

U.S. NAVY MEDICAL DEPARTMENT ORAL HISTORY PROGRAM

ORAL HISTORY WITH CDR (ret.) ANTHONY DePALMA, MC, USN,

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TELEPHONIC INTERVIEW

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Telephone interview with CDR Anthony F. DePalma, MC, USNR, physician aboard USS *Rixey* (APH-3) in World War II.

How did you join the Navy?

I joined up February 1942.

Were you already practicing medicine?

Oh, yes. I was an orthopedic surgeon working in the New Jersey Orthopedic Hospital at that time. I was about 37 years old.

Were you from New Jersey?

Yes, originally from Orange, NJ.

What do you remember about joining the Navy? Did you join at Church Street in New York?

Yes, at Church Street. I was then sent down to Parris Island, SC, and was with the Marines there for about 14 months. Then I went to New Caledonia to pick up the *Rixey*.

When was that?

I left San Francisco in September, 1943 and picked up the *Rixey* on the 9th of November. And I was on the ship until I came back to the states in 1945. So I was on board for about 18 months.

What were your impressions of New Caledonia?

I had quite an impression of that island. I never saw anything more miserable in my whole life. It was a horrible place. The only thing they had there was a leper colony. I was only there for about 48 hours before the ship came in.

You hadn't been assigned to a ship before. What was your impression of the *Rixey*?

It was quite a novelty. I had never seen anything like it. It looked just like any other transport except it had guns on it. When I got aboard, I was surprised to see the kind of men they had gathered as a medical staff. They had excellent people, 10 specialists in all the major specialties, and about 54 corpsmen.

Then you came aboard as the orthopedic surgeon?

Yes.

How long was it before you got down to work?

Right away because we began making that trip up and down the slot back and forth from Guadalcanal and down to New Zealand bringing casualties down from all those islands including Espiritu Santo, Efate, etc. Most of those casualties were being given quite primitive treatment, mostly first aid. We picked them up and worked on them until we got them to a base hospital in New Zealand.

What was the ship's sick bay like?

There was a lot to be desired. There weren't the best accommodations in that sick bay. It was the first attempt in trying to get a ship like this together.

What kind of ward setup did you have on the Rixey?

It wasn't the best. The acute wards were two bunks. But the thing was the heat. It was terrible down there in the hold. It was too hot and too crowded, and they didn't have any facilities like showers or air conditioning. We worked under terrible conditions. Sometimes the heat would be 106 in those holds, and so unbearable that we used to work in our skivvies in the operating room. Yet even though that sick bay was inadequate, we were taking care of hundreds and hundreds of casualties.

Our walking casualties had to be put into bigger wards and they were nothing more than transport bunks with three, four, or five tiers. I remember an incident when we came out of Guam. We had casualties stacked up where the troops were but fortunately a lot of them were walking casualties and they could come out and live on deck. When the ship came back in 1945, that sick bay was completely remodeled. They installed air conditioning.

You had an operating room?

Oh, yes. In fact, we had quite a few operating rooms. We had an orthopedic operating room, a general surgery operating room, a ear, nose, and throat operating room. They were small. And then we had an x-ray department with a very competent x-ray man. We also had a good laboratory. In other words, we had the facilities but didn't have the room. It was very tight.

What kind of equipment did you have in those ORs?

We had to improvise a lot. We used a turnbuckle, a very crude method to make traction. For example, if I wanted to make traction on a leg to keep it straight, I would put a turnbuckle on it and weld it up against the bulkhead. You then could adjust the tension.

When you were out there in the Pacific, there were times you

rendezvoused with other hospital ships to offload patients.

We brought in the troops, let's say the 1st Marines or the 3rd Marines, or units of those divisions, and then we would unload the troops. Then we would stay as close to shore as possible and act as a field hospital. And we took on all the casualties from the other ships such as destroyers. For instance, when we were at Okinawa, we took all the casualties from the surrounding ships. We did the same thing at Guam. In fact, at Guam we were 9 days off the beach. There were no white ships because they couldn't come in at that time. We could handle several hundred casualties without any trouble.

When we were loaded we would transfer our casualties to transports that were leaving the area and then they would take them to a base hospital or a hospital ship and we stayed right there.

You differed from a hospital ship in that you were armed and could get closer to the beach and defend yourself.

We were right on the beach, about a half mile offshore.

You were like an armed ambulance.

That's exactly right

Could you do a lot of definite care?

Yes, we did a lot of definitive work. We had to. For instance, on Guam, I did 47 amputations. When our patients left our ship there wasn't very much left to do to them. They were already convalescing. After the Japanese began using kamikazes off the Philippines and Okinawa, we got a tremendous number of burns. Many patients we treated at Okinawa, we brought all the way back to Pearl Harbor.

In many ways, you were doing the same kind of work that they were doing on the *Solace* or any of those hospital ships.

We got them before the *Solace*; we got them right off the beach. I don't know who thought of the APHs but they were one of the finest things the Navy came up with.

Would you say you could have used a lot more APHs?

We could have used a lot more.

What would have been a typical day on the ship during one of the active campaigns?

We got up at 4:30; it was very simple. We would go from the transport area to the beach. At the end of the day all the ships would go out to sea and then come back the next morning. The bombardment was already going on and we would go right to work. And

then we would stay there until things were over. Go to sea at night and come back in the morning. We went out to sea because the activity on land was over for the night so we went out to sea with the other transports as a matter of safety. That way, they wouldn't be concentrated and targets for suicide planes.

You would then stand by off the beach. You wouldn't be at anchor?

No. We were underway all the time.

When you weren't below in the OR doing surgery, you were probably on deck watching the activity.

Very little. When we were in combat, we were down in the hold working. However, we could hear a lot of it.

Do you recall any particular day when things were particularly hectic.

The most hectic days out there off Okinawa in the Kerama Retto area when our ships began using smoke screens to protect the transports. Well, somebody forgot that a lot of people might be sensitive to smoke and we had a helluva time with people on our own ship who came down with acute pulmonary edema. As a matter of fact, at Leyte, CAPT Pierson, the senior medical officer on our ship, had to be taken off. I suddenly became senior medical officer from then on. The poor guy was a heavy smoker and a bit elderly too. He almost died.

The other terrible thing we experienced at that time were burns because of the suicide planes. I remember many times a ship behind us, in front of us, or next to us would get hit with kamikazes and go up in flames. We would get all the casualties. The burns were terrible. They had to be treated right away.

I've got to say another thing about the Navy. We never lacked supplies. We always had enough plasma, enough antibiotics, enough plaster.

How did you find the corpsmen you worked with?

I think the strongest friendships that I formed were with the corpsmen. When they were working, those kids would be stripped right down to the waist. Down in that sick bay you couldn't carry patients on stretchers. There wasn't room for a stretcher to go by in those passageways. You actually could take a stretcher one way only but couldn't pass another one going the other way. These young corpsmen picked up the patients and carted them up and down those ladders and into and out of the bunks.

I remember one strong kid named Saltz. John was one of the finest anesthetists I ever worked with. John would give an intravenous pentathol anesthesia and I could forget about the patient; I knew he would be well taken care of. Those guys were unbelievable.

And you didn't have a nursing staff like the hospital ships did. The corpsmen were the nurses.

They were not only the nurses but also the hospital personnel that worked in the operating rooms. They were x-ray men, laboratory men, the anesthesiologists. When I went down to Parris Island there was a chap in charge of the radiology department. All of a sudden he was transferred. One day I got called in by the captain who told me that I was now the radiologist. He said, "You're head of the radiology department, I don't have a radiologist and I can't get one." Fortunately, we had corpsmen who knew how to take x-rays so all I had to do was read them. That's how expert those boys were.

When did you begin seeing the use of penicillin?

We didn't have penicillin when I got on the ship; it was just beginning to come out. But from Guam and Saipan on, we had penicillin. That would have been beginning in May 1944.

We went to Saipan with the same fleet and stayed offshore picking up casualties. We had the 3rd Marines aboard as a reserve division. After Saipan was secured we went to Guam and took Guam.

In practicing your own particular specialty--orthopedics--did you find that because of the climate you ended up having to use external fixation rather than plaster?

It wasn't so much the temperature. We had to devise methods which were useful in both saving lives and limbs. I devised a plan in which we would transfix a badly fractured leg with pins above and below the fracture site, and then incorporate the pins in the plaster. The patient could then be moved all around. He could move from bunk to bunk, from one ship to another. These methods worked very well. I'll never forget what the doctors said when we got to Pearl. "We don't have to do anything to your patients except send them home."

There's been a school of thought in recent years that says that many medical breakthroughs occur during wartime. The opposing school says that the breakthroughs occur during peacetime and war comes along and those techniques are put to good practice. In your experience, did the war occur in a lot of innovation?

I think it worked both ways. The methods we had to devise under

pressure were based on the knowledge we went in with. We had to have some basic knowledge of fixation. But there's no doubt that a lot of things that we did at that time under war conditions were valuable in civilian life. Take our Stator (sp.?) splints for example. The stator splint was a method of fixation developed by a veterinarian to hold fractures in dogs. We picked up the idea and used it. As a matter of fact, that method is still used.

Did you find the stator splints the treatment of choice in that climate?

I don't think the climate had anything to do with it.

Why would you use that method instead of the method using pins going through the cast?

It depended upon the type of wound. You could have a severe fracture of the leg with a very small external wound. On the other hand, you could have a severely lacerated leg with a small fracture. You used whatever method and material were suitable for that condition. Temperature had little to do with it.

Were you able to fabricate parts for these splints on the ship?

Sometimes we had to improvise. We had men on the ship make splints for us that we could use externally to reinforce a cast. Very often, we used the ship's facilities to help us out. Those boys were very competent.

What was the average length of time you would keep a patient aboard?

It depended. As a rule, we would load our ship let's say in Guam or Saipan. From Guam, we went to Manus and came right back and started all over again. Once the island was secured, we would pull out and of course by then the field hospitals would be operating and all our ship would do then was to pick up the casualties and bring them back to the rear to other base hospitals.

The last major campaign you participated in was Okinawa. How long were you there?

The *Rixey* was there with 10 other ships. We were up there for 10 days before the other transports came in. We came in there carrying troops of the 77th Army. The idea was that we were supposed to take those two little islands up in Karama Retto to be used as a naval base where our ships could go in for repairs. So we were there 10 days before D-day on Okinawa. It was hell up there because we had a small squadron.

We left the end of May with a ship full of casualties bound for Pearl Harbor. Shortly after that the Bomb was dropped and the war was over.

Do you remember how you felt when you heard about the Bomb?

I was really sorry that we had to drop that Bomb but still it was necessary.

Did you go back to California?

We went to San Francisco and then I was transferred to the Philadelphia Naval Hospital. After the war I couldn't get out of there. I didn't get out of the Navy until late '46. I was chief of the orthopedic department at Philadelphia and I was also given the job of consulting at the Army hospital at Valley Forge. After my discharge I went to work at the Jefferson Medical College.