A Short Primer on Aeromedical Evacuation

The Vietnam War was accompanied by an almost revolutionary jump forward in the aeromedical evacuation of wounded soldiers from the battlefields and from the theater of war to hospitals in the United States. U.S. Army medevac helicopters under fire airlifted wounded soldiers during ongoing battles to nearby medical facilities. U.S. Air Force C-141 strategic airlifters were transformed into medevac aircraft for the trip home to America. Once a wounded soldier was stabilized at major airfields like Danang, Tan Son Nhut, and Cam Ranh Bay, he could be in a major military hospital in Oakland, California in less than 24 hours.

When Carol deployed to South Vietnam, she became a key part of this lifesaving infrastructure.
In the late 1960s, I was a C-141 Aircraft Commander on many cross-Pacific missions from Travis Air Force Base, California to Southeast Asia and back. We usually flew tens of thousands of pounds of cargo to Southeast Asia and were seldom full coming back. So, when the medics in Vietnam were ready to send patients out of Vietnam, an inbound C-141 was picked for the transformation.

As cargo was unloaded from our aircraft, a team was standing by at our parking spot to take over the empty cargo compartment. They had a plan telling them how many seats to install for ambulatory patients and the medical crew. Then they would add supports for stretchers/litters to be installed in kind of a bunkbed layout. Here's a more modern picture of the stretcher setups probably on a USAF C-17.

They also would load on medical equipment required for the long flights. As the refueling of the aircraft was completed, big blue USAF medical buses would arrive to start on loading patients selected for that flight. The medical crew usually consisted of a Chief Nurse, maybe two or three other nurses, and maybe four or five med techs, all depending on the expected needs of the patients over many hours. The patients were selected based on being well enough to safely endure the long flights.

As the Aircraft Commander of a C-141, I was responsible for accomplishing any assigned mission with full decision-making authority over what was required to safely reach the destination of each flight. All Aircraft Commanders on aeromedical evacuation missions understood they should immediately implement any request made by the Chief Nurse.

I only flew maybe three or four aeromedical evacuation missions and don't recall any conversations directly with the Chief Nurse. So here's a little summary of what I would expect were some of her (in that era most of the USAF nurses were women and probably most of the med techs were men) many responsibilities on each mission she led.

Her job started long before we landed. She would need to understand the conditions of all the patients and concur with being able to take care of their needs during the time they would be on the aircraft. She likely had to approve the list of medical supplies carried for the patient load. In some cases, patients with spinal injuries would come on in Stryker frames, which were kinds of a bed with attachments to the frame to try to eliminate as much jarring of the patient, as possible. So those undoubtedly got extra attention from the Chief Nurse.

Maybe half or more patients would be ambulatory, and the total number of patients likely were about 50-60, but I might be a little high. So the Chief Nurse was the team leader to resolve whatever expected and unexpected issues would arise over the coming hours.

I have a memory of one mission we flew into Cam Ranh Bay with cargo and out with patients. Everything had gone smoothly through the onloading and starting for the runway. The loadmaster called and said the Chief Nurse needs of offload a patient. It wasn't up to me to ask why. I told the copilot to tell ground control we needed to stop somewhere on the taxiway to offload a patient. Ground control probably already had a request from one of the medical buses for access to the taxiway to meet us. My conclusion was that obviously the Chief Nurse was concerned that the patient might not survive 4 or 5 hours to Yokota AB near Tokyo. Someone told me later that the patient's temperature had risen to 104 degrees. That illustrates the weight of responsibility on the Chief Nurse to make the medical decisions necessary.

Our flight to Japan was uneventful. Since my crew's duty day had started in the Philippines before flying to Vietnam, another crew was waiting to make the nine-hour flight to California. Some patients might have gotten off for additional medical treatment in Japan. Most probably stayed on for the flight to California. Seems like there were special procedures for refueling the aircraft with patients on board. I believe one or two of the big firetrucks were standing by ready to attack any fire that might break out during the two-hour ground time. Actually, I recall now that procedures called for a firetruck to accompany any medevac aircraft while on the ground with patients aboard.

So from the time the medical crew and the patients on loaded in Vietnam about an hour before take off, through Japan and across the northern Pacific, they would be aboard the C-141 for about 17 hours. Travis had a major medical facility for any special needs, but for longer-term recovery, most of the wounded would go to Oakland, about an hour away by bus.

So that's just a short look at one of thousands of aeromedical evacuation flights from Southeast Asia back to the United States. Carol would've had many such experiences which would've honed her abilities for a career focused on aeromedical evacuation. It's likely some lessons she learned on her missions helped shape further advances over these intervening 50 years.
As you will see from the obituary, Carol had a career and a lifetime to be proud of. She and Dave must've had some glorious times together on their many adventures after retirement.

Jimmie Butler, 1963