI soldiers and either had malaria or hepatitis or they were just medically depleted or sick or had been dehydrated or something like that. Now very few of them were ever evaced back home. They just kind of recovered with us and then sometimes would be transferred for a longer term recuperation at Cam Ranh Bay, but they weren't considered critically ill at all; a lot of jungle rot, you know, infection or something like that, but not…it wasn’t anything that was life threatening or serious for this large ward.

But, there might be a day where if you were not real busy on that ward and they needed you someplace else you would transfer so you’d kind of…I don’t remember the first day I saw the first casualty because it could have easily been the first week I’d been there just in terms of working something part time.

SM: The men who would come in and stay in this large ward with I guess mostly chronic illnesses; malaria, things like that, were those the two biggest diseases, the malaria and hepatitis?

LH: Hepatitis, they were the worst. They really were. There were a few…we had one small little medical intensive care unit. You know where those are because they’re the only place that’s air conditioned, and believe it or not, just because there was a huge population of men in that environment, you had some folks that were suffering...
maybe a heart attack or concern that there may be a heart attack or lung infection or
pneumonia or something like that but there was a medical intensive unit but it wasn’t
very often used it wasn’t filled with lots of people. There might be one or two people
who were really seriously ill medically and the rest of them were more in a recuperation,
in that large ward hospital.

SM: Any strange diseases come through there as far as other than the malaria and
hepatitis?

LH: No, not any that I remember.
SM: Yellow fever?
LH: No.
SM: Cholera?
LH: I don’t remember…
SM: Plague?
LH: No, not that they were diagnosed there. If they’d been that sick, they would
have probably been Air-evaced home medically. But, I don’t remember anything that
dramatic. A lot of really bad jungle rot on the feet and things like that and then mostly
just the other medical conditions.

SM: What was the usual stay for soldiers in that ward? How long would they
usually stay there before they were transferred?

LH: Sometimes they stayed a couple weeks, and then they would get to go
maybe [?] back to their unit. Or, if it looked like their recuperation was going to have to
be longer then they would go up to Cam Ranh Bay. They had a much bigger [?] that was
nothing but a recuperation hospital up there. But, I think it wasn’t just the in and out
though. If in fact you got the fresh load of like a unit might have shown up and
everybody showed malaria, patients there or a new group of people would come in with
hepatitis, then you moved people out. So you think a lot of this at the time was based on
whether you take care of them and then you got word that there would be more incoming
patients and a lot of times, then there would be movement out and that happened often
with the Vietnamese, the badly injured. Some of them stayed a long time with us because
there was no place to send them. But, if we got word that there’d be another plane
arriving with some more fresh casualties then we’d have to really turn around very
quickly and move people out. See, I had enough problems ordering an evac hospital ship for [...] but with the Vietnamese you just literally in some cases were sending them out on the street and the pigeon language that so many of them, you learn after a while with the Vietnamese, and everything’s number one, number ten, beau coup, ti ti.. I can remember entire families crying wanting to stay longer but they couldn’t stay longer and they’d be saying, “GI number one, Vietnamese number ten,” like that’s the only good place for us to be able to stay here with you. We often had just literally empty beds up. We had fresh patients coming in. Your priority always was the next fresh load coming in to be available to take care of them.

SM: One more question about diseases; how about tuberculosis?

LH: You saw it in the Vietnamese, a lot in the Vietnamese, ARVN soldiers, [...] cure Vietnamese civilians. A lot of them had tuberculosis. There’s not much treatment you could provide because it was long term that they needed so there really wasn’t much that you could do. I didn’t see it in our American GI’s.

SM: What about taking steps to prevent infection of the staff of those types of diseases?

LH: The only thing we really did was we all took our malaria medicine. A lot of us were sick a lot with the vague kinds of things. I was actually in the hospital for probably about ten days at one time and was going to be sent home if I didn’t get better. I mean they didn’t want me…I was no longer…they needed to clear out your space and get somebody who could work. I had hepatitis then, but there really wasn’t much treatment except for a little bit of bed rest. A lot of times, you had vague diarrhea type fever, but there wasn’t a great deal of prevention. We were TB tested before we came back, and I think a lot of people probably reacted because we’d been exposed to [...] antibiotics [...] hepatitis [...] it would be…it probably would be very hard to [...] what your patients [...]?

SM: I actually have one more disease question; what about dysentery?

LH: Oh, you have it all the time. It wasn’t probably official dysentery. You had GI problems out…it was hard to tell sometimes because most of the anti-malaria medicine makes you, I thought, made me sick. I didn’t feel bad often you took that and then you had cramping and diarrhea from the malaria medicine. That was kind of
common; I mean, it was never a debilitating or anything that I know of it was
commonplace but it was just kind of part of the everyday experience.

SM: What about for GI’s out in the field being exposed to different types of bugs
and maybe dysentery, stuff like that; did you have much of that kind of stuff in your
hospital?

LH: No, no, not a lot. Diarrhea was a…unspecific diarrhea, was for a lot of
soldiers but not that would be associated with hepatitis though, too...Sometimes we
would have had medical problems with people just run down or dehydrated or losing a lot
of body fluid and just basically bed rest, hydrating them for a while and they eventually
got better. But, you weren’t doing a lot of cultures, analysis, exotic lab work and things
like that and you got better enough to go back to your unit or you went home, so a lot of
follow up that would have happened in a traditional hospital in terms of infectious or
disease control. You didn’t have access to that kind of [?].

SM: Would your rehydration regimen include IV’s and stuff like that?

LH: Yeah, in most cases IV’s.

SM: You mentioned earlier that a lot of times your unit suffers shortages and
things like that; what were the worst shortages that you endured?

LH: You know, some of them were the weirdest things and tragic because they
made your nursing very difficult; having the right gauge needle. I can remember having
to do, because everybody needed massive amounts of antibiotics and at least one or two
very strong mixtures of penicillin streptomycin and then penicillin, it’s a thick white
medication and unless you have the right gauge needle, it was very difficult to administer
and there would be periods of time for a month where we didn’t have a needle with the
gauge that was any bigger than like a tuberculin syringe; little, tiny, itty-bitty needle, so it
would be excruciatingly uncomfortable process to have to inject somebody. You put the
needle in and then very slowly have to push the syringe in. Before you were done,
literally, the needle popped off two or three times and I could remember finishing making
my rounds after doing that medication in the morning and you’d just be covered with
drops of the penicillin and streptomycin all over you. The needle would pop, the syringe
would pop off, and you’d put it back on and then slowly, slowly, slowly trying. That was
a shortage. Sometimes we didn’t have the right kind of gauged needles or IV’s, the
butterflies; something as simple as we didn’t have aspirin suppositories and everyone had
fever so you wanted to bring down the fever and we would spend hours emptying out
Darvan capsules, Darvin the little kind of gelatin capsules, emptying that powder out,
pounding out the aspirin and putting it in the Darvan capsules, pricking a little hole in the
end of it, and then using that as a rectal suppository. So, there would be a lot of kind of
make due kind of things you’d have to do. My dad was in active duty Navy and a lot of
my letters were asking him if he could send antibiotics, send antibiotics over, samples of
different things, particularly the suppositories were a big deal so we could get them or
they’d melt before they could get there. Of course if we had civilian women and
children, for a newborn baby we didn’t have any baby bottles or formula or anything like
that and we had a lot of babies with our rubber gloves where you just prick a hole in one
of the fingers and literally kind of milk into the baby’s mouth. There was a lot of rigging;
we managed to do a lot of rigging to get by. It’s made me very flexible in terms of
rigging, getting by with what you have, but the shortages thing to be like that should not
happened, particularly something as essential as if you have the right gauge of a needle.
You could get beer and whiskey anytime you wanted in the shipments. And, if you had a
ward master then he would go out and scavenge out things for you. Sometimes it just
wasn’t available; the shipping wouldn’t arrive or it just wouldn’t get there. Sometimes
we had shortages of medicine. Sometimes we ran out of pain medicine. In Vietnam we
counted Lomotil as if it was a narcotic. You know, Lomotil is an anti diuretic, it is
diarrhea medicine. Its’ common to buy over the counter now, but 30 years ago it was a
rare, wonderful medication. And every change of shift count all your drugs. You would
count your Lomotil tablets because it was hard to get, for the people who did have
diarrhea.

SM: It’s an anti spasmodic?

LH: No, no, Lomotil right now is you buy Imodium, it’s a derivative of it. Its
not anti spasmodic, it just slows down everything in such a way, one of the best anti
diarrhea medicine that exist but now its common place it was a big deal.

SM: The shortages of antibiotics, was this a bi product of selling on the black
market in Vietnam or do you know why there were shortages?
LH: I think some of it was a shipment just wouldn’t arrive. One of the things that also kind of contributed to my dislike and distress of the Vietnamese people for so long is that you were so aware when you were able to move around in the village, it was what the Black Market had to offer. The things that you knew should be in the PX but weren’t there, but it was just boxes of tide so you could do your laundry. Other things [?] soap and a lot of other things. I’m sure the antibiotics, that happened also. It didn’t have a lot of good explanations except we didn’t have it for a while and you’d put in frantic orders to get a resupply. But, I think the black market and the abuse of some of the American products that we had over there, abuse, now I understand the desperation of the Vietnamese people had to make a living no matter what. It would make you angry if you didn’t have a bar of soap like Dial soap and you couldn’t do your laundry and then you go down to the village and the black market and see how they sold it there. That kind of contributed to that. I also used to do some medical missions. They had volunteer called MEDCAP missions, but I can’t remember what the initial stands for, but we would go into some fishing villages nearby and literally just kind of use like a first aid call and that’s a lot of the stuff I’d ask my dad from where he was stationed from the military base to send samples of antibiotic creams or things like that that we could hand out because you couldn’t really give much out; you didn’t have a lot of other things to provide the villagers but we would spend hours scoring bars of Dial soap and then handing that to someone who may have had bad skin conditions but we had to make a mark on the soap so that they couldn’t sell it on the black market so they’d have to use it and that all seemed to be a terrible tragedy. We were wasting time, good time, ruining something so someone would have to use it. Again, I’d like to go do those MEDCAP missions now I think I could do…I’d have a better understanding of what the people needed and how we could have helped them.

SM: Those types of civic actions, going out in the villages, did they help infrequently?

LH: They did until Tet and then we couldn’t do it anymore, but I did them every time that there was a chance.

SM: Do you recall how many there were that you went on?
LH: I think we would go regularly on our day off; I mean, it was just a regularly planned thing.

SM: Like once a week or something?

LH: Yeah, I think once a week. Then we did some work with an orphanage because I have pictures of the Christmas party that we had so that must have been that first Christmas I was there before Tet where we decorated and brought toys and things, and again my family sent a lot of...they were real supportive of sending things over to be handed out to children at the orphanage. So, we did some small kind of in roads of trying to make our contribution to the community greater than what was going on at the air base. You know, then the airbase and the hospital itself was a tremendous source of employment for a lot of Vietnamese, incredible.

SM: How many people worked in the evacuation hospital; Vietnamese people?

LH: Oh, I don’t know that. I don’t know; probably 40 or 50. I’m sure it was a lot, support stuff

SM: What kind of functions?

LH: Cleaning, kind of keeping the grounds. It was all very janitorial kinds of things; some translators. Translations were a problem. Not having enough translators was difficult, and particularly then if we would get a shipment of like Montagnards. That was terrible because we didn’t have any translators at all, or someone from just the highland villages. Some of the tragedy was not only did we not speak their language, we didn’t really understand some of the culture. I can remember a beautiful...I think she was just a highland tribe lady. Whether she was Montagnard or not, I don’t know. I’m more aware that there’s so many tribes now that I didn’t know about, but it was a tradition that when a family member dies you wrap them in this blanket that is kind of like almost a family blanket and when this lady’s little boy died and he had been just terribly ill, we did everything we possibly could, and when he died she was inconsolable but we also didn’t know that she needed to have him wrapped in this blanket and it took about a day before there was actually a translator to let us know. We were able to somehow find them a blanket and then eventually people would take his body many arrangements to have him, but that’s the buried. I remember for this woman that was so inconsolable. Most
Vietnamese are much more stoic and don’t express so much grief. Her grief was terrible; much more of it was just that we weren’t able to meet her needs, which is what she needed, culturally. That was just a good example again of when Americans not knowing the culture.

SM: When Montagnards or highland villagers would come to your hospital, would they be accompanied by Army personnel, Special Forces personnel, or anything like that?

LH: Sometimes, yes. Sometimes they’d have…

SM: If they were there, would they help with translation?

LH: If they could, yes. Just anyone who could possibly. We’d commandeer anyone who could, whether it be a soldier or sometimes family members. Now, not so much for the Montagnards or the villagers from the more remote areas but in a lot of times if you could just make due with some family member who could speak a few more words of English who maybe they’d worked for GI’s or something, you just kind of got by the best way you possibly could. One of the things that was extremely hard for us as Americans is the naming for Vietnamese, the three names, and you know no one could pronounce them, no one understood them, and the names seemed the same, and so if we got – this is a good example – triaging, a lot fresh casualties, Vietnamese casualties. They would all come in with their names but with no identification and you couldn’t understand them so we literally named the Vietnamese ourselves. So, one whole fresh load of people might be named after brands of cars or brands of beers or flowers or after a while we were kind of desperate, football teams or sports just because it didn’t mean anything if you told me Khan was in bed four. But if you said Ford or Cadillac, you could create a name and an identity. We actually put those names on their medical records and that is the way they would be on there brands and medical records. If you knew their real names, it’s their real name there. But in many cases you could have four Khans and that was not helping. I [?] embarrassing, I embarrassed him, but [?] after being injured [?] people [?] call me by name or whatever [?]. It wasn’t disrespectful, it was the only thing we could safely do for them but [?] favorite patients [?] or Ford or Cadillac and remembered different people whose names [?] we could do so you wouldn’t get them confused.
SM: The evacuation hospital itself, were there specific units that you supported or was it just for a general region? When you received casualties, where would they come from?

LH: That’s a good question. I wish I knew better who to answer that. We were supporting, basically, geographical areas. We were not like the support like the 1st cav or something like that but in that geographical area whoever might be in that area. So, as I said, we supported…and a lot of our fresh casualties, more seriously injured casualties, were Australians. They used our hospitals, they didn’t have their own. They had like a first aid station but then Australians…and it kind of changed as different units moved in and out and for a long time you’d see a lot of casualties from one battalion that you’re familiar with and then after that it would be a different area, different unit, and the same thing with the Vietnamese, too, the ARVN. For a long time we had probably more ARVNs than GI’s and we had more Australians than we had American GI’s. Now that just leads to the point I was going to make about not knowing about the country and the culture. We knew a lot about kind of arcane military [?] what’s a battalion, what’s a platoon, what’s the history of things but I don’t think we really understood kind of…again, we were a lot more like lay people in the military than we were military experts that we didn’t really know no one showed us this on the map; “Okay, this is where you are and this is where your units are and they’re engaged in fighting here and you might be getting some casualties from this group or from there.” Like if we would get a group of people from the highlands, I didn’t know what happened there; was there a campaign that we had initiated or was it just retaliation of a bunch of Viet Cong that went through a village. We often didn’t know about the glory behind the guts. We didn’t know what had precipitated or what had happened. Sometimes the GI’s, they would tell you, “We were in the battle and we were 50 clicks down and we got overrun by or ambushed…” Outside of that, you really didn’t know what had happened. When we, after Tet, we had brought in so many civilian casualties, particularly women and children, and so many of them were suffering from napalm burns. I didn’t know where that was coming; did our soldiers drop napalm on our village? What has happened that they were injured? Because you couldn’t speak English to them, you didn’t have a lot of background, of what had happened, what campaign or battle had occurred? How long
had they been in the field, for a couple of days, before they were picked up? How did
they get picked up? You just didn’t know that kind of information at all. The other thing
that, one of the things I didn’t have a real understanding of, the history of the war and I
didn’t understand the political leadership, what our invention was, but I did seek out the
base library, one of the things I did, and tried to do as much studying and homework and
reading, there were very few textbooks. I did a little bit of history then, it just helped
familiarized some of it. Without that, I would have been totally bereft of any
information. I think maybe I might have had a little more intellectual curiosity than
maybe some of my nurse colleagues. I don’t remember that being a point of interest to
other people. I was [?] trying to figure out why we were there and what point was it, who
were we helping? That was, again, wishing I had more of that before I went overseas but
I tried to as much as I could acquire it when I was over there. I also was able to take
some extension courses. I went to school at nighttime and I actually took a couple of
courses from the University of Maryland. Again, before Tet, there was not a lot to do and
our hours weren’t as long working hours so I remember I took American history and a
couple of government courses, correspondence courses. So, the base library was a place
to hang out because it was air-conditioned and it didn’t smell bad and I remember
spending a lot of time there, as long as I could after active duty assignments or sometimes
in between shifts I’d go there, too.

SM: Did you talk much with your father about these types of issues? I mean,
here we are in a country fighting a war that’s undeclared war but with…and here you are,
you have no understanding of why we’re there and what we’re doing, and isn’t that kind
of scary?

LH: It was, and I think I expressed some of that feeling to him but I didn’t get
any long military treatises from him at all. No, I talked about since then he doesn’t have
a real defense. I mean, there wasn’t anything really to say other than, “Boy, that must
have been hard,” but there wasn’t a whole lot of defense, but so he had a very clear
answer of why we were there; we were really to prevent the roll out of communism and
in many parts of the world. His is a very interesting, uncluttered, absolute black and
white but he’s spent his life doing that. He was also very supportive of a bunch of
younger children who grew up in a much stronger anti military, anti Vietnam [?]. My
younger brother was a lot much more involved in it, in that generation of protesting, rather than they were supporting.

SM: How much notice would you typically get of an incoming group of casualties that you had to care for?

LH: Oh, very short sometimes, very short.

SM: Could you give me a little bit more?

LH: You know, I’m trying to think, Steve. You might…

LH: No, it would be a couple of hours because a whole lot of that would be immediate processing, trying to move some people out. It wasn’t days or weeks, but it would probably be at least two or three hours. A lot of it was just kind of undercurrent. Sometimes it was rumors and it wouldn’t come into fruition or maybe they would bypass us, if it was folks being flown in and they would go on to Long Bin and go on to Saigon. Or, sometimes a plane might just show up and we’d have no preparation. I mean a Huey might bring in some of these guys and they were very close and there was no time to even call. But as a whole, it would probably be three or four hours at least allow us some of getting other planes there to land to move some people out, trying to...and making a decision…I can’t remember how the decisions were really made about where somebody would go. Some of it was just availability and what planes were there, whether the plane was going to Guam or going to Hawaii or whether it be going to Japan. I don’t remember it being a real orderly fly out process where, “He had this kind of wounds and therefore he needs to go here.” I don’t think it was that well designed or well thought out. It was more, “Just get the first person, ship in, get somebody on this plane, and get them out.” All you were telling somebody you have to go back to the front or you’re on your way home. That would be kind of his, in most cases, the GI soldiers didn’t question. They were always so grateful that they were in the hands of somebody taking care of them. They didn’t really mind that they were on kind of a multi-stepped assembly line, you know, all it was was taking them further away from the front needed care if it was going to be a long process in some cases just to get home.
SM: Do you think the medics played much of a role in that, I mean, there must have been some combat or battlefield level triage going on where a medic would say, “This guy needs help as fast as possible. We’ve got to get him to that medical facility.”

LH: Yes. I mean, and that’s why a lot of them had been triaged initially when they got there and probably in some cases the triage would include maybe someone who they knew wouldn’t make the transport or died before the transport to get there. But no, I think the field medics did an outstanding job and there were a few cases, not often, but a few cases where there was, the casualty, would come directly to us as if we were the field hospital.

SM: Were there ever any instances that you recall of a patient dying as a result of a lack of supplies? You mentioned a lack of antibiotics, a lack of needles, and things like that. Were there ever incidents where a patient’s infection became systemic and they died as a result because of a lack of supply?

LH: I think not one, you know, not anyone stands in mind because of supplies. I know a death that I’ve never been able to forget that occurred because we didn’t recognize, we, the doctors and nurses, that he was bleeding internally and needed blood, and where we thought that he was being argumentative and kind of irrational, he was a difficult patient, we thought, to take care of, in the end we hadn’t realized that he was bleeding to death. In reality, if he had been in a hospital with better access to this timely lab tests we would have done a better job in monitoring, to say that he was fine. It was inadequate septicemia and I don’t match those deaths. That was the day we didn’t have any of the streptomycin. Again, you would triage even the medications. If we were out of stuff then you would heard whatever needed for the sickest people and maybe wouldn’t be give as much. We have a lot of medication prophylactic just because you were afraid everyone was going to develop an infection, but I don’t remember anyone who had infections when we didn’t have adequate drugs to treat it.

SM: We’ll end CD number one of the interview with Lynne Hudson. This is CD number two of the interview with Lynne Hudson. So describe the events surrounding Tet of 1968 and what happened at your hospital, your evacuation hospital.

LH: Well, our hospital, as I was saying, was really kind of…our living environment was pretty wide open being able to access the village and the beach and
freely get back and forth from the hospital to our living quarters, and then all we heard
again, and not in an organized military way of briefing or updating, this sort of series and
series of rumors about large portions/different parts of the country being overrun and that
there was a great deal of concern about a north Vietnamese unit that was moving in close
to where Vung Tau was and that’s when - and our perimeter of defense was being
provided by the Koreans and the Australians – we began to get a lot of fresh casualties in
that were Australian soldiers. From that time forward, we just kind of moved into…as I
said, weapons were issued. We were on alert a lot, we had a lot of incoming. The base
was rocketed several times, but not with a lot of devastation. It was a lot more misses
than probably…but that sound of incoming you sure did learn to recognize. A lot of…it
just became a much more desperate wartime kind of condition. We were immediately all
going on 12-hour shifts. We just kind of worked around the clock, and there was
probably a period of three or four weeks that I don’t think we had a day off in between;
you just worked 12 hours, went home asleep, and worked 12 hours again. There was no
ability to get time off just because we were inundated; not only the soldiers, but a lot of
civilian war casualties. Now who made the decision that they’d open up this hospital to
civilians, I don’t know or I don’t know how that happened. It didn’t seem to have been,
again, a judgement or a decision that was shared or explained. If it was just purely
humanitarian or if they thought we had some way some excess capacity and we could do
it. But, our hospital environment became absolutely almost like a Vietnamese village
after that time where you’d put together maybe two beds and have a mother and five
children being together in these two beds. Every one of them would have injuries. We
often, because so many of the little children were burned real badly and as they got a little
bit better we often gave their mother or their father, if their father was there, or
sometimes an older sibling a pair of scissors and a pick up, a little forceps, and have them
because you tediously for the burns we’d have to clean away the dead skin, the bad skin,
and you could just do a little bit at a time because we didn’t have enough pain medicine.
You didn’t want to be giving narcotics to the little kids so they’d assiduously just sit there
for hours just gently kind of cleaning the wound. You would kind of teach them how to
do that, which again was kind of primitive nursing but people just made due. I can
remember putting soldiers and Vietnamese people that had casts on out in the sun,
literally, and out in the air, cutting a hole in the cast because we knew there was a bad
wound infection, and literally wanting it to be infested by maggots because the maggots
would clean the wound. That was part of our routine care.

SM: Maggot therapy?
LH: Maggot therapy, right, and it did work. So anyway, Tet became a time of
intensity. It totally shut down in terms of having access to the village or being able to
move around and it literally I think was that way from that January, the end of January,
February, all the way through I think until probably the summertime. The intensity let up
a little bit, but for four or five months it was…so it changed, for the first time, a little bit
of personal concern for personal safety; not intense, not terrible, but it was very different
than just kind of visiting a third world country. It was just nothing but really dedicated,
dramatically hard work. There was an Australian group of casualties I’ll never forget that
were brought in and one particular young man, he had had both of his legs amputated but
we were desperately trying to save his arm, his right arm, and finally after infection set in
and it couldn’t be saved we had to amputate his right arm and depression and heart break
he went through becoming a triple amputee, we were all kind of…I mean, its just a
patient I’ve never forgotten. The Australians do a wonderful thing, though, is when
someone’s critically injured they bring a family member into even the war zone and they
brought his mother in and she actually was there with him. She stayed at the Australian
camp, but she would come and spend everyday and be with him in the hospital. I have
pictures of this wonderful lady standing by the bedside of her son. She didn’t come
immediately. She came after he was more in and in a convalescent time and she brought
a load of kiwi bears as gifts to give all of us as nurses because I’d sent them home to my
brothers and sisters, but one of the things that really stood out about the Australians is
again, I told you they take wonderful care of their soldiers. It wasn’t a voluntary Army,
so it’s a very different thing the way they took care of their soldiers, but he was visited by
a senior officer very soon after he’d lost his arm and that senior officer, Australian
officer, was a double amputee who was still in the service whose job was to visit
seriously injured soldiers and his whole mission was to tell this young man, his name was
David Mackenzie, I just remembered the patient so well, that he had a job the moment he
went home, he would have a job, and I will never forget his recovery from that time
forward. He kind of moved out of being just a victim and feeling terribly depressed to ready to go home and he wrote several letters since then back to our hospital with thank yous. He sent Australian bush hats to us just to stay in contact. We’ve lost…I’ve lost contact with him, but one of the things I’m hoping to have happen at this reunion I go to is that there’s another Australian soldier that was injured at the same time that has contacted a couple of other nurses and has actually come over to the United States and visited with his wife that he knows how to get a hold of this young man. But, it was intense, bitter-sweet, poignant memories that were…and intensified I think because of the human nature of it, mostly because of the women and children we took care of and then some of these very severely injured particular Australian soldiers. The women and children taught me kind of an openness of compassion. In Vietnamese world life, when somebody’s sick and in the hospital, and it is this way today, the whole family goes to the hospital with them, and it took me a long time to get used to the fact that right outside the windows or right outside there would be three or four family members squatting around cooking their food; they’d milled a little fire, fix pots of…little tins of rice. One of the things that we did stupidly to them, again, we weren’t prepared to take care of the Vietnamese nor understand their culture, is that we fed them GI food and the amount of waste, the throwing away plates of canned peaches and things that they’ve probably never eaten before in their lives, it was just silly that we didn’t do more and try to offer them nutrition that was more familiar to them. That didn’t happen either, and one little girl, a little girl was Chrysanthemum that I could remember, was a little girl that had a terrible injury to her jaws, we had wired her jaw shut, and she was really not getting any kind of nourishment. We’d make all these blenderized drinks and drink through a straw and she couldn’t tolerate any more IV’s. Those days you wouldn’t have done a feeding tube, and finally she only began to get nourished again because her father would stay with her hour after hour and place one kernel of rice, one by one, through her wired together jaw and that was the only thing she would take as nourishment. Well that was against every medical practice that I’ve ever had is that you never want to give anybody who’s jaws wired shut anything they could choke on, and a kernel of rice is not…its small, but you would be worried about someone choking on it, but that is the only way that little child was able to get nourished again and start to get better because before that
she would refuse all food, everything we tried to do for her, and it was her father who
saved her life just patiently feeding her kernel by kernel of corn between her teeth. It was
lessons like that I learned because that would have been against every rule of American
nursing or American medicine.

SM: Were there ever any instances of the Vietnamese family members trying to
administer a traditional or folk remedy or medicine to their family members in your
hospital?

LH: They would do that a lot, and after a while you didn’t stifle that. Mostly it
was just taking a coin and rubbing it. You know, if someone would say they would have
a pain or they would hurt you’d see the striations where they kind of make a bruise, it
was almost like making a hickey by taking your coin and by friction; the point was if you
create enough friction it would let the demons out and that would not be something
unusual to see them taking coins or the objects, metal objects, and rubbing it on forehead
or arms or shoulders but those were the most things I ever saw.

SM: What about herbal remedies, or ginseng or anything like that?

LH: They didn’t seem to have…a lot of these people were refugees. By the time
they got to us they’d been displaced from wherever their homes were and literally were
just kind of camping out to be with this person who is wounded or their whole family
members would be wounded; maybe there’d be one unwounded person but I didn’t see
that as much.

SM: What about the American GI’s? What memorable experiences do you
remember with them?

LH: Well, number one, I can remember some seriously, terribly injured,
heartbreakingly injured young men and the gratitude and the cooperation they’d give,
knowing you’re going home, and then that ward, that big ward that had a lot of malaria
and hepatitis, there was, I think, always this undercurrent of suspicion of malingering;
ankle breaking just because people wanted to be away from the front. You never quite
knew, you never had quite the…because they didn’t look hurt and didn’t have terrible
wounds, probably the empathy level was less and it was more like a drill sergeant to them
with the regimenting or “Everybody wake up, everybody take your pills, everybody…” it
wasn’t the kind of tender hearted nursing I would have thought of. It was a lot rougher
and that was harder for me because that was my very first assignment so it was a little
harder for me to toughen up a little bit. I think that knowing that they could go home was
probably one of the best thoughts and that there was going to be, all along the way, good
care for them.

SM: Now for American soldiers that came through during the Tet period, did you
have serious problems with amputees like you had with that Australian gentleman?
LH: I don’t remember amputees as much as just terrible gunshot or shrapnel
wounds, abdominal wounds, chest wounds, but I don’t remember. The amputees were
happening to stand out more with the Australians for some reason. I think that was a land
mine. The others were more shrapnel and just gunshot wounds.

SM: Now for the Australians, did they have an evacuation hospital to which they
would go after being treated there?
LH: No, they’d go home straight to Australia.

SM: So they would be treated by your hospital, and then they’d just go home?
But for the Americans, once they were stabilized, they were sent out to the next higher
hospital?
LH: Right…closer, too, I mean Australia’s so much closer to Vietnam. That
made all the difference. There was kind of a half way point where normally there would
be evacuated and stabilized some more before they came home.

SM: So for the American soldiers, many of them, once they’re stabilized, if later
on they develop some kind of a septicemic infection or whatever, that would have
probably occurred in another hospital?
LH: Uh-huh, absolutely, yeah.

SM: So your dealings with that kind of stuff by American soldiers was different?
LH: Exactly, right, and so they may have…the hospital in Japan and Hawaii
would show up with some really bad…everybody had strep. The smell of strep today
reminds me of walking into that war and I can smell it and identify it in a second. Strep
was just almost endemic in every wound, open wound, but you wanted to prevent
[asceptacemia] where it just became black and white like that.

SM: Any instances of the skin born strep that eats flesh?
LH: I didn’t know about it then. I didn’t know about it. I mean, it wasn’t a medical phenomenon that we knew much about. A lot of broken bones, terrible broken bones, and an awful lot of splints and open pins. Those would be terrible. I think I dreaded those the most, the orthopedic patients just because the pain was a lot more intense, it was harder to deal with them, we didn’t have the kind of bar apparatus to move them, and it was just much harder to deal with. The beds, everything about it was terrible and you hated it if you were going to have to lift someone who had their femur pinned off the bed and throw them on the ground and cover them with a mattress which you…it happened a lot, vector tests in terms of the…because of the air raid warnings or the air warnings that would come in.

SM: Now you mentioned earlier a rocketing.
LH: Uh-huh.
SM: You also were threatened by potential air attacks?
LH: What I meant was rockets coming in.
SM: Rockets coming in? How about mortar attacks, did that happen?
LH: Mortar, too. You could hear more in the distance and I don’t remember ever feeling like we were hit by it but you never knew if it was going to get closer. That was the only thing. Because we weren’t very smart about knowing who was defending us and who was in charge of who, you never really kind of had a sense of, “Oh, it’s all going to be okay.” I think the lack of information, the lack of communication from a military point of view. I think the military’s going to write you off as being lay people and not interested in that, but you also weren’t very well informed, either. It was rumors were a lot, but you just really didn’t know the validity of it at all.

SM: And what about small arms fire at your hospital?
LH: No, I don’t remember that ever. There was fear of it, there was. The only time I heard small arms fire was within the 24 hours of Tet, but I think that’s still sporadic and close by, but it wasn’t like I never saw anybody shoot a gun in front of me.
SM: Now what did you think and what did your fellow hospital staff members think about the war after Tet, and did you know that General Westmoreland had gone back to the United States late in ’67 and talked about the light at the end of the tunnel, the
war would be won soon, and everything else? Did Tet have an effect on your morale and
on your perception of exactly what we’re trying to accomplish?

LH: I think what we were trying to accomplish definitely had an effect on
morale, just the fact that our boon dock days were over, and that gosh, we’re not doing
very good in this country if we were so quickly and easily overrun in so many areas.

Then the next thing I can remember that was impactful was, because I was working
nights and listening to armed forces radio when LBJ decided that he was not, or declared
or announced that he was not going to run. That was amazingly poignant and it was
almost frightening in a way because LBJs role was so deeply the heart of our role and I
didn’t know the war had started with Eisenhower had sent troops over and then Kennedy
had sent troops over. It was LBJs war in my mind and to have him kind of give up, I
mean… I don’t think we felt abandoned but it was very dislocating in a way and I think
that, too, that such a prized dream of his to be president was really over because of what
was going on in Vietnam. What was going on at home, but the lack of success in
Vietnam, I think, was the real….obviously caused the end of his presidency. The only
things that were going on at home, you know, during that year Robert Kennedy was shot,
Martin Luther King was killed, you’d hear about incredible protests, but it was very
disarming to be in a war torn country and worry about violence in your home country. In
my letters home, they’re also quite full of that; the sadness I feel or this confusion in not
understanding. Its not that I didn’t understand the anti war movement, but that I couldn’t
believe that we would get to that level of violence and that people would be assassinated.
Now that was just confounding to me. So, I find letters home as an interesting history of
that, the last years of that decade, in a way.

SM: Now did you talk amongst the other medical staff about these types of
issues, about LBJs resignation and about assassinations and stuff?

LH: I don’t remember that, I don’t remember that. I really don’t. I don’t think
so. I don’t think that there was a lot of serious conversation at all. You were either kind
of sleeping or you were working, and when someone was socializing I think you were
having a drink in the hut, but I don’t remember any heavy personal growth developing
any kinds of conversations that I either shared my thoughts with anybody or learned from
anybody. Everybody wanted to go home; there was a lot of talk about home, but I don’t
remember a whole lot of, “Gosh, what’s happening when you go home.” That was very immediate, very here, and very now.

SM: What about conversations with soldiers that were coming in as patients, American soldiers especially?

LH: No, I don’t remember any. You didn’t really have much time. I mean, I don’t think that there was a lot of…besides, “How are you? What can I do for you? Do you need a pain shot?” that kind of thing. We didn’t have a whole lot of engagement. Actually, for some reason, the Australians that I’m remembering, there seemed to have been more bedside time with them than I can remember any other group of soldiers, and I don’t know if just that they happened to be in a lull and we got to know them better, but there wasn’t an awful lot of that kind of social intercourse that would go on. You’d get a lot of attention from the American GI’s just because you were a round eye and that kind of was more…things had to be almost very business like and there wasn’t a whole lot of maybe exploring thoughts and ideas to the same degree just because they were all so homesick and they all wanted to be a round eye and it was hard to get used to the attention that you got as a female, only because you were a female round eye, but not because you were a good person or a thoughtful person or a kind person or making a person to man kind. It was just literally you reminded somebody of home. At 21, that was probably a harder adjustment to make was to get used to all the attention and not feel like I deserved it. You know, “Where is it coming from and why am I having it?” and that’s actually interesting in some shared stories with people that I talked to. Often, a lot of the women expressed a sort of disease of almost put on a pedestal. You couldn’t walk down the street, you couldn’t go anywhere without being whistled or just kind of a yearning of the GI soldiers towards the round eye. That was a hard thing to get used to. Some of the thoughts and the memories I had of Vietnam is its been fun now and then to find somebody else who had same thoughts or memories because I think that I don’t have to hold dear…its not an obligation I have to keep this fresh anymore. It’s shared by somebody else. Its not just my job to never forget this, and that has been so little bit of the reading and then the few times I’ve had a chance to talk to somebody else who’s on the same wave length, its like this tremendous burden because I thought to give honor and value and credit to what I had experienced, I could never let it go and just blow it off.
I had to give homage to it, and when I know somebody else who’s giving homage to the
same thought I think, “Oh good, I can go off duty on that one. I’m not in charge of that
thought,” and someday I feel like it would be good if I wrote it down because then I
could really give up the sense that I don’t want to forget these things, you know, the
lessons learned.

SM: Well you mentioned the Koreans were also in your area?
LH: Uh-huh.
SM: Did they get cycled through your hospital?
LH: Uh-huh.
SM: What was that like?
LH: They’re mean. They’re the meanest people I’ve ever seen. There were
sometimes when the Vietnamese would wake up and realize there was a Korean next
door to them and they’d be frightened. Sometimes our GI’s would wake up and realize
next to them was a Vietnamese and it would be frightening to them, too, because they had
been ambushed but the Koreans were rough, mean. I mean, they weren’t mean as injured
people but when we also knew them kind of in that R&R environment you just knew to
stay away from the Koreans. They were kind of well known as being almost vicious in
the way they treated people. You [?] Korean has. I [?] myths. They’re so stocky and
healthy looking and very powerful. The Vietnamese men are frail and not strong looking.
An Oriental or as an Asian, the Korean just really stands out as someone who’s pretty
powerful because he looks powerful. The Vietnamese men were absolutely kind of a
demonstration of people in bad physical condition. They’re not strong, not healthy, and
of course they’re all very, very lean and they probably were a lot more strong and
powerful than I imagine they looked. The women were always beautiful, always
beautiful, and the children were always beautiful. In the Vietnamese culture, the women
are very strong hard workers and there was a saying that actually someone taught me last
year that a Vietnamese man is as rich as his wife will work, and you get that sense that
the country’s industry is on the backs of the women. You see that they’re the ones that
are in the rice paddies or they’re the ones toting the huge poles, they’re the ones selling
baskets and baskets of produce along the roadside. They’re very industrious, very hard
working. You don’t get that sense that the industry’s in the men at all. You didn’t get a
sense that their skills as soldiers either and you didn’t get a sense of their pride in uniform or that they were dedicated, skilled soldiers.

SM: And with the source that would come in, American, Australian, Korean, whoever, ARVN, one of the things I read about in terms of the guilt that some men would feel in being taken off the battlefield even though they are injured. They would feel guilty that they’re leaving their unit behind, they’re leaving their buddies behind. Were there ever any instances in their hospital where they would want a…they showed an obvious desire, a need to get out of there as quickly as possible so that they can get back to their unit?

LH: Not particularly, only because I don’t know of any instances where they casualties that we saw went back to their units. They had to go on for more treatment somewhere, so there was regret that they couldn’t go back, but I didn’t see anyone, “I’ve just got to go back.” They knew that they were going to have to be passed on someplace else. But, the medical guys, the ones that were in the medical treatment piece, I don’t remember a lot of intensity of them begging for them to go back or anyone to hurry up and get…I think that there was probably a little bit more undercurrent. They’d gotten clean beds even though it was a hammock – not a hammock, but you know, in a Quonset hut – and they were out of wherever they were, and in those cases I didn’t see…I just never saw any kind of heroic behavior. It could be the very nature of if you end up in the hospital because you’ve got malaria, you didn’t take care of yourself in the front end or something, I don’t know, this didn’t have the same kind of level of honor in a way. They were more the people that were just glad to be in a safe place.

SM: Speaking of the malaria again, how would you know someone had malaria? Who did the testing?

LH: There is a blood test that they would do.

SM: Was that done locally in the hospital?

LH: Yeah, it could be that it was a malaria prep. It’s not real hard to do. Oh, mononucleosis was another thing, too. We did a lot of mono prep and you get a lot of people with mono; just kind of worn down, run out condition. They pretty well exhibited the fevers, the classic fevers, night shakes and things like that, but you can actually
measure the something, the level...the tsetse fly. You can measure, I can’t even remember
the conditioning where its not...what is the mosquito that...

SM: Monopolies?

LH: Monopolies, that’s right. You could measure blood levels when it was
starting to improve.

SM: What about other blood work as far as, like for instance, you mentioned
earlier that gentleman that died from internal bleeding, not being able to do the blood
work to get the information?

LH: We could have done, I mean, we had primitive we could run hemoglobins,
they could do cross match, they could do blood transfusions. I think some of our part
was that there was probably some human error along with not accessing what was
available because it wasn’t real easily available, but we did have the fundamental ability
to do it, but it wasn’t like you had a full operational lab that was there all night long. It
meant you’d have to wake somebody up and it would have had to have been done on a
one on one basis. Its not like you could say, “Okay, routinely I want to do lab work every
four hours; come draw blood,” and do that. You didn’t have that kind of luxury that you
had in a big hospital.

SM: And would you routinely send off blood and tissue samples to labs and
stuff?

LH: You know I don’t remember. See, I don’t remember because you were
talking about that lab…

SM: The 9th med lab?

LH: …the 9th lab. I don’t think so. I really don’t think so. I don’t know. That’s
funny, I don’t even remember what our lab looked like, but if we sent it anywhere it
would have been Saigon, and that just seems like it would have been a very inefficient
thing to have done, to take up the packet room on lab tests. In most cases, if you needed
that kind of diagnostic work up, it was easier to send somebody home or get them out of
that hospital environment and send them either to a hospital in Saigon or send them to
another hospital where there was a commercial lab nearby. I just don’t remember why, in
any case, we would have done that kind of treatment therapy. We didn’t see rare stuff,
you saw common, repetitive wounds over and over again. You knew everybody had
strep. You could diagnosis it by the smell. You didn’t have to wonder. You didn’t do wound cultures because it was real classic. Pseudomonas was rampant. You’d see that, you know, that glistening green color that kind coats a wound. There wasn’t a lot of reason for lab analysis that I can think of. Now, I don’t know, that lab…that would be interesting to ask that man “What kind of lab work did you do and what kind of patients did you do it on?” but I haven’t really ever really remembered drawing blood to send to the lab other than to see what someone’s matacrate [?] level was or anything, and I don’t even remember for the malaria patients that we really measured the tiders very rigidly. I think you just kind of gamble with after three weeks of this kind of treatment then that was enough, and then you move on. A lot of it just kind of played by the numbers. You just kind of went with the norm.

SM: And the typing that you did when you were doing transfusions…

LH: Cross typing, uh-huh.

SM: Did you…were there ever any shortages of blood?

LH: I don’t remember that. We used a lot of blood plasma expanders and it used a lot of kind of artificial rather than…it wasn’t really often that you used fresh blood, and when you did it was real dramatic and you were just pumping that in and that time, a lot of times, you were not worried about the type and cross matches; just get the blood into them. It was actually pumps that we put on to just pour that blood in, but most of the time it was plasma expanders. A lot of people would have IV’s but you wouldn’t see as many ongoing IV’s in that environment as you probably would have in a civilian hospital. If anyone could really almost orally hydrate themselves or be conscious or be awake, then you kind of saved that IV and that needle and that set up and you didn’t want another open wound so you didn’t do it as much as you would do normally.

SM: Well, this ends interview number one with Lynne Hudson.