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REMINISCENCES LTJG HERMES GRILLO, MC, USN

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A Surgeon Remembers Korea

New Englander Hermes Grillo attended Harvard Medical School under Navy auspices during the last days of World War II. When he completed medical school at 23, he began surgical residency at Massachusetts General Hospital in Boston. Three years later when the Korean War broke out Dr. Grillo had become a civilian again. He now had four choices: the Public Health Service, the Air Force, the Army, or Navy. "For someone interested in surgery the Army made sense, but I liked the Navy and I figured I'd do 2 years. . . I'd spend 1 year at sea, and I like the sea. I pictured myself on a ship in the Mediterranean, of course--naturally the sun, the Med squadron, and then, a year in a Naval hospital doing something moderately interesting."

After a very short tour at Naval Hospital Chelsea, MA, where he worked in neurosurgery, Grillo received orders to the Fleet Marine Force. That could mean only one thing, his dream of serving aboard ship in the Med was over.

Following orientation Camp Lejeune's Field Medical School, LTJG Grillo went with the First Marine Division to Korea. His introduction to the war was immediate and dramatic.

They got us together on the airfield and told us we'd be flying up to the forward area. They said the weather was bad and weren't sure they could land but would try. The weather opened just enough to drop in through clouds onto a gravel strip. We got into an open truck and it was pouring by that point. This would have been the end of February or early April [1951]. It took about 4 hours to finally get to the forward area and by that time it was night.

I reported to the commander, who turned out to be CDR [Richard] Lawrence, head of the medical battalion 1st MARDIV. He was in a dugout with sandbags, a kerosene lantern, and a 4-day growth of beard. Artillery shells were whistling around and we could hear the crackle of machine gun fire. It was really active. The sky was lighting up and I remember thinking, "Geez it's like a World War I movie." It was kind of exciting.

They wanted doctors. In a sense, I think, nobody looked at what we did, or had as backgrounds. So we were just sent up, undifferentiated, as a mass of medical officers.

The commander asked about my background. I said "3 ½ years of surgical residency, sir." He looked at me, his eyes got big and he said, "All surgery?" I told him yes. And he said, "Company D." I didn't know what that meant and so I picked up my pack and my rifle.

You couldn't get there walking so they jeeped me up to an old rice paddy. It was dark and raining and pouring. I got to a tent and

that was Co. D. It was a squad tent with a kerosene lantern hanging there. I spoke to the first person I saw sitting on his cot. He told me the commanding officer was over there and he jerked his finger to the rear. I walked to a cot at the back and I could just see a gray rotund belly lying there. I couldn't see a face. I had no idea what I was going to be doing. I thought that I might be helping some red hot board surgeon. That seemed pretty good.

"I was told to report here, sir." There was silence. So I just stood there for awhile. And then a voice with no face attached to it came out of the dark dripping with sarcasm.

"So you're the new surgeon." I quickly figured that I'm the surgeon here, not just an assistant.

I was it, I thought. Well that didn't sound too bad so I just stood there thinking: I don't know what kind of surgical work they do here; maybe it's first aid. I said nothing more; I didn't know what to say. Finally the voice said, "How much training have **you** had?" I said, "3 ½ years, sir." There was dead silence, and then the voice said, "Jesus Christ, another one."

And then I got a stream of vituperation. Not foul language but... "These kids out here are getting wounded bad, they're getting all shot up, their guts are getting shot up. We don't need boys out here; we need men. We need board trained surgeons. We need experienced surgeons. We don't need a bunch of kids like you."

I thought to myself, "It's cold up here. It's wet, It's dangerous. There's machine gun fire out there. It's muddy. This guys sounds like a son-of-a-bitch." I felt like saying, "If you don't want me I'll go home." I knew a little better than to say that so I just stood there.

After awhile he cooled down and that was the end of that. Somebody showed me where my cot was and I stowed my stuff. About 3 minutes later a corpsman stuck his head in the tent flap and said, "Guy with a belly wound out here."

I walked across to the "hospital" tent and found a kid with a belly wound. I think it was a bunch of fragment wounds. He wasn't in bad shape. He wasn't in shock; he just needed to be fixed. I looked at him quickly. You don't do much of a physical. They are 18 years old, healthy, hard as nails, and they've had a recent wound. That was the whole history for every one of them.

So I went back in. I didn't know the drill. I had no idea what was going on. I didn't even know who anybody was. I went back to the commanding officer and said, "The patient has an abdominal wound, sir, and he needs to be taken care of," or words to that effect. Again there was dead silence. So I wondered, maybe this is like a residency and he's the boss. So I said, "Do you want to check him over, sir?" I just felt we had to get off dead center. The voice said, "Check him over? Hell no! You want anesthesia, I'll give you anesthesia.

You don't want it, I'll stay in the sack."

I remember a tremendous feeling of relief. First of all, I had information. I now knew he was the anesthetist. And the second thing was I now felt this guy, whom I thought at this point was a son-of-a-bitch, which he wasn't, was going to be off my back with regard to medical decisions. I felt okay. I don't mind making my own decisions; he won't be around second-guessing me because obviously we are not going to get along. I said, "I want anesthesia." So he clomped out and went in and put the kid to sleep very effectively, very efficiently. I just went to work. There was nothing to it after 3 ½ years of surgical training. I just zipped the kid open and cleaned him up as best I could. The lights were terrible, and the equipment was terrible, but we managed. I sewed up the holes, debrided them, and made sure there were no other things that I overlooked, and then sewed him up. It didn't take very long, and it went very well. He watched very closely, didn't say word. When I finished he said, "I think we're going to get along." I consider him a friend--he's dead now, poor guy. His name was Dan Pino.

After a few days, he began to warm up, even though he was not a man of many words. He was very laconic, I would say, but a very good guy--very well motivated. I said, "CDR Pino. If I run into some problems I can't handle or don't quite know what to do with, is there somebody I can call? Who can I call?" We had a field telephone. He

looked at me thoughtfully for a moment then shook his head and said very sadly, "There's nobody." I couldn't understand that. This is a division, a reinforced division. I don't know whether it was 25,000 men with tanks and artillery and all the rest. And I thought I'm **the** surgeon for this division? This has gotta be crazy. Well, it turned out that I had the most experience of anyone in that division.

The first place we were was someplace south of Inje, a small city up toward the [38th] parallel. We were actually on the side of a gently sliding little hill, which went down into a rice paddy. At that point it was very small. When wounded men came in and if they were in good shape they would put the stretchers on the ground with the head up the hill. If they were in shock they would put them with his head down the hill. We had one operating tent, another debriding tent, a minor operating room, and then a couple of squad tents for the post-ops, who were evacuated very promptly to Company A--the medical company. If they were minor wounds they would go back down there until they got well enough to go back to the front. If they had major wounds we kept them until they were stable. And then we tried to move them out as fast as possible because our conditions were terrible.

That summer they started the so-called Panmunjom truce talks. We actually had our heaviest casualties that fall when we decided to "straighten the line." We had a couple of thousand casualties in

a couple of days. It was a slaughterhouse because the Marines went up the hill against bunkers where the North Koreans were dug in. Occasionally, things would quiet down a little bit and then we would have another great run. With our limited personnel it didn't take long to absolutely saturate us.

The medical organization was like this: Theoretically, you had battalion surgeons, battalion aid stations. Then you had collecting and clearing companies--C, D, and E. Then there was the base medical company, Company A, and that was supposed to be on the beach. And from the beach, patients would evacuate to a hospital ship, where they would have surgery. That was the theory.

We were close to the 38th parallel at that point. We eventually ended up near the Punch Bowl, north of the parallel. The hospital then was in Pusan, a long way down. Obviously if you tried to move the wounded down there, many would never get there. As you know, the helicopters were helpful. But for the largest percentage of wounded, the helicopters were theoretical. First of all, you had the mountains. Even on good days, the fog often didn't clear until 10:00 in the morning.

Most of the time ambulances brought down the wounded. In the mountains they used to bulldoze roads out of the side of a mountain or hill. Sometimes the road would wash out in heavy rains or sometimes they would be moving troops or tanks and the ambulances had to wait

because they were not first priority.

So they had reorganized medical evacuation. They took a couple of the collecting/clearing companies and made them into hospital units. When I was there, there were two. Ours was Dog Company and then there was Easy Med Company. Those two were made into surgical units of a sort. The advantage was that we were very close because theoretically we supported one regiment. There were two regiments up and one back in reserve. Ours was the Fifth Marines. We also had a second regiment of Korean marines and we gave medical support to them because they had no other medical support. They were hellions, a bunch of youngsters who were determined to do anything that the U.S. Marines could do and do it better. They got into all kinds of trouble.

We also treated anything that came down the line-- U.S. Army troops because often we would have an Army group next to the Marines, the next unit over. Their collecting and clearing was sometimes to the rear of where we were doing surgery. If they had a really badly wounded man they would not send him further back to the rear to a MASH which was many miles back. A MASH supported a division rather than a regiment. They would send the patient up to the front to us to be operated on because we were 15 minutes away and the other MASH might be several hours back.

The hospital ships weren't of any immediate use. What they did

do, as far as I understand it, was this. After we debrided the relatively minor wounds, we would get them out the next day, or even the same day, in ambulances back to Company A, where they held them. The worst ones they eventually shipped down to the hospital ship. We would keep the severely wounded men until they were stable, which was usually 5 to 7 days. And then we'd get them the hell out of there and they would go back to the hospital ship. Some of them made it directly to Yokosuka Naval Hospital after they had been triaged. Most of the severely wounded ones eventually ended up in Yokosuka. One of my friends from Mass General, a year behind me in residency, was on the surgical staff there. He saw a lot of my patients after they got there. He could later tell me about cases and what happened to them. That was the general triage. But the definitive surgery was done in our units. There were five doctors but I was the only surgeon.

Basically, we had only one major operating room, and that was mine. I processed the wounded as fast as I could. They did work out a system later on, where they could direct helicopters either to Easy Med or to us, depending upon who was or was not bombed with cases at the time. Occasionally a company would get overwhelmed. I think it was Company A, at one point, that suddenly got hit during an attack. They were overwhelmed and they called us on the field telephone. Pino said okay we'd come down. So he and I got in a jeep and drove down there. They set us up in a tent and we just operated for what seemed

to me several days steady. I never did know. Sometimes I would step out and it was day and other times it was night. You'd go out and pee, and then they'd bring you a hamburger or a sandwich and some coffee and I'd go back. I was only 26 or 27 at that time. I actually got to a point where I thought I would drop from exhaustion but we just couldn't stop. In my own unit I couldn't ever stop since there was no alternate.

I got the flu some time that winter and I was running about 102 or 103. I would lie in my cot and they would get a Marine on the table and then would call me. I'd go through the snow and operate on the guy and then go back and lie down again until the next one came along. There wasn't anyone you could call on. Unfortunately, nobody ever came through who had surgical training. It was that kind of situation. One advantage was that we were so close to the front that I'm sure we probably saved people who would never have made it back to the rear.

That was the principal concept that various consultants came up with from their experience in World War II. Do definitive surgery--not patches and dressings and such--as close to the front as possible so that you can immediately treat casualties who are bleeding massively, who have guts blown out and so on. That was the MASH concept. But, of course, the MASH's, since they supported at least a division, had to be further back, since lines of evacuation

are perpendicular to the front. We, on the other hand, could be right up close because, theoretically, we were only dealing with a regiment. That was an advantage and it worked out pretty well, I think.

Equipment-wise, it was so bad that it taught me a tremendous amount about improvisation, which has served me well for the rest of my career. We had a miserable little kerosene sterilizer. We had an operating table, which was a small collapsible metal thing that was so low to the ground we stood it on ammunition cases to get it up to a height where I could use it and not have to break my back. You could not adjust it in any way. You just had to put the patient on it and then move him around.

We had plenty of sterile supplies, linens and such. We had no true operating room lights. We had a bulb hanging from a cord over the table. I stole a reflector from an engineering searchlight and put that over the top of the bulb, which made it a little better. I borrowed an engineer's searchlight once and it was so hot it cooked and desiccated the tissues so I got rid of that in a hurry. We had no real operating room lights. Initially, I learned to operate with a flashlight clipped to the back of my belt. Sometimes at night the lights would go out; the generators were not dependable, and everyone would be stumbling around and I would say, "Reach in my back pocket and you will find a flashlight." And somebody would fumble around.

I remember finishing a bowel anastomosis with this flashlight.

We had a very thin supply of instruments in terms of variations and variety. But you know you can do most of that kind of surgery with ordinary instruments. We had no suction machines. So when I had a belly full of feces and exudate and twigs and blood, I would just scoop it out with my hand onto the dirt floor. And then we would take big abdominal pads and just wipe the belly out, pour saline in and clean it out as best we could. If there was a mess of bleeding welling up, all you could do was to put pressure on things and then slowly work your way in, because there was no suction of any sort available. For deep wounds, you were way down somewhere in the depths.

There were no deep abdominal retractors. There were all these miserable little things a few centimeters long. I took some 155 mm brass shell cases--which are big and heavy and long--and I drew on them outlines of retractors that I wanted, like Deaver retractors. On a piece of paper I drew the curve I wanted and we took them down to the engineers and they cut these for me from the heavy brass, bent and filed them, and these are what we used. They weighed a ton. I wish I had taken one back for a souvenir but I had to leave them there for other guys to use. But because we had no big abdominal retractors, we had to use these things and they were very helpful.

They shipped us blood, which was all universal donor or blood with substances to neutralize the antibodies. There was no cross

matching. The blood was just poured in. And we used huge amounts of it, sometimes 6 or 8 [units] for a guy who was exsanguinating when he arrived. The problem was that there was a custom. As new blood came in, each unit to the rear would take the new blood, put it in their refrigerator, and send the old stuff forward. So the stuff we got--where a lot of blood was really used--was full of stringy clots and it looked awful. I don't know how many people we killed with that blood, probably not too many; they seemed to survive it. We had a refrigerator and kept it cool with a generator. We had all the blood we needed. There was never a shortage.

This was not MASH. MASH was very well equipped in comparison. MASH was not bad. MASH had good equipment, good lighting, x-ray machines, and a corps of trained surgeons who were at my level. And these were the second order people. They had board trained Army surgeons. They had nurses. They had endless supplies and they had staffs that didn't have to work around the clock because they had enough people; they could be on rotations. Of course, when they got bombed everyone would all pitch in, but normally, you'd be on duty, you'd be off duty. We had no on-duty/off-duty for the doctors.

We were on duty and when it got very busy, we just went and went and went. There was never even a question in my mind of ever stopping. I didn't feel I had the option. There's a guy on the table and you have to do something for him. We had enough corpsmen so they worked

in shifts. But I remember one time when we were absolutely overwhelmed, just working away. I looked up and saw this corpsman--a good guy--who worked in the operating room. I said, "You know you've been on for 24 hours now." He looked at me and said, "Well, we figured if the doctors can do it, we can do it." These were the good things you saw; these fellows felt that they were obligated too. And the morale went zooming up after we got things moving and better of organized.

We moved about four or five times while [I was in Korea] and I can't even tell you where. It was always some valley. The commanding officer would go up in a jeep with the Medical Service Corps officer and they'd find a place in the area close enough to the front but a reasonably safe place, sometimes behind a hill or in a little flat place but near the MSR (main supply route) so they could get to us quickly. We first started in a rice paddy and then we moved to Inje, then up to a valley that was just over a ridge from the Fifth Marines. They brought the wounded back over the hill.

Then we moved again another time. The final place got pretty well set up once the talks started in Panmunjom. Later, we got wooden decks for the operating tents, which we hadn't had. By this time, we had figured out a way to bring jeeps up so we could hook up to their generators if we lost power at night. We even had screens for the hot weather late that fall. Before that I always had one extra

corpsman stand at the table keeping the flies off. It was aesthetically troublesome to me to be sewing up someone's intestine and have a fly sit on it. This didn't seem to do anyone any harm; the patients did all right but it was very upsetting to me.

When I think about it, the only obligation the Navy Medical Department had in the Korean War was the Marine division. Oh, the Navy ships went up and down the coast and fired a few shells and occasionally an artillery observer went ashore. They had 25,000 men there getting shot at, and out of the whole huge complex of the Navy Medical Department, they couldn't muster up two board surgeons--that would have been the minimum need, or even a couple of more guys like myself and there were lots of them. When I got back to St. Albans Naval Hospital, the place was just loaded with surgeons of all types--regular Navy, reservists, and so on. You would also think they could get somebody who had at least 1 year of anesthesia residency.

I left Korea just before Christmas near the close of '51. When I got the information that I could leave the next day--my number had come up--I had this tremendous sense of relief. But I was so involved in this thing and thought we were doing a good job. You have this feeling. You've got a job to do here and you're doing it well and who's going to take over? Then I thought, "You've gotta be crazy. Leave when you can."

At the time of this recording, Dr. Grillo (1923-2006) was Professor of Surgery at Harvard Medical School, Cambridge, MA, and Visiting Surgeon and Chief of Thoracic Surgery, Massachusetts General Hospital, Boston, MA.