The AMEDD Historian

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Contents

Welcome to the latest installment of the *AMEDD Historian*! This issue is principally concerned with medical support for large conflicts. The subject matter is relevant, as the current U.S. Army adjusts to focus on Large Scale Combat Operations (LSCO). Through our articles one can view previous incarnations of medical unit organization and functions to support a much larger force. The articles such as "Looking Back: AMEDD Doctrine for Large Wars", "New Thinking for New Battlefields", "An Analysis of World War II Army Medicine in the European Theater of Operations", "In Theater, But Off-Shore", "Planning the Medical Support for Large Scale Operations", and "Large Scale Casualty Evacuation: Railroads and the AMEDD", all convey the scale and complexity previously needed for medical operations with a larger Army.

One particularly significant point found in "New Thinking for New Battlefields" an exploration of the Army's Pentomic divisional organization, demonstrates the dangers of exclusion when the AMEDD was omitted from the divisional planning process. This is just as significant today for military planners. All aspects must be considered.

As mentioned, medical support for a large force is the feature, but one might ask "how large?" World War II is often the standard for Army enormity. The article "World War II Army Medicine in the European Theater of Operations" notes that the medical force *requested* to support the invasion of France (hospitals in England included) was over 168,000 Soldiers. (continued on page 11)

Looking Back at AMEDD Doctrine for Large Wars

For most of the Twentieth Century the Army expected large conventional wars (what are now termed large scale ground combat operations) and organized its doctrine and force structure to deter or fight a major war. The AMEDD then planned to provide support for that in the theater of operations (now termed area of operations) in several ways:

* Unit medical support, from the combat medic to divisional medical units
* Evacuation units, including ambulance companies, hospital trains, and later air ambulance units
* Area-support units, to support units that would take few casualties (and thus had minimal unit medical support) but would have sick and injured troops
* Hospitals, both in the combat zone (CZ, to about 25 miles from the front) and the communications zone (COMMZ, further back)
* Preventive medicine units, to detect medical threats to the force and supervise corrective action

Through the century, changing technology affected what was possible and how these functions should be performed, and thus unit organization. Yet the system was largely unaffected. In WWI there were aidmen attached to infantry companies, battalion aid stations, an ambulance company (with treatment and ambulance sections) to support each infantry regiment, and short-term holding capability in the division. In

the 1990s there were combat medics in infantry platoons, battalion aid stations, a forward support medical company to support each brigade, and short-term holding capability in the division.

After WWI, Surgeon General Merritte Ireland honed the AMEDD's force structure and doctrine. Given military budgets of the 1920s and 30s, most of the work was on paper and most of the units were partly-manned National Guard or Reserve units, but the plans were on the shelf when they were needed for WWII. Some of them, like separate medical battalions to treat gas warfare casualties, were obviously the lesson-learned from WWI that was not needed later, but they were re-purposed for .

In WWII, upgrades were plugged in. Plasma and whole blood were now available, plasma far-forward and whole blood to hospitals. Sulfa drugs to delay infections were included in the first-aid packet, but removed when data showed they were little use. Units structured for WWI casualty rates were the wrong organization for WWII and new organizations were tried and tested, but performing the same role, of urgent surgery and patient stabilization in the combat zone. When new functions were needed, such as forward psychiatric care for combat fatigue patients, they could readily be added: a divisional psychiatrist was added.

In Korea and Vietnam evacuation saw some changes, as helicopters first supplemented ground evacuation and then became the default method. Medical regulating, however, was not new: the term came from the hospital trains of WWI, which were regulated to a particular hospital (or hospital center) based on the mix of patients on board. The specifics of preventive medicine units changed as diseases and vectors were better understood and tools other than (literally) draining the swamp were available. And for all their work, disease still caused more soldiers to be hospitalized than wounds did, but new drugs and treatments returned more men to duty, and did so faster than before. In Vietnam, with no front there was no rear, and the COMMZ hospitals were largely out of the country, some in Japan, but the doctrine did not change while capabilities got better and better, as ICUs and kidney dialysis machines were deployed, improving care but at a logistics cost.

After Vietnam, the line Army was recasting doctrine, with AirLand Battle and then AirLand Operations, and the AMEDD followed suit with Health Service Support for AirLand Battle. The force that went to Saudi Arabia for Operation Desert Shield/Desert Storm was ready to execute AirLand Battle, while the AMEDD was in the process of reorganizing, while the AMEDD increasingly grew focused on efficiently operating the brick-and-mortar hospitals. The AMEDD doctrine published in 1978 was essentially unchanged from WWII, which was itself clearly based on WWI. In the early 1980s Surgeon General Mittemeyer had to admit to Congress that capabilities for wartime care were questionable, with shortages in key personnel (especially physicians), aging field equipment, and little field training because clinicians were needed for TDA care. In December 1984 Vice Chief of Staff GEN Maxwell Thurman started a Medical System Program Review. He recognized that the All-Volunteer Force did not have the deep reserves to reconstitute combat power, so troops returning from medical care would be the main reinforcements for the first 120 days of a war. Moreover, hospital care had become highly efficient and to save more lives they would need to look at pre-hospital care. Thus the MSPR added more training for medics (and Combat Life Savers), and reorganized hospitals to provide more OR tables. But there were substantial cuts, in the low-acuity hospitals that had taken care of disease and non-battle injury in the COMMZ. With more pharmaceuticals available, more emphasis on safety, and better preventive medicine DNBI rates would be lower and recoveries faster, so medical companies with cots could replace station hospitals with staffed beds, although low-acuity field hospitals would continue, with missions including prisoner-of-war care.

After Desert Storm the AMEDD had a major change, substantially reducing both CZ and COMMZ hospitalization. The MASH was deleted from the CZ, replaced by the FST for surgery with helicopters to provide prompt post-operative evacuation, and almost all hospitals were removed from the COMMZ as well. Under a joint concept summarized as Essential Care In Theater, "The essential care in theater concept enabled the Army Medical Department to decrease the deployed medical footprint in the [Area of Operations] by shifting the definitive, convalescent, and rehabilitative phases of patient treatment to the CONUS-support base and retaining only those medical care resources required to provide essential care to decrease morbidity, mortality, and long-term disability, to stabilize patients for further evacuation," The concept relied on the U.S. Air Force to fly patients from a theater of operations, and also on their being enough space in the logistics pipeline to fly recovered patients back to the theater as reinforcements. If those assumptions are challenged, the medical footprint may be too small to provide hospitalization for the wounded, much less a meaningful flow of replacements.

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FM 8-10, Health Service Support in a Theater of Operations, 2 Oct 1978.

New Thinking for New Battlefields – the 1950s edition
Sanders Marble

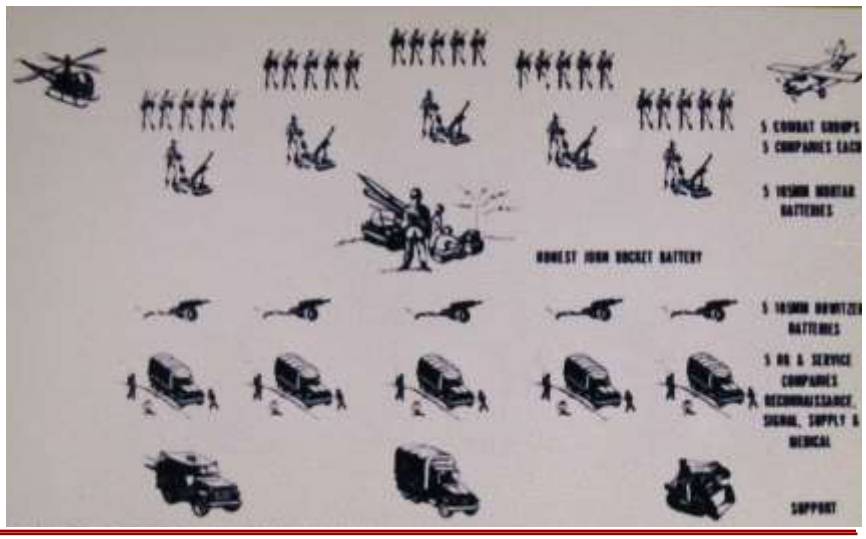
Today, the Army is envisioning future multi-domain non-linear battlefields. In the 1950s the Army also contemplated what future battlefields would look like, and while the terminology was substantially different, some elements were the same. Lethality from modern weapons would be very high, mobility and coordination would be vital to survive as well as inflict damage on the enemy. Linear was out, dispersion and mobility were in. The continuities and changes can give us pause for thought.

In both WWII and Korea the battlefield had been largely linear. Armored forces had, at times, broken through, but supply problems had always led to a return to linear warfare and grinding forward or holding the line. American forces had been noted for highly effective fire support, both artillery and aircraft, and had not needed to worry much about rear-area operations. But the Cold War threat was different: the Soviets had nuclear weapons, and warheads were getting smaller and smaller, leading to great concerns about tactical nuclear warfare. (Of course, strategic nuclear warfare also caused concerns, but the Army had few missions with civil defense.) Army leadership was concerned about how to fight on an atomic battlefield, and identified dispersion and mobility as key elements to survival and effectiveness. Tactical units would have to be small (so they would not be lucrative targets), have combined arms to operate if surrounded, and have enough integral logistic support to fight isolated for some time.

Pentomic Divisions

During 1954-56 the Army reorganized its combat divisions to something called Pentomic, combining 'penta' (for five) and atomic. Instead of the traditional three main combat elements in the division (three regiments for infantry and airborne divisions, three combat commands for armored divisions), there would be five, judged to be the maximum span of command with modern communications. Each of the five commands was going to be a "battlegroup," about 1500 men, thus between traditional battalions and regiments, and supposed to have more capabilities. The division artillery would also change substantially, including nuclear-capable missile artillery. (Artillery branch insignia at this time added a rocket over the crossed cannons.) Reorganized airborne and infantry divisions were fielded starting in 1956, with armored divisions coming a little later.

The Pentomic divisions were supposed to operate over greater frontages and in greater depth than before, to reduce the number of valuable targets for nuclear weapons, or chemical weapons as well. (The 13,700 soldiers of one division would have to cover approximately 14 miles in frontage by 15-30 miles in depth.) Helicopters and fixed-wing aviation (each division was to have a fixed-wing aviation company) were supposed to help, although most tactical mobility was still from shoe-leather. (Divisions were supposed to get enough armored personnel carriers to move one battle group at a time, and the APCs were also supposed to be available to move wounded.) Logistics officers were worried about their ability to support the highly-dispersed division since the distances had increased but not the number of vehicles.



Schematic diagram of the Pentomic Division. Support at the rear is suggested

What did the changes mean for the

AMEDD? Army publications said almost nothing about medical support, other than mentioning there were medical units in the division. The infantry battlegroup's medical detachment was about 50 men, appropriately reinforced from what the battalion medical detachment had been. However, the infantry divisional medical battalion still had three ambulance companies and three treatment platoons – it had not been updated at all, either in structure or equipment. It looked like the AMEDD had not been paying attention to the changing field Army. By 1959 the armored division's medical companies had four platoons, and the airborne division's companies had five platoons. This suggests nobody was quite clear whether medical support was on a unit basis or an area support basis.

The M28/M29 Davy Crockett Nuclear Weapons System was developed to as a key element of the Pentomic division. Ranges were 2-4 KM
Courtesy Army Historical Foundation

AMEDD Combat Developments

The AMEDD did not have an element looking at major force developments. The Surgeon General's Office was largely focused on TDA medicine, policy, personnel, and clinical care. The Medical Field Service School was a school, focused on training, but a Training Doctrine division did review manuals. In late 1955 a Field Medical Service Development Unit was organized at the MFSS, and personnel were assigned in January 1956. Its role was to test equipment for field service, which it did at Camp Bullis. In August 1957 the MFSS created an Assistant for Combat Development and Training Literature. That organization not only handled combat development projects, they reviewed Field Manuals, Technical Manuals, and Tables of Organization and Equipment. It was not until the spring of 1958 that OTSG recognized the AMEDD had missed the boat. They claimed there had been "years of study and planning" and now the AMEDD would revise field medical units to support dispersed, fast-moving operations, and switch to area support instead of the linear chain of evacuation that had been standard since the Civil War. Recognizing new equipment would be needed, Surgeon General Silas Hays established a Development Branch to prioritize projects for the Medical Equipment Development Laboratory – although how the MEDL at Fort Totten, NY, worked with the FMSDU at Camp Bullis is unclear. Recognizing the problems was a necessary step, but it still was not until April 1959 that anyone was put in charge of solving them. Then MG Hays appointed COL James Pappas as Special Assistant for Combat Development, first based at Walter Reed Army Medical Center, then in 1961 moved to Fort Sam Houston.

Solving the Problems

Since the AMEDD was slow responding to the changing frontline force structure, they had to support field exercises with poorly equipped and organized units. In the late 1950s field training exercises in Germany had divisions operating on 40-50 mile frontages and similar depths. From the "front lines" to the division clearing station was an average of 29 miles, from there to the surgical hospital another 31 miles, and from there to the evacuation hospital in the Corps area was an average of 49 miles – 109 miles from the front line to hospital care. With real concerns about mass casualties from atomic and chemical weapons, there was simply not enough medical support in the division: the three clearing platoons did not match the five battlegroups, and the ground ambulance companies would not be able to transport the patients across the large distances. Helicopter ambulances could help, but there were not enough of the two-patient helicopters to take the slack. While field exercises were supposed to practice treating and evacuating the large numbers of casualties that nuclear warfare could generate (2000/corps/day was supposed to be practiced in one FTX), tactical commanders did not want medical play to take over the whole FTX and largely ignored casualties.

The medical problems of dispersed, high-intensity warfare were readily identified. The 1950s AMEDD diagnosed the need for more training in self-aid/buddy-aid, more medics, more forward holding and treatment capacity, more front-line ambulances, more air ambulances, and something like today's forward surgical

teams. Medical units would need better communications equipment. Identifying the problems was easier than solving them.

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New ACHH Archival Donations

* One CD of Annual and Monthly Reports documenting the 53d Medical Battalion during World War II.
* Collection of documents, photographs, and training manuals belonging to MSG Ernest Terry who served as a senior medical advisor during the Vietnam War.
* Digital photographic collection of 20 images taken by orthopedic surgeon MAJ Timothy Floyd that document the experiences of the 934th Forward Surgical Team while deployed to Iraq during Operation Iraqi Freedom.
* Documents relating to Project AMEDD Vanguard, Task Force Aesculapius, and the reorganization and realignment of the US Army Medical Department.
* Photocopied Korean War service records, a 45th Surgical Hospital Newsletter, 35mm slides, and 35 stereoscopic 3D slides belonging to LTC Charles E. Hollingsworth.
* Handouts in English and Arabic for the "Workshop on Control Strategies for Infectious and Emerging Infectious Animal Diseases in Iraq".
* 46 digitized images and 5 certificates and medical diplomas belonging to 1LT George Robert Wilbourn who was a Medical Corps officer, USAR during the Korean War.

Additions to the AMEDD Museum Archives

None

Books

Huck, Leslie G., and Ronald L. Burke, eds. 2019. *Military Veterinary Services*.
Zoccarato, Ivo, Patrizia Peila, Mario P. Marchiso, eds. 2019. *Military Veterinary Services of the Fighting Nations in World War One: Historical Congress*

Large Scale Ground Combat Operations: An Analysis of World War II Army Medicine in the European Theater of Operations, Part 1

Scott C. Woodard and Sanders Marble

LARGE SCALE GROUND COMBAT, challenging ground evacuation with no rotary wing assets, were accomplished by our grandparents. The experience of the medical services in the European Theater of Operations (ETO) during World War II may provide insight into the future battle and help medical planners today. World War II was 75 years ago, but we can still look at their experiences for information on the possible problems soldiers will face in the future. Medical planners had to try and anticipate the problems and prepare solutions within the limitations of the force structure and competing priorities. They had to address the same functional areas as today, although the term had not been invented.

Organization and Administration

The ETO Surgeon, Paul Hawley, was continually frustrated. While responsible for medical policy, he had to work through an over-arching logistical headquarters, the Services of Supply. In early 1942 while American forces were still building combat power in England, Hawley pushed for theater-level representation of the medical services. He recommended unified and centralized technical control of medical service throughout the theater. Hawley emphasized the criticality of a single medical service entity with specific responsibilities: technical supervision of medical unit training and operations; coordinating evacuation through several levels of command; control of the technical aspects of communicable diseases in those commands; and responsibility for medical records management. Since medical evacuation and treatment was continual, control of the operations, training, and patient movement should be centralized. He further argued with this centralized responsibility for planning, the position should also possess the means of execution. As an example, he noted that communicable diseases did not adhere to the chain of command, so a single point of contact should establish the technical standards and coordination to combat it. In that same spirit, Hawley believed the theater chief of the medical service should have the duty and responsibility for liaison with the British. Not establishing this relationship would add to the confusion that comes with overlapping US Army commands and varying Army surgeons competing against one another for hospital locations in Britain.

MAJ. GEN. PAUL R. HAWLEY
(Rank as of 27 February 1944)

Hawley insisted the chief of medical services in theater should exercise control over certain essential functions. He could exercise these functions properly in the Services of Supply only if the commanding general of the Services of Supply was given clear authority to issue orders or directives to the commanders of other subordinate commands in the theater. If not, Hawley would have no means of making medical directives effective outside the Services of Supply.

As the theater matured and expanded, the Army established additional command elements. The Supreme Headquarters, Allied Expeditionary Force (SHAEF) assumed responsibility for the larger combined Anglo-American war effort. The European Theater of Operations, US Army (ETOUSA) still had the responsibility of logistics and administrative support in theater. Despite MG Hawley's subordination to the SHAEF Surgeon, MG Albert Kenner, he successfully led the theater-level technical direction for medical support. Kenner's authority was more formal than substantial, and Hawley was able to influence through personal relationships, presence, and personality. He understood he was not in command, and he made it clear, stating:

> I am too old a soldier not to know that the authority of a commander is practically unlimited, and that, if he so desires, he can dictate the technical operations of the services without regard to the policies of the Chiefs of Services. I also have great respect for the responsibilities and prerogatives of command. However, I have also a great responsibility to my own

commander. So long as my technical policies are carried out in any echelon, and medical units are not hampered in their functions, I shall accept full responsibility for all medical failures. But, if the technical operations of the medical service are interfered with by the commander of any echelon, I have no alternative than to place squarely upon him the response bility for any medical failure in his echelon.

The responsibility and technical supervision exhibited by Hawley, a major general by February 1944, replicates the command and control exhibited by today's Medical Command (Direct Support). By 1 September 1944, the Surgeon's Office consisted of 51 officers, 362 enlisted, and 125 British civilians. As the senior medical voice, Hawley was needed by the theater commander for consultation on matters of planning for US Army medical support. Even as the staff representative for technical services under the Services of Supply, he was directly involved in planning with the European Command element and provided technical supervision of all medical assets.

Many hospitals were a mix of wooden temporary buildings and Quonset huts (bottom right). Often, the facility had been a British training camp and handover had to be coordinated with British forces and U.S. engineers, who both upgraded the facilities to American standards and adapted them for hospital use.

Forces and Plans

The United Kingdom Base was probably the greatest concentration of US Army medical facilities in history, and Hawley had technical supervision initially of well over 150 medical units operating over 150,000 beds, because patients who recovered would be the main source of replacements. The medical force requested to support the invasion of France was over 168,000 soldiers. Those numbers were driven by the overall plans, which recognized the Germans as formidable opponents who would inflict many casualties. Plans also anticipated disease and injury patients, and based the disease estimate on medical intelligence received from the Surgeon General's Office. Since the buildup moved at the pace of trans-Atlantic convoys, around 10 knots, plans had to be made well in advance, equipment and supplies stockpiled, and units waiting in England. The stockpiles were insurance against whatever unexpected problems developed.

As the ETOUSA Surgeon, Hawley was responsible (subject to coordination with the staff) for training mobile medical units during the pre-combat period, for planning their movement into combat areas at the proper time and in the proper proportion (the so-called "phasing in") and for their utilization during combat. These units ran the gamut from medical kitchen augmentation teams, hospital ship platoons; medical groups; medical battalions; separate collecting, clearing, and ambulance companies; field, evacuation, and convalescent hospitals; medical depot companies, auxiliary surgical groups, a medical laboratory, and a few medical gas treatment battalions.

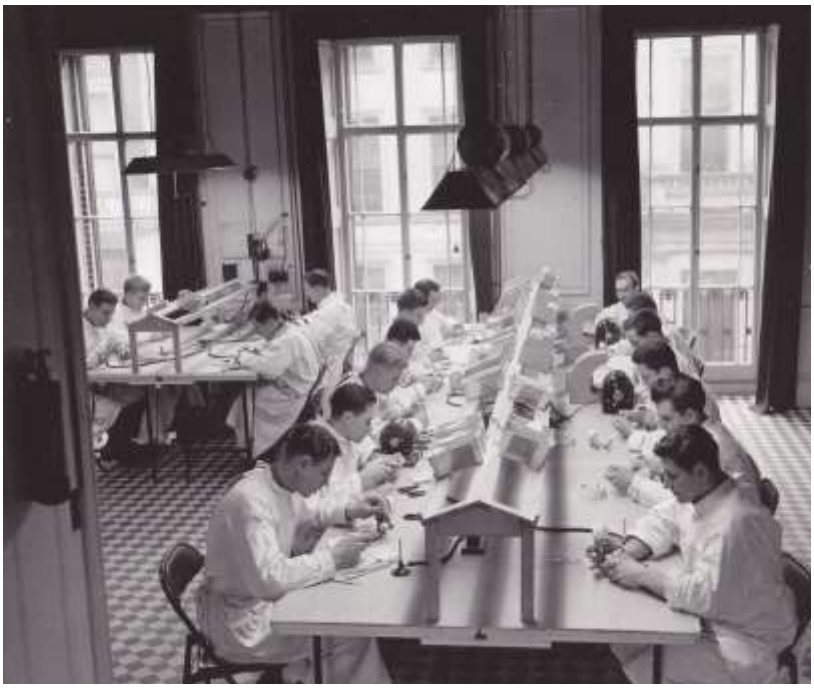
Initial plans anticipated needing hospital beds for 10% of the invasion force. Most of those would be wounded, but since patients would be held up to 120 days (so they could recover and rejoin operations) the hospital structure would be large, and thus there would be more laboratories, more blood available, more dental care (dental care was integrated into other medical units), and more supplies.

Evacuation and Hospitalization

Hawley was not responsible for medical operation in combat, but he had to plan the force. He request-

ed a large number, and wide variety of evacuation units. Closest to the front were ambulance companies. Further back, hospital trains (see the article on them in this issue) and (from the U.S. Army Air Forces) Medical Air Evacuation Squadrons (MAES). Moving patients to Britain and the US, hospital ships (and hospital ship platoons, medical units to attend patients loaded on troop ships) were the strategic element.

(Above) Cargo aircraft were fitted with brackets and tie-down points for litters and litter-supports. Medical crew flew forward with the cargo, installed the litters, and accompanied patients on the return flight.
(Below) Soldiers at a dental laboratory in London, making clasps (to fasten removable dental appliances in place) and gold teeth. This unglamorous work kept soldiers fit for duty when they could be overseas for years.



Aircraft were not dedicated to air evacuation, but the MAES would ride forward on loaded cargo aircraft and convert the aircraft to backhaul patients. Buses were adapted to move up to 12 litter patients, to supplement hospital trains. There were challenges in safeguarding neuropsychiatric patients during transit; windows were screened to protect patient from self-harm.

There were hospitals in the Corps and Army areas, but Hawley only controlled those in the rear, the COMMZ. He negotiated with the British for enough facilities, while making sure the 100-plus hospitals all saw enough patients before the invasion that they would stay clinically ready. In the spring of 1944, realizing the supply situation was getting out of control, he brought in trouble-shooters (one of whom would become Surgeon General). Preliminary planning was done on moving medical units, from humble ambulance companies to sophisticated general hospitals, to France once there was a safe rear area for them. Planners hoped to use French hospital facilities, since the buildings were purpose-built.

Much effort, of course, went into medical support for the invasion. That ranged from providing extra medics to the landing units (part of their overall augmentation, recognizing the casualties they would take), to augmenting medical units in the Engineer Shore Brigades that would control the beaches once cleared, to equipping landing craft to provide en-route care (including surgery) on the trip back to England.

<u>Occupation</u>

The fighting would be amid civilians, and the military had to deal with their medical problems. In occupied countries the responsibility was absolute, because the Allied forces were the government. Failure to treat a civilian patient population problem would became an Army problem. It was a force protection issue: good civilian healthcare protected the Army. In addition to keeping soldiers safe,

caring for civilians prevented the spread of disease by local populations and allowed for a healthy pool of labor for community support and rebuilding.

Conflict over jurisdiction between Civil Affairs medical and public health and Hawley's Civil Affairs Branch was never fully resolved. Early on Hawley made it clear he had no control over Civil Affairs medical policies, and had no additional personnel or facilities to carry out that work, and therefore, could not assume the responsibilities. These two separate organizations interpreted the same guidance differently in executing their missions.

In planning for displaced persons camps, the priority was supplies: medicine would allow remaining civilian personnel to resume their work, while sanitary supplies and equipment would reduce the chances of epidemics. Army officials noted that civilian health systems paid little attention to contagious disease issues and often made mistakes in diagnosis because their focus was trauma treatment. Army medical leadership rightly understood that Russia had purposely pushed lice-infected refugees into Poland as a weapon in the First World War and the Soviet Union was repeating this in Eastern Europe. Fortunately, lice-borne illnesses were readily defeated with DDT, developed by the Army during WWII. Non-governmental organizations (NGOs) were critical in supplementing food and medicine distribution to displaced persons camps. Civilian care objectives would differ in time and place, and it was important to delineate the type of operation and the status of a civilian. For example, liberated civilians worked under "civil affairs" operations. Conquered civilians might do the same work under "military government." No matter the label, the civilian populations would likely be starving. Among all Allied military physicians, there was not enough knowledge on the treatment of starvation, and its associated psychological conditions.

(Above) Soldiers checking and recording whole blood being shipped. Blood was received from the U.S., but also collected in England.

(Below) Soldiers were not sent back to the U.S. if they would recover within 120 days, so there were long periods of convalescence. These soldiers ate at the 74th General Hospital in November 1944. Army hospitals were not usually segregated, even though the Army, and American society generally, was.

Shortages of fuel, vehicles, and civilian medical staff, coupled with destroyed infrastructure caused US forces to provide even more for public health in liberated territories than expected.

On taking over as surgeon in 1942, Hawley knew the responsibility was large. By the end of the conflict, the Army medical system in Europe had treated approximately 2.8 million soldiers, plus many civilians, and prisoners of war.

To be continued….

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In Theater, But Off-Shore

During the Korean and Vietnam Wars, off-shore bases served as the communications zone for supplies and hospitalization. Lengthy hospitalization in theater did not always mean a large hospital system 'in country' with the fighting, as long as patient evacuation was simple. Sometimes having the hospitals out-of-country obscures the amount of medical support actually being provided.

In the Korean War, the hospitals in Japan operated around 15,000 beds, utilizing military personnel along with US and Japanese civilian employees. Specialty centers were established for psychiatric patients and certain diseases, such as hepatitis or frostbite. Some hospitals focused on wounded who would be treated en route to the United States, while others focused on patients who would clearly return to duty. Overall the hospitals in Japan treated thousands of patients, sick and wounded alike, and around 80% of those returned to duty could return to Korea.

Japan could be the Communications Zone because evacuation to Japan was simple. Water evacuation was the main route early in the war, but later more cargo aircraft were deployed. Air evacuation was short duration and the aircraft flew low enough that lower air pressure was little problem. Flight nurses mitigated even that risk. Aircraft flew cargo forward, with medical staff riding as passengers, then flew to forward airstrips – sometimes right beside MASH units – and loaded litter patients. One flight nurse recalled:

> head injury up front, in the position third from the top, so you can give him oxygen or plasma easily; paraplegic opposite him, so that his drainage will function properly; a man whose left leg is amputated ... on the floor, so there is enough room for the large round hoop holding the skin traction in place; ... a man with hepatitis in the top position, since he won't need much nursing during the flight; and so on until you have all 30 patients on board.

During the Vietnam War, air evacuation was the standard route. (The Navy operated hospital ships off the coast, but the patients were flown out of Vietnam if needed.) The C-141 jets then in service could fly further, and faster, allowing the offshore hospitals to be further away. That allowed using existing hospitals in the Philippines, Okinawa, and Japan. In 1966 troops who could easily be returned to duty were being flown back to the US, so several general hospitals were established in Japan, and units already there were augmented. That allowed patients who could recover within 60 days to stay in Japan and return to action in Vietnam rather than going back to the US and being reassigned from there. Japan alone received over half the wounded from Vietnam for treatment, typically 100 patients arriving each day, and 2,500 sick and wounded from Vietnam in hospitals. Specialty care included a burn center and hepatitis care.

Just looking at the maps of hospitals in Korea and Vietnam does not show the depth of the medical support, and how many Soldiers returned to action from the over-the-horizon hospitals, but transportation to and from those hospitals had to be safe and easy.

Planning the Medical Support for Large Scale Operations

In 1921 the first students reported to the Medical Field Service School, new officers receiving training that would prepare them for the first few years of duty, the Basic Course. Over time additional courses were added, including a correspondence course. The next course was a Field Officers Course that was intended for National Guard and Army Reserve personnel, but took Regulars on a space-available basis. That course added on Corps and Army level medical support, logistics, and mobilization.

In 1925 an Advanced Course was added, to prepare a few (only 8-12) senior officers for Army-level medical planning. After some background on the industrial base and mobilization, and a refresher on division-level medical operations, they wrote a medical annex for a theater-level war plan. They had to brief out how their headquarters would work, the force structure they would need, how they would train up units, how they would cover preventive medicine, medical supplies, and finally evacuation and hospitalization. That was plenty to pack into nine weeks of rigorous work, although classes typically continued on Saturday mornings.

This course was organized at a time when the AMEDD quota for Army-wide professional military education was four: two officers per year at the Command and General Staff School, and one each at the Army War College and Army Industrial College. Since the small peacetime Army had no troops to conduct large-scale maneuvers or even funds for command-post exercises, the AMEDD came up with a course to fill the gap. A correspondence course

After WWII the course changed. More AMEDD officers were attending PME (or the distance-learning version), while the larger Cold War force had staffs in headquarters, so more field-grade officers got actual planning experience. The term Advanced Course moved to a new course, filling the same place as the current Captains Career Course.

(continued from page 1)

A very real number as substantiated by “Large Scale Casualty Evacuation: Railroads and the AMEDD” that mentions 22,925 patients were transported by hospital train in the first few weeks of the invasion.

“Vietnam Medic Saves Lives, on and off the Battlefield”, describes the heroics of William Koutrouba, who not only earned numerous awards for valor, but also worked to help those battling PTSD after the war. Koutrouba did not hesitate to move forward on the battlefield, and later had a pivotal role in recovery for many veterans. Another valorous Soldier, Bellenden Seymour Hutcheson is presented in “A Victoria Cross to an American Doctor in the King’s Forces”. Hutcheson served as a military doctor on the frontlines of World War I with the Canadian Army. Recognized with both the Military Cross and Victoria Cross awards, Hutcheson demonstrates his medical skill while under fire.

Please read through our current issue and let us know your thoughts. We would like to hear your comments and are always seeking new articles for publication. If you are at Fort Sam Houston please stop by the AMEDD Museum and see the new additions to the World War II exhibit.

Our websites, with attached social media feeds, have more information:

History: http://history.amedd.army.mil/

The AMEDD Regiment: http://ameddregiment.amedd.army.mil/

The AMEDD Museum: http://ameddmuseum.amedd.army.mil/index.html

These websites serve as great resources for the history of Army Medicine. Peruse our documents online, exploring valorous awards and medical advances as well as interesting biographical information.

Large Scale Casualty Evacuation: Railroads and the AMEDD

Charles Franson and **Paula Ussery, AMEDD Museum**

Over the last quarter-century, and especially since the end of the Cold War, American military experience has been of limited fighting. Battles have been small, casualties moderate, and the US has generally enjoyed uncontested airspace. More recently, the Department of Defense has shifted its planning to near-peer adversaries. Battles could be larger, casualties larger, and evacuation far more problematic.

During operations in Afghanistan, Iraq, and Syria, the U.S. has had the luxury of swift and efficient casualty evacuation by air, beginning with DUSTOFF picking up the wounded at or near the point of injury, proceeding through evacuation to larger facilities and to CONUS on large well-equipped fixed-wing aircraft. In future conflicts, contested or denied airspace may adversely affect this capability, delaying the evacuation and movement of American wounded. Tactical evacuation may be forced to rely on ground transportation from the battlefield to medical care. In that sort of scenario, with more casualties and unreliable air transport, a look to the past provides a possible answer: railroads.

Rail transport for military casualty evacuation dates to the mid-19th Century. The first use of a railway for casualty evacuation came during the Crimean War, with the construction by the British of the Great Crimean Central Railway in 1855. Trains brought supplies forward for the Siege of Sebastopol, and returned with cars loaded with the sick and wounded. The first use of railroads to move casualties in the United States was during the American Civil War. Both sides realized that this new technology could be utilized to move supplies, personnel, and wounded. Generally the railroads were used to move the wounded away from the battlefield to urban centers where more advanced care could be concentrated, such as Philadelphia, Richmond, or Washington DC. Initially the wounded were moved by boxcar with straw strewn on the floor or by using a rope suspension system. As the war continued cars evolved and patients rode in three tiered racks with stretchers slung between vertical posts anchored to the floor and ceiling. A slightly different design had wooden bunks built inside the car with the wounded riding on straw filled bed sacks with “elastic slats” underneath. By the end of the Civil War the Army had some hospital trains with purpose built ward cars, a kitchen car, a dispensary car, and a staff or personnel car. Ward cars also had water closets, water coolers, stoves for heat, fresh air ventilation, seats for medical attendants, and sometimes a surgeon's office.

When Congress declared war on 6 April, 1917, the AMEDD had no hospital train cars. Learning from the British and French, the AMEDD adopted this method of evacuating patients. The majority of the cars that the AMEDD used were built in Great Britain. A typical British-made train consisted of 16 coaches, organized by function: 1 coach for infectious patients; 9 ward cars; 1 pharmacy car; 1 personnel car for the enlisted men; 2 kitchen cars; 1 train crew/storage car, 1 staff car for the doctors and nurses; 1 men’s mess car; and a caboose. These trains were designed to hold 360 litter patients. In emergencies the staff gave up their beds, increasing the capacity to 396 litter cases. The trains had electric fans, roof ventilation, steam heat, and permanent bunks for litter cases. At times there were more casualties than space in hospital trains, and passenger or cargo railcars were

The AMEDD Museum’s unit car, built in 1953, showing arrangements for litter patients and sitting patients. The car also has a bathroom and kitchen.

used, with or without any medical attendants accompanying the patients: evacuation was the most important thing.


A hospital rail car from WWI.

World War II saw the most use of hospital trains both in the United States and overseas. In 1939 the AMEDD began preparing for another war, and developed new hospital trains. A typical hospital train in Europe consisted of 14 carriages, 7 of which were ward cars. These trains could accommodate between 250 to 317 casualties in ward cars, along with a pharmacy car, kitchen car, sleeping quarters for medical staff, and an emergency operating room. Between 6 and 27 June 1944 22,925 Army patients were carried by 15 hospital trains to medical facilities in the UK. As Allied forces marched across Northwest Europe the AMEDD began operating trains on the continent as well. Even though great effort had gone into obtaining hospital trains in England, damaged French ports facilities meant the first trains used there were improvised from boxcars.

There were three designs of hospital cars used during WWII:
* the Ward Car was a rolling hospital ward with suspended stretchers for litter patients
* the Ward Dressing Car, a ward car with an area to change dressings at one end
* the Unit Car, developed in 1943, was especially popular as it was a self-contained facility with berths for litter cases, a dressing changing area, and a small kitchen to provide specialized meals for patients.

At the end of WWII the AMEDD had 202 Unit Cars, 80 Ward Cars, 38 Dressing Cars and 60 Kitchen cars.

After WWII the Army continued to operate hospital trains. In 1953 *Stars and Stripes* reported the 325th Hospital Train, based at Landstuhl, Germany, had completed its first trip. It collected patients between across France on a two-week circuit, shuttling them to the 320th General Hospital in Landstuhl for more advanced treatment and/or evacuation to other Army hospitals. In 1956 another *Stars and Stripes* article stated the 57th Medical Battalion operated five hospital trains and carried approximately 400 patients a month. Hospital cars were also used in the early years of Exercise REFORGER, an annual NATO exercise held from 1969 until 1993 to practice rapid deployment into Europe in the event of a threat from the Warsaw Pact.

The Korean War was the last conflict in which the AMEDD utilized railroad evacuation. The extensive railroad network was a critical logistical asset during the Korean War. From June through November 1950, the AMEDD used converted box cars, passenger coaches, and some Japanese hospital cars that remained on the peninsula from when Korea had been a Japanese colony. By November 1950, hospital cars began arriving from the United States. Eventually all serviceable AMEDD cars were shipped to Korea. The AMEDD also used rail-auto bus ambulances that could travel on roads or railroad tracks, to transport patients to the nearest hospital train cars or to airfields for evacuation to Japan.

The success of railroad evacuation during the Korean War prophesized a bright future for hospital trains. However advances in vertical and fixed wing airlift capability in the 1960s and 1970s, the terrain in Vietnam, and the irregular warfare prevented the use of AMEDD hospital trains in this conflict. The need for hospital trains was re-evaluated in 1970, and in 1971, The Surgeon General concluded that the 96 AMEDD cars in the US were no longer needed. A few trains were kept in Germany for an emergency.

Hospital trains are now a part of history in the United States Army. The Republic of Korea Army, however, has retained a hospital train. A new generation of American military personnel was introduced to the use of railroads for evacuation in 2017. Exercise Dragon Lift, a biennial joint medical exercise of the Army of the Republic of Korea and the United States, used the South Korean railroads as one means to evacuate simulated casualties. Quoting Major Stephen Duryea, theater evacuation planner for U.S. Forces Korea, we cannot afford to ignore the 2,000-plus miles of rail in South Korea. “You’ve got to be prepared to use all assets.”

Vietnam Medic Saved Lives, On and Off the Battlefield

Robert L. Ampula and **Ronald O. Wallace Jr., AMEDD Regiment**

I first heard of William Koutrouba from a renowned valor award researcher with whom I have collaborated for almost two decades while collecting AMEDD valor awards. He had received some dubious information on a Vietnam War medic who had reportedly been highly decorated, but no general orders or official records existed in his collection. He was concerned that it could prove to be a case of 'stolen valor,' and because the soldier was a medic, he asked if I would assist him to check this information. We had worked together on suspected 'stolen valor' reports in the past, and because of his vast collection of valor awards, he is often consulted on these types of complaints. The story that unfolded was not what I expected and proved more intriguing than I originally imagined.

William G. Koutrouba joined the Army in April of 1959 and completed training to become a Medical Specialist. After an assignment to Augsburg, Germany with the 539th General Dispensary, he returned to Fort Sam Houston for the advanced medical specialist course in 1964. He then was assigned to the student detachment at Letterman General Hospital and attended the Orthopedic Specialists Course. He had subsequent assignments to Ft. Jackson and Ft. Devens as a Cast Specialist. In March of 1967 he was notified that he was on orders to Vietnam. After arrival, he was further assigned to HHC, 5th Battalion, 7th Cavalry, 1st Cavalry Division (Air Mobile).

On 29 June 1967, SSG William (Bill) G. Koutrouba was serving as a medical aidman during a search and destroy mission near Kontum, Republic of Vietnam. SSG Koutrouba moved through a rain of rifle fire in order to reach a member of his platoon who had received a very serious leg wound. The soldier, lying in an exposed position, was physically unable to move from the line of fire. After reaching that soldier, Sergeant Koutrouba, with total disregard for his own safety, carried him to an area of relative safety and immediately started administering first aid to stabilize his patient. He then procured medical evacuation for his comrade. This was but the beginning of his commitment to his fellow Soldiers. For his actions, Bill Koutrouba was awarded the Bronze Star with "V" Device for valor.

Scarcely more than 3 months later, his valor and devotion was once again on display. At about 0300 on 10 October 1967, at a place named Landing Zone (LZ) Colt, the firebase was attacked with mortar, rocket, and automatic weapons fire, wounding many soldiers. Enemy troops, wearing U.S. uniforms, entered the base and attacked the operations center, killing and wounding more Americans and destroying communications equipment. A grenade was thrown into the commander's tent seriously wounding him and killing another soldier. Observing a number of wounded men lying in an exposed area, Sergeant Koutrouba exposed himself to the heavy enemy fire as he moved forward to assist his fellow soldiers. While administering first aid to a casualty, he observed an enemy soldier shooting the already seriously wounded commander. He engaged and killed the enemy soldier and then rushed to his commander's side. He had to use all of his skills as a medic in order to staunch the bleeding and stabilize his patient, saving his life. He then continued to move from casualty to casualty, rendering aid while the battle still raged. When communications were restored, he prepared the wounded for medevac. This included his commander, who would spend more than a year recuperating from his wounds.

In December of that year, Staff Sergeant Koutrouba wrote home from Vietnam to say that he had no money, nor any place that he could buy anything to send his father as a Christmas gift. His father, Evan Koutrouba, was a pilot during WWII in the U.S. Army Air Forces in Europe and participated in many missions, including the bombings of Berlin. "So", Bill continued in his letter, "I am enclosing my orders on an award

I just received." The award was his Silver Star, earned for his heroic deeds at LZ Colt that October. His father told the local newspaper that the citation meant more to him than any other gift he had ever received.

In May of 1968, SSG Koutrouba left Vietnam and was assigned to Walter Reed General Hospital with duty as a Wardmaster. It is possible that he was sent to Walter Reed to recuperate from wounds, as he was awarded the Purple Heart three times. However, his military records do not elaborate on that assignment. During this abbreviated tour he was able to visit with his former commander who was rehabilitating from the wounds received at LZ Colt. They built a lifelong bond. After this short stint, he was on his way back to Vietnam in October 1968. SSG Koutrouba would continue to display his deep compassion for his comrades on multiple occasions. Many soldiers survived their wounds as a direct result of his dauntless courage under the most extreme fire and total disregard for his own personal safety.

On one occasion he braved concentrated enemy fire to cross an open area to reach wounded soldiers and treat them while under fire. Realizing they had to be moved to a more secure area, he utilized a truck to move them. By now, mortar rounds were zeroing in on the truck, but he persisted and successfully evacuated the wounded. On another occasion, he moved through intense enemy fire to within 10 meters of enemy positions to retrieve wounded soldiers, treat them, and move them to relative safety for extraction. For these actions, Bill earned his second and third Silver Stars for gallantry. On yet another occasion, SSG Koutrouba braved enemy fire to provide aid to members of his unit in order to stabilize them before preparing them for evacuation. For this he earned another Bronze Star with "V" device.

His three Silver Stars and two Bronze Star with "V" awards make him one of the most decorated soldiers of the Vietnam War. SFC Koutrouba retired from the Army in 1979. Among those thanking him for his service was his former commander. He sent a note that read "To Bill and Burnice Koutrouba, with deep appreciation for your superlative service to America, and everlasting thanks for helping to save my life."

Bill went to work for the Veterans Administration, yet the war was not over for Bill and many other Vietnam veterans. Bill often spoke of seeing the faces of the men he held in his arms as they took their final breaths. He also openly spoke of his thoughts of suicide and how he battled those feelings daily. He petitioned for disability for what would be diagnosed as Post Traumatic Stress Disorder (PTSD, first defined in 1980), to no avail. Unlike today, there were no provisions for PTSD disability, but he continued the fight. Bill's wife, Burnice, said Bill's PTSD was very much evident to her when he came back from Vietnam: he had frequent nightmares and headaches. Bill once had a confrontation with his neighbor over something trivial that almost turned violent. Surprisingly, that was when he discovered his neighbor had fought in Vietnam and was also struggling with his wartime memories. Together they formed a group of veterans to help each other with their disorder.

At one of the group's therapy sessions, Bill expressed a desire to return to Vietnam to help rid himself

of some of his harrowing memories. Another member of the group, a former Army nurse, commented that she would like to revisit her hospital site to help her manage the memories of young soldiers dying from gruesome wounds. Bill circulated the idea to have their entire therapy group return to Vietnam as part of their continued treatment, hoping it would help them come to grips with their wartime memories. Unfortunately, Bill's therapist was unable to make the trip. Bill was aware of a PTSD program at American Lake VA Medical Center and decided to see if they might be willing to lead their group to Vietnam.

That was when he first met Dr. Raymond M. Scurfield, a Clinical Social Work/Therapist who specialized in PTSD. During Vietnam, he deployed as an Army social work officer on a psychiatric team in 1968-69. After he left the Army, he was highly involved with the VA and PTSD treatment. He was selected as the first director of the specialized Post Traumatic Stress Treatment Program (PTSTP) at American Lake VAMC in Tacoma, Washington. The program used innovative techniques to treat patients, including taking groups of veterans to visit veteran's memorials. Other techniques were their Outward Bound course and Helicopter Ride Therapy. Dr. Scurfield evaluated the idea of a Vietnam return trip from a therapy standpoint, and deemed the trip a viable tool in recovery, if correctly managed.

This would be the first trip of its kind, and because of an economic embargo at that time, the group would have to go as private citizens and fly to a third country in order to enter Vietnam. The trip was coordinated by Stevan Smith, himself a Vietnam veteran. A former newsman, he also made plans to film the trip for a proposed PBS special. The resultant documentary aired in 1990 and was titled "Two Decades and a Wake Up." Bill was one of the main characters in the special and was quoted in a New York Times article "They're never going to make me well." He went on to say "I just want to find a way to live with my memories of that war. This trip should help."

The trip was deemed a success and Bill, in particular, felt that it helped him deal with his PTSD. Of course, it didn't eliminate it, but it did give him competing memories: the wartime Vietnam he remembered, and the peaceful Vietnam of the present. Bill would go on to lead other Vietnam veterans back to the sites of their past. He also petitioned VA to make the trips part of the rehabilitation program. He encouraged as many Vietnam veterans as he could to seek out the trips as part of their therapy. Bill and Stevan would become close friends.

William G. Koutrouba died October 13, 2012 at Madigan Army Medical Center. Prior to his death, he received a letter from LTG Patricia D. Horoho, the Army Surgeon General at that time. She thanked him for his service during the Vietnam War and for speaking out about Post Traumatic Stress Disorder, paving the way for other veterans to seek the care they need to treat the invisible wounds of war.

The day Bill died, Burnice Koutrouba received a hand written letter of condolence from the commander whom Bill had saved so many years before. In it he said in part

> Words alone cannot ease your grief but there may be some comfort in knowing how much Bill was admired and respected by all who were blessed to know and serve with him. As you know, Bill helped save my life on LZ Colt, so I and my family, will be forever grateful for his professional leadership, devotion to duty, and love of his fellow man."
>
> General John Adams Wickham Jr., 30th Chief of Staff, U.S. Army

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Photos courtesy Mrs. Burnice Koutrouba

A Victoria Cross to an American Doctor in the Kings Forces
Pete Starling

Introduction

The Victoria Cross (VC) is the highest award for bravery in the forces of the United Kingdom and equates to the Medal of Honor. It was awarded twelve times to doctors during the First World War. This number includes second awards to Arthur Martin Leake and Noel Chavasse, and three awarded to doctors serving with commonwealth forces. This is the story of the last VC awarded to a doctor during the war, one of those commonwealth doctors but an American by birth.

Five Americans were awarded the Victoria Cross during the First World War: the American Unknown Warrior, buried in Arlington Cemetery, and four Americans serving with the Canadian Forces. This is the story of an American doctor serving with the Canadian forces.

Bellenden Seymour Hutcheson

Bellenden Seymour Hutcheson was born on 16 December 1883 at Mount Carmel, Illinois, to Bellenden and Luella Hutcheson. He was educated at Mound City High School, a small town three miles north of Cairo, Illinois and after graduating from there in 1901 he went on to the Northwestern University Medical School where he graduated in 1906.While at Northwestern, in April 1901, aged 18, he enlisted in the 4th Regiment Illinois National Guard, giving his occupation as a student. He only served until 1902.

By the time the First World War broke out, Hutcheson was a practicing surgeon. After a few months, he decided to seek a position as a medical officer in the Canadian Army. His reasons for doing so have been stated as having a great sympathy for the Allied cause and that his ancestry was chiefly English. He also felt that by going to war he would gain some surgical experience. He was commissioned on 6 November 1915 but it would be 18 September 1916 before he eventually embarked at Halifax, Nova Scotia, for England where he docked at Liverpool seven days later.

Initially based at the Canadian depot at Seaford, he was attached to various Canadian units, and was briefly hospitalized for pleurisy. On 22 March 1917 he finally arrived in France. At first he was assigned to various Canadian General and Stationary Hospitals and then to the 76th Brigade, Canadian Artillery.

On 15 May 1917 he moved units again, this time to 75th Battalion of the Canadian Expeditionary Force (CEF), replacing a doctor who had become sick. The 75th Battalion were part of the 11th Brigade of the 4th Canadian Division. He stayed with the 75th for many months and it was with them that his bravery was initially recognised with the award of the Military Cross, the third-highest award for bravery. Whilst passing through Le Quesnel he witnessed a Canadian unit coming under direct enemy artillery fire resulting in several men severely wounded and killed. He went forward with two of his stretcher-bearers (medics) and quickly dressed and evacuated the wounded, as shells continued to fall in the area. He also treated some enemy wounded that he not only found in the village but also later that day, he came across a tented medical post full of German wounded.

The citation for the award of the Military Cross states:

Captain Bellenden S. Hutcheson, Canadian Army 75th Battalion (Toronto Scots). On August 8th 1918, before the battalion reached the jumping off position, the enemy put down a heavy barrage and many casualties were sustained. This officer worked unceasingly in attending to and dressing the wounded under heavy fire in open ground. During the mopping up of a village (80 miles north of Paris) he passed through the streets several times attending the wounded. He also voluntarily dressed nearly 100 enemy wounded who had been

left behind.

The Drocourt-Queant Line

In August 1918 the allies focused their attention on breaking the fortified Hindenburg Line. For the Canadians, that summer found them located east of Arras and facing some formidable German positions. The success of the forthcoming battle to capture the Hindenburg line depended on the capture of the Drocourt-Queant line (D-Q Line) in front of Cambrai. (The D-Q line extended northwards from the Hindenburg line and had been constructed by the Germans to block the Allies breaking through and advancing into the Douai plain). The D-Q line was regarded as one of the most powerful and well organised defence systems composed of concrete shelters, dense belts of barbed wire and machine gun positions. The Canadian Corps was given the task of breaking through the D-Q Line and advancing to the Canal du Nord and then swinging southward. They were to do this without artillery or tanks.

The Canadians moved in to the line between 19 and 24 August, with Zero hour set for 3am on Monday 26 August. By 7am Monchy-le-Preux had been captured and success after success followed during the day. The battle continued until 2 September when, after several postponements, the operation to capture the D-Q line itself was launched. The 75th Battalion advanced at 6am and by 6.30 had captured its first prisoners and by 7am the battalion had crossed the Arras-Cambrai Road. The battalion had by now encountered heavy enemy machine gun fire and was taking many casualties including the commander, wounded in the early afternoon. Despite the intense opposition and receiving many casualties the battalion pushed on. When the battalion was finally relieved at 9.30pm their total casualties were 22 officers and 291 enlisted men – a total of 246 wounded from a battalion attacking with approximately 700 men.

They moved back into rear trenches but their rest was not to be for long. Orders were received that the battalion would move forward in the late morning and relieve the 102nd Battalion. It was on the 2 September that Hutcheson would perform gallant acts resulting in the award of a Victoria Cross as the citation testifies.

For most conspicuous bravery and devotion to duty on September 2nd, when under intense shell, machine-gun and rifle fire, he went through the Queant-Drocourt Support Line with the battalion. Without hesitation and with utter disregard of personal safety he remained on the field until every wounded man had been attended to. He dressed the wounds of a seriously wounded officer under terrific machine-gun and shell fire, and with the assistance of prisoners and his own men succeeded in evacuating him to safety, despite the fact that the bearer party suffered heavy casualties. Immediately afterwards, he rushed forward, in full view of the enemy, under heavy machine gun and rifle fire, to attend a wounded sergeant, and having placed him in a shell hole, he then dressed his wounds. Captain Hutcheson performed many similar gallant acts, and by his coolness and devotion to duty many lives were saved.

The Sergeant referred to in the citation was Sgt McCullogh of the battalion scouts. He had been sent forward by the battalion commander to see what progress was being made on the right flank of the battalion and after going about 100 yards he fell, shot through the pelvis.

Hutcheson and his men waited behind the battalion and treated the wounded resulting from shelling. At one stage he was knocked into a shell hole with a German landing on top of him. The German had sustained major wounds to his femur and chest from which he died a few minutes later. Hutcheson then began to move forward behind the battalion, encountering badly wounded men as he advanced. Initially enemy fire prevented the evacuation of the wounded but eventually, with the enemy driven back by the battalion, all the casualties were evacuated by lunch time.

At some time he was again knocked to the ground when a bullet made a deep score in his steel helmet but was

unwounded.

On 21 September Hutcheson was granted fourteen days leave and would then re-join his battalion and remain with them through the final days of the war. It would not be until May 1919 that he would finally leave France and proceed to England, where he would stay until 31 May when he would embark to return to Canada. He was finally demobilised on 12 December 1919. Whilst in England on 22 May he was presented with his Victoria Cross by the King at Buckingham Palace.

As if he had not had enough of military service, in 1933, now back in the United States and married, he joined the Illinois National Guard as a captain and medical officer in the 130th Infantry. At age 49 he was a slender 145 pounds, down 10 pounds from 1915 when he had last volunteered. He served only a few years before returning to civilian life.

Bellenden Seymour Hutcheson, VC, MC died on 9 April 1954 at Cairo Illinois of adenocarcinoma of the pancreas and he was buried in Mount Carmel Cemetery, Illinois. On 9 June 1991 a memorial to Captain Hutcheson was unveiled outside the Courthouse in Mount Carmel. His Victoria Cross and medals are held by the Regimental Senate of the Toronto Scottish Regiment and the Regimental Headquarters of the Toronto Scottish Regiment is named after him.

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Pvt. Alonzo E. Reed Collection
Grant Harward

A "big vacation" is how Pvt. Alonzo E. Reed, known as Lonnie to his family and friends, described his service in France as an ambulance driver to his mother in a letter on May 21, 1919. After arriving in Rennes on September 23, 1918, he was soon assigned to a medical detachment in Laval, well west of Paris, supporting the 61st Engineer Regiment, Division 16, Transportation Corps that kept soldiers and supplies flowing from ports on the coast to the U.S. armies on the front. Although Lonnie missed most of the war and never saw combat, his letters illuminate the largely forgotten story of the American Expeditionary Force (AEF) following the end of fighting. "The wounded soldiers are on their way home now," he wrote on 24 November, thirteen days after the Armistice, "and the idea that they are on their way back to America is better than medicine, and makes them forget their aches and pains. Some of the fellows are in pretty bad condition but they are all smiles and jokes with us, when we're at the depot."

The U.S. Army had expanded to over 4 million men with nearly 2 million soldiers in France and all, except for a small force occupying Germany, had to be demobilized. This took railroads and time. "An outfit operating a R[ailwa]y cannot be relieved every so often like an outfit at the front," Lonnie explained on January 7, 1919 to his mother, "for it takes time to get crews accustomed to a road and everything working smoothly. And now there is as much or more traffic than there ever has been: with troops and materials coming back from the front." The AEF was also still training in case peace negotiations in Paris collapsed and war again broke out. The mass of men crowding the railways was dangerous as it facilitated the spread of the so-called "Spanish flu" that had first struck in the U.S. in March and September 1918 and quickly made its way to Europe to ravage the population there. A third wave hit after December 1918. On February 25, 1919, Lonnie wrote, "The 'flu' is raging here as bad or worse than ever before, but since I have just recovered I do not feel in any danger myself. Two of our family [who we are billeted with] are sick now and I have to do some extra work."

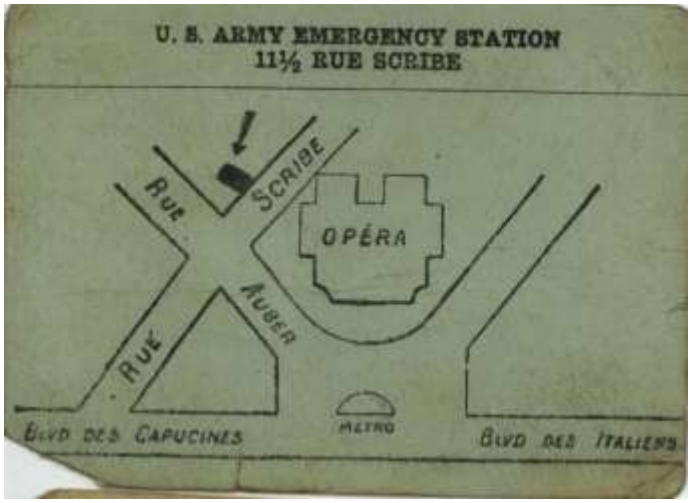
Staying in France was not just illness, death, or training, especially after Germany signed the Treaty of Versailles in June. There was plenty of time for Lonnie to go to the YMCA, visit with Russian soldiers who had somehow ended up in France, attend medical classes taught by officers, go see shows, and tour the country, especially Paris. "When it comes to comparison between Paris + any of our large cities, it is out of the question. American cities are devoted to commerce + Paris to art, each has the other only as a side issue," Lonnie wrote on 11 May 1919. After working in the dock dispensary in Brest until October 22, 1919, he was transferred to an embarkation camp and shipped home in time for Christmas.

These are just a few excerpts from dozens of letters written by Lonnie in the collection stored in the archive of the AMEDD Center of History and Heritage located in the AMEDD Museum. The collection also includes photographs, official records, a class notebook, and even one of his two six month overseas service stripes. This collection offers a unique view from the bottom of AEF demobilization a century ago. It has recently been processed and is now available to


MUNICIPAL THEATRE RENNES
FRANCE
DEC. 31, 1918
Ye old Time
MINSTREL SHOW
Presented by the A. E. F. Troops located at Rennes
"Après la Guerre"
Written and Directed by:
Ens. East. — John Koerber. — Royal F. Letchworth.
Guy J. Edwards (Y. M. C. A. Couch)

Reed took classes on anatomy, and his troops in the Rennes area organized their own minstrel show to pass time.

researchers. If you or your unit are interested more information about this collection or would like to donate something similar, please contact the archives staff at 210-808-3297, DSN 471-3297 or usarmy.jbsa.medcom.mbx.hq-medcom-office-of-medical-history@mail.mil.



The Red Cross provided "Practical Hints on Paris" while all soldiers who visited Paris were informed where the "emergency stations" (prophylaxis stations) were located.

Writing for *The AMEDD Historian*

We are seeking contributions! We believe variety is the way to attract a variety of audiences, so we can use:

- Photos of historical interest, with an explanatory caption
- Photos of artifacts, with an explanation
- Documents (either scanned or transcribed), with an explanation to provide context
- Articles of varying length (500 word minimum), with sources listed if not footnotes/endnotes
- Book reviews and news of books about AMEDD history

Material can be submitted to **usarmy.jbsa.medcom.mbx.hq-medcom-office-of-medical-history@mail.mil**
Please contact us about technical specifications.

The opinions expressed in The AMEDD Historian are those of the authors, not the Department of Defense or its constituent elements. The bulletin's contents do not necessarily reflect official Army positions and do not supersede information in other official Army publications or Army regulations.

AMEDD Center of History and Heritage

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