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Welcome to Issue #42 of *The AMEDD Historian*! This edition covers several subjects of interest, such as ensuring medical professionals serve in the Army, museums as educational facilities, and pioneers of Army medicine.

This year marks the 50th anniversary of TRADOC and the All-Volunteer Force for the Army. How did the end of conscription affect physicians, and how did they enter the Army in previous years? Read Dr. Sanders Marble’s article to gain more insight. The AMEDD Museum is always changing, read how it is adapting to ensure that visitors learn more during their visit.

Articles on William F. McFee, Alexander T. Augustus, and yellow fever relay the difficult circumstances that these early doctors faced. McFee served in both World War I and World War II, commanding the 2d Evacuation Hospital during the latter war. Augustus was the first African American officer and physician in the Army and fought to serve during the Civil War. Of note, he was recently memorialized with the renaming of the Fort Belvoir hospital on May 16, 2023. Based upon the research of several physicians William C. Gorgas, a future Surgeon General worked to conquer malaria and yellow fever during the construction of the Panama Canal.

(continued on last page)

The AMEDD and the All-Volunteer Force

Sanders Marble, PhD, ACHH

From 1940 to 1946, and 1948 to 1973, the U.S. drafted varying numbers of young men into the military. On 1 July 1973 the draft ended; since then the U.S. military has had an all-volunteer force. (There were a few exceptions; personnel who were in a delayed -entry status still had to perform their service.) Draftees served in the AMEDD, including officers. Physicians, dentists, and veterinarians could all be drafted from 1950 until 1973, and osteopathic physicians from 1967.

The ‘doctor draft’ was new in 1950. In WWI doctors (this article will look at doctors rather than veterinarians or dentists, since far more doctors were drafted) were subject to the draft but most volunteered. In WWII doctors were not drafted but were subject to intense pressure to volunteer. After WWII doctors lobbied to be exempt from the draft, and the American Medical Association strongly supported them, arguing that doctors were more patriotic than average Americans and would volunteer when there was a crisis. In 1950 there was such a crisis, doctors did not volunteer, and the AMA stepped aside as Congress started drafting healthcare professionals.

There were some quirks in drafting doctors. Draftees served as enlisted personnel, and the Medical Corps was only commissioned personnel. Congress provided for any doctor who would not volunteer, but waited to be inducted, to serve as an enlisted man but perform the duties of a physician. The lower pay etc. of enlisted men were strong incentives to volunteer. Recognizing that these were not pure volunteers, how-

ever, Congress allowed drafted doctors to serve only two years, while volunteers normally served three years. Initially, osteopathic physicians were exempt from the draft (their education was not considered equal to allopathic medical schools), and female physicians were always exempt.

Overwhelmingly, doctors were drafted right after medical school; they were deferred during medical school, but internship and residency training did not meet Selective Service's definition of education. The military generally allowed doctors to complete their internship so they could be licensed. Thus, the 1950 act could provide as many doctors as the military needed, but overwhelmingly they were inexperienced.

In 1954 Dr. Frank Berry took office as Assistant Secretary of Defense for Health Affairs and promptly introduced a plan to solve several problems. Medical schools and hospitals did not like losing doctors at whatever point in the academic year the draft boards finished their paperwork. Doctors wanted to be able to schedule their service. The military wanted better-trained physicians. Berry solved those problems by allowing doctors to schedule their service, within limits: they could apply to serve immediately after internship, after part of a residency, or after a completed residency. The services would get better-trained doctors in the quantities they needed (for instance, they could decline too many would-be pediatricians, forcing them to serve after internship rather than residency). The hospitals would have more stability among their junior staff.

The Berry Plan operated for decades with hardly any changes, a remarkable achievement. There were, of course, hiccups since it involved planning years ahead. Expanding or contracting military strength was not necessarily predictable three years ahead. In 1967 the doctor draft was extended to osteopaths, whose education was now considered equivalent, and an analogous osteopathic residency program was established the next year.

By the late 60s there was sufficient dissatisfaction with the draft that presidential candidate Richard Nixon pledged a study on how it could be ended – a barely-disguised promise to end the draft. After his election, the study began, and the services had some time to figure how to cope with the consequences. For the AMEDD, the doctor draft was the key part; they would have to recruit enlisted personnel, but recruiting doctors was considered far harder. Two programs were started, the Health Professions Scholarship Program and Uniformed Services University of the Health Sciences. Instead of drafting doctors, the military had to provide their medical education. The several years this took, including graduate medical education, did cause a far higher percentage to choose to stay in the military. Around 1% of draftee doctors stayed in beyond their service obligation, even briefly, while around 25-30% of HPSP volunteers stayed in and a substantially higher percentage of USU students.

However, it would take several years for USU and HPSP students to be fully trained and ready for independent practice. In the early- and mid-1970s the AMEDD had to find ways to cope with a doctor shortage. Many things were tried: using Physician Assistants and Nurse Practitioners; non-physician behavioral health providers were used more widely; Medical Service Corps and Veterinary Corps officers were used in more positions; and more civilian physicians were hired. There were even efforts to cut back on paperwork and reduce administrative requirements, although those battles are never over.

There is still provision for a draft. Should the military need more personnel, Congress could reinstate draft calls. Also, the Selective Service System has a plan for a healthcare draft, and that would include females, and cover from ages 18 to 46, recognizing that many healthcare personnel need education but need not be as fit as combat troops. That would also require legislation to enact.



Drawing the draft lottery, 1 December 1969. Courtesy Selective Service System.

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— 27 July 1775 —

Medics at the Marne

On July 15, 1918 the 3d Division won its reputation as Rock of the Marne. The Germans had reserves for one last offensive to win World War I, and were going for broke. The far western point of their attack was around Chateau-Thierry and hit the 3d Division.

The division was on the south bank of the Marne, with all four infantry regiments in line. There was an outpost zone, with troops scattered around in platoons, squads, and machinegun nests, while the main line of resistance was at a railroad line slightly to the rear. The Germans massed 2000 guns, one every 20 meters, and fired almost four hours of preliminary bombardment, including thousands of gas shells. Then three divisions attacked the inexperienced Americans.

The division's medics played a key role in keeping the troops fighting and sustaining morale. Some men were bandaged and returned to the fight, while others stayed because they knew they would get help if they were wounded. Each regiment had a medical detachment of 7 physicians, 4 dentists, and 48 enlisted men. Some ran a Regimental Aid Post while others were attached to battalions and either ran Battalion Aid Stations or were attached forward to companies. With the frontline troops spread out the German bombardment did not have good targets, but the medics had to dash from trenches to shellholes to bandage the wounded. Other units (for instance artillery, signals, and machinegun battalions) also had medical personnel, which was important at the Marne because the German shelling hit throughout the division's area. The aid stations were in village cellars a few kilometers in the rear, and regimental aid posts were sometimes up alongside the battalions or sometimes a little further back.

The division had four field hospitals and four ambulance companies. The ambulance companies had stretcher-bearers who were supposed to bring the wounded back from the regiments, an aid station that checked bandages while waiting for a vehicle, and 12 ambulances. In many cases the stretcher-bearers, and even the men from the dressing station, were pulled into the infantry regiments to replace casualties among their medical personnel. Even though there were extra ambulances available, 80 trucks had to be borrowed to help move the wounded – there were over 3000 on the 15th alone. One field hospital had been stripped of men to fill in regimental medical detachments, one had been detached and was working 25 kilometers in the rear as an evacuation hospital behind both the 3d Division and the 2d Division a few kilometers west near Belleau Wood. Of the remaining two, one took care of the gas patients and one (augmented with surgical teams) took most of the heavily wounded, stabilizing the patients for further evacuation to definitive care.



Left: Capt. F.T. Rice, surgeon, 4th Infantry Regiment, examining a gassed patient.

Right: Wounded of the 30th and 38th Infantry Regiments at the aid station of Ambulance Company No. 5, Courboin, 15 July 1918.
 U.S. Army photos



When the French 125th Infantry Division was pushed back, it opened the right flank of the 3d Division, and the 38th Infantry Regiment had to pull back a bit. The Germans overran the battalion aid station at Paroy, with about 70 patients in the wine cellar. Captain (Dr) Hoddie W. Daniels had already gone to get help, and was coming back with two ambulances and a YMCA truck. When he saw the Germans had captured Paroy he took charge of an infantry patrol and pushed the Germans out of Paroy. The wounded were evacuated, and the Americans pulled back. Three days later, Dr. Daniels heard about a group of captured Americans, many of them wounded, and went out with a small infantry patrol. They snuck a kilometer into the German positions and found the Americans. Daniels stepped out and the Germans, surprised, fired at him. The infantrymen then shot at the Germans, killing some, wounding some, and causing the survivors to surrender, whereupon Daniels led the whole group back to US lines. He was killed the next day by a sniper.

Nine of the 3d Division's medical men received the Distinguished Service Cross for their actions at the Marne, and nine received the Silver Star. Two YMCA workers, attached to the division, also received Silver Stars for treating the wounded. The Army and their comrades recognized the gallantry of these men in providing aid and comfort, under fire, and several times while wounded themselves.

In 2018 a clinic at Ft Stewart was dedicated as Marne Medics Troop Medical Clinic to recognize all the AMEDD personnel who served at the Marne.

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27 July 1775

On 27 July 1775, the Continental Congress established “an hospital” to support the patriot forces assembled around Boston. Those troops – mainly Massachusetts militia – had been designated the Continental Army on 14 June. They had their militia doctors, and were using local facilities as improvised hospitals. Why not ‘a hospital’ then?

First, there probably weren’t yet many sick to take care of. The local facilities were presumably adequate, and militiamen could be sent home if needed. But with the sanitary problems that armies had then, the longer they stayed camped around Boston the more sick there would be. Second, unit medical staff could be swamped by battle casualties. Between June 14 and July, the Battle of Bunker Hill showed what battle casualties were like, around one-fifth of the force engaged, and units needed more support. Third, as troops from further away arrived, they would not have local support and would need pay and authority beyond what Massachusetts could provide. Fourth, the local support only worked locally, while there were starting to be operations elsewhere in the colonies.

Around the same time the Continental Congress was looking at other support services for the Army, and established chaplains and legal support on 29 July 1775.

Congress struck a hard bargain, only authorizing \$1.33 per day for a surgeon, and proportionately less for other personnel.

— 27 July 1775 —

Let’s Talk: Breaking the Barrier of Silent Museums Angelique Kelley, AMEDD Museum

When we think of history museums, we often picture quiet hallways and open galleries; pictures are hung on walls and cases filled with old things. The people in the building speak in whispered voices, children are hushed for showing too much excitement, and there is a sense of reverent silence. What if it didn’t need to be this way though? What if we allowed the museum to come to life? The idea that museums, especially those focused on history or art, are meant to be quiet spaces of reflection has been around for decades. The very act of entering a room of historic items or works of art seems to cause an instant reaction in many visitors to walk softer, speak quieter, and retreat into their thoughts. While it is true that museums should be treated with a level of respect, and we should be cognizant of other visitors to the museum, let’s view these museums with a different lens.

First and foremost, museums are classrooms. They are opportunities to learn new things and engage with the world around us. They are public spaces for sharing thoughts and ideas, and for experiencing new concepts. Museums are places of wonder and enjoyment. If we think of them in this light, the potential for active learning opportunities at a museum grows exponentially. So, the challenge for museums then becomes how to present all the “old things” in a way that excites visitors and encourages discussions.

At the AMEDD Museum, we try to bridge this gap by making the history of Army medicine relatable to the average person. We use different methods including: sharing personal stories and ephemera from Soldiers in the field, showing how military medicine and civilian medicine overlap, and juxtaposing medical technologies of the past with their modern-day counterparts. In the future, we will create panels with a question based on the nearby exhibits, encouraging visitors to actively engage with one another to discuss their thoughts. These panels would foster an environment where visitors are not afraid to speak up and talk about what they are viewing, thereby creating an active learning situation with participants rather than visitors.

Another method used by museums to bring exhibit objects to life is to create a variety of display options. Exhibits do not need to be simply visual but can instead incorporate sound and touch as well. For example, using interactive elements such as a 3D map or touchscreen device, can help tactile learners interact with the museum’s story. Immersive displays can also help transport visitors to a particular location through visual aids and ambient sounds. Immersive exhibits can make it easier for visitors to visualize how the objects around them relate to one another, and they can more easily see themselves in the environment. These types

of experiences can create a sense of awe, but more importantly, they can help visitors feel more connected with the story being told.

Immersive display at the AMEDD Museum depicting a courier from the 66th Armored Regiment being treated by a medic from the 326th Airborne medical Company in Carentan, France during WWII.

Finally, a museum can help liven up galleries with educational programs. For most people, 'museum programs' make you think of a traditional guided tour in which someone from the staff leads around a group of visitors pointing out the stories the guide feels are significant. While this is one method of engaging with visitors, it is not for everybody. The AMEDD Museum has approached this problem by creating hybrid programs which blend staff interactions and



discussions with self-paced exploration. Typically, staff or volunteers will provide an introductory overview of the museum, typically curated specifically for the group requesting the visit, followed by a period of self-exploration of the galleries. Groups may then be pulled back together at the end to discuss their findings and engage in a dialogue. Other types of programs offered at the AMEDD Museum include facilitator support, in which museum staff work alongside educators to find ways that they can incorporate Army medicine into other programs such as STEM courses, college classes, and professional military education.

A group of Soldiers from the Basic Officer Leadership course receive an introduction to the AMEDD Museum from director George Wunderlich before breaking into small groups for further discussions.

So how does a museum create these immersive, educational environments? You may be surprised to learn that there is quite a bit that must be considered behind the scenes as part of the process. The most obvious step taken by staff is careful curation of the information being presented so it is appealing to a wide range of visitors. Since every person absorbs information differently, museums must ensure they are writing panels and displaying topics in a way that can



be enjoyed by both their youngest and oldest visitors, as well as everyone in between. Museums must also consider that visitors come from a variety of backgrounds. This becomes even more challenging here at the AMEDD Museum where the museum must ensure that content is relevant to the Soldiers serving in the Army Medical Department while remaining easy to understand for their families and friends and the general public. Museums must also take accessibility into account. The exhibits must be easily viewed from a seated wheelchair position as well as varying standing heights. Visitors with hearing or visual impairments should also be considered, as well as visitors that speak languages other than English. Ultimately, the goal is to create an environment that is welcoming and accessible to a variety of audiences.

At the AMEDD Museum we are preparing to refresh our current gallery spaces making them more conducive to active learning, while also tackling our current accessibility concerns. If successful, the museum will be able to enhance our current storyline to better tell the AMEDD's history by allowing us to redesign our exhibits and significantly increase the number of artifacts on display. As a result, we will be able to tell a broader story, giving a better depiction of not only how vast the Army Medical Department truly is, but also a better representation of the unique individuals that make up our proud AMEDD family. Regarding accessibility, the refresh will also allow us to create an exhibit space that is more handicapped accessible than our current design. Additionally, we will be able to incorporate audio tour options which will allow us to translate the galleries into other languages, creating a multilingual environment. These features will allow us to better serve our veteran communities, foreign national visitors, and the Army medical community.

While history museums show snapshots in time through static objects, doing so should not make the museums themselves static. Instead, history museums should be living, evolving entities that grow with their audiences and make the past come alive. At the AMEDD Museum, we see the past alive and well in every Soldier that passes through our doors. Our mission is to support those Soldiers in learning how the past can help inform the future, while also serving as the voice of the AMEDD to the American people. We strive to be a place not where old things go to be preserved, but where the past meets the present and sparks a desire to learn more, discuss opinions, and ponder facts. So the next time you visit us, don't be afraid to speak up, ask questions, and get involved. It's time for the "silent museum" to become a thing of the past.

If you are interested in learning more about the AMEDD Museum's programs for military training and professional development, or civilian education opportunities, please feel free to reach out to us at (210) 221-6358 or email us at usarmy.jbsa.medical-coe.mbx.amedd-museum@army.mil. Be sure to also follow us on social media and our website, <https://armymedicalmuseum.org/>, to hear about the exciting changes that are coming soon!

— 27 July 1775 —

The World War II Service of Professor William F. McFee, 1890-1974

Peter C. Wever, MD, PhD, Jeroen Bosch Hospital, 's-Hertogenbosch, The Netherlands

In the Summer 2019 issue of the AMEDD Historian, a manuscript on the 1917-1919 WWI service of Professor William Frank McFee was published. He had served as a battalion surgeon with the 2nd Division of the American Expeditionary Forces. This follow-up to that write-up presents details of his WWII service, in which he served as commanding officer of the 2nd Evacuation Hospital.

In 1939, William McFee served as director of the surgical service at St. Luke's Hospital in New York City. In September of that year, when Germany invaded Poland, plans were instituted at St. Luke's Hospital to re-activate Evacuation Hospital No. 2 which had been operated by the hospital during World War I. The Surgeon General's Office formally requested the formation of a 750-bed evacuation hospital in March 1940. Unit personnel would consist of 40 officers, 60 nurses and 300 enlisted men. McFee was commissioned lieutenant colonel on February 8, 1941. On December 27, 1941, the unit was alerted to an early call for active duty as the 2nd Evacuation Hospital. The unit was officially activated at Fort Devens, Massachusetts on January 22, 1942. McFee was appointed unit director and chief of surgical service. Between January and June 1942, the personnel of the unit underwent intensive military training, with little or no medical work. Daily classes on customs of the service, military courtesy and discipline, orientation lectures, drills and hikes were conducted. Personnel

was sent to work in local hospitals to acquire experience in the wards and in the operating rooms. Additional classes dealing with first-aid, hygiene, sanitation, hemorrhage control, arm and leg splint applications and other medical matters, etc. were taught. Long marches with full equipment were held for hardening the men.

On July 21, the organization departed from Fort Devens for Camp Kilmer, New Jersey, in preparation for its movement overseas. The 2nd Evacuation Hospital put to sea on the RMS *Queen Mary* from the New York Port of Embarkation on September 5, 1942, and reached Greenock, Scotland, on September 11. Subsequently, the unit was stationed for various periods at various places in Northern Ireland, England, Scotland and South Wales. In a letter dated November 4, 1942, McFee wrote his wife: "Have finished the period of observation in the British Hospital and am now back with one section of our unit." Notably, he specifically instructs his wife to send him his military ribbons as "Several of the men have been insisting that I should wear them."

The seven months from late December 1942 to early August 1943 were spent at Diddington, Huntingdonshire, England. There, the 2nd Evacuation Hospital opened a 750-bed hospital for patients of the 8th Air Force. The organization functioned largely as a station hospital for the sick and injured but also served as an evacuation hospital for Army Air Force wounded returning from bombing missions over the European mainland. During the stay at Diddington, there were 4,625 admissions among which 1,921 operative cases and 9 deaths (death rate 0.2%). Only 4.3% of admissions were battle casualties, nearly always with multiple wounds mostly caused by explosive shells, often 20mm flak. McFee performed a study in some 250 fresh Army Air Force casualties whose wounds were closed per primam after debridement and were administered the broad-spectrum antibiotic sulfonamide. Only four cases of infection occurred, none of which were serious, demonstrating the important role of sulfonamide in preventing wound infection. Subsequently, McFee was placed on one month's temporary duty as a special consultant with the Eastern Base Section to supervise and control a study on the value of penicillin with Army Air Force casualties.

During the three-and-a-half months from late October 1943 to mid-February 1944, 2nd Evacuation Hospital took over a hospital for contagious diseases at Cowglens, Lanarkshire, Scotland. There, 2,498 patients were handled, most of whom were admitted directly from incoming convoys. Only one patient died (death rate 0.04%). No battle casualties were treated. On February 10, William McFee, chief of surgery since the unit's inception, assumed command of 2nd Evacuation Hospital. The remaining months before D-day, June 6, were spent in South Wales and England.

McFee went on detached duty in late May with headquarters personnel of the First U.S. Army. He reached Omaha Beach, France, on a hospital carrier on D+1 (another source mentions D+2) and led medical teams responsible for supporting soldiers in the Normandy landings as well as those involved with treating the early casualties evacuated from Omaha Beach. On D+4, he was promoted colonel. McFee returned to 2nd Evacuation Hospital on June 29 and resumed command on July 1.

The 2nd Evacuation Hospital landed on Omaha Beach on D+17. On June 28, the unit moved to a location near La Mine, some 17 km south of Omaha Beach, where it established a 750-bed hospital under tentage – and was about 8 km from the frontlines. In the first few days following opening, patients arrived in large numbers, plunging the hospital at once into full activity. Casualties received belonged to the 1st, 2nd, 29th and 30th Infantry Divisions. In July, the unit was honored with a visit of British Field Marshal Bernard L. Montgomery. Photos taken during the occasion show McFee and the field marshal engaged in conversation. In an August 6 letter, McFee wrote his wife, "The progress of the past 10 days has been spectacular but that of course means casualties. Fortunately the number is not excessive for the advance gained, but for the individual who gets hit it may be catastrophic." The next day the hospital closed its operation at La Mine for patients



World War One-style Red Cross brassard with 1929 Geneva convention statement stamp of Lieutenant Colonel William F. McFee, his Red Cross identification card (brassard and card with matching numbers) and his dog tag (author's collection).



Above: The 2nd Evacuation Hospital at La Mine, France, where it operated from late June to early August 1944.
COL McFee, third from the left, in conversation with British Field Marshal and Bernard L. Montgomery sometime in July 1944 at La Mine, France. Both author's collection



and started preparations for its next move. During the six-week period at La Mine, there were 5,263 admissions, 3,238 operations and 63 deaths (death rate 1.2%).

On August 13, McFee was detached from his unit for a three-man mission to Washington D.C. to inform The Surgeon General of the urgent need for flying whole blood from the U.S to the United Kingdom and from there to the continent. The men succeeded in their mission and the first shipment of blood was flown to Prestwick, Scotland, on August 21. In the meantime, 2nd Evacuation Hospital had moved some 50 km south to Mesnil-Clinchamps where it operated for little over a week. But the war was moving fast and the 2nd Evacuation was bypassed. The unit subsequently moved some 170 km to the west to the medical concentration area at Senonches, where it stayed until September 27. McFee rejoined his unit on September 15.

The next stop was Eupen, Belgium, some 475 km northwest of Senonches. There, a large sanatorium was procured that had been used by the Germans to treat soldiers with tuberculosis. A receiving ward and additional tent wards to augment bed capacity were erected in front of the building. The unit opened for patients on October 2. First, it operated as a transfer point and evacuation facility. The transfer point stopped operations on October 6. In the succeeding two weeks, the unit received the greatest concentration of seriously wounded during the current year. Aachen, Germany, was one of the major Allied objectives at that time and the fighting for it was bitter and intense. Patients arrived constantly in a steady stream. After the fall of Aachen, pressure lessened. The month of November saw an increase in the number of operations as compared to October, but not as many seriously wounded. However, due to landmines and booby-traps, a large number had traumatic amputations.

On December 16, the German army launched a desperate counteroffensive and breakthrough attempt, known as the Ardennes Offensive or the Battle of the Bulge. Enemy shells landed in the immediate area of the 2nd Evacuation Hospital and in the evening German planes dropped bombs on the city of Eupen. While other medical installations in Eupen were pulled out, 2nd Evacuation Hospital was selected to remain, despite German paratroopers being dropped in and around Eupen. German forces reportedly pushed to within eight kilometers of the hospital and roadblocks were set up behind it to stop the Germans should they overrun the position. McFee reflected to his wife on January 6, 1945, in a self-censored V-mail: "Think if we were about to be over-run the army would see to it that the personnel got away even if the equipment was lost. That happened in some areas." He cryptically referred to the offensive as "the storm": "we were not directly involved in the storm and didn't get anything more than the winds which usually arise on the periphery of a storm center. We had no runs and no hits." In a January 13-dated V-mail, he wrote: "We were a little anxious, naturally, because it was generally



December 19, 1944 time-lapse photo of the sanatorium at Eupen, Belgium, where the 2nd Evacuation Hospital operated from late September 1944 to late March 1945. The photo was taken on the fourth day of the Battle of the Bulge and the light streak left of the building is a German flare. Photo by 1LT Richard Allynn; author's collection.

believed that our area was within the German plans. ... There was no panic and really very little excitement in the unit and I was very proud of their behavior under fire. The Germans are being pushed steadily back now, and everything seems to be under control.” Eventually, the Allied forces erased the enemy breakthrough and pushed the Germans back toward the Rhine River. The 2nd Evacuation Hospital closed its operation at Eupen in February. During its 143 days of operation at the site, there were 30,734 admissions, 4,878 operations and 199 deaths (death rate 0.6%).

On March 31, 2nd Evacuation Hospital departed from Eupen to Zülpich, Germany but the frontlines had moved far ahead of the hospital. In an April 2-dated V-mail, McFee wrote: “At last we are in Germany but too far back to be doing any work, just sort of boarding.” The next moves were to Kassel on April 14 and subsequently to Naumberg which was reached on April 16. On April 20, McFee was, however, relieved as commanding officer of 2nd Evacuation Hospital and appointed surgical consultant of the Fifteenth U.S. Army. It was the last field army to see service in northwest Europe during the war. In April 1945, the Fifteenth Army crossed the Rhine two to three weeks behind the other allied forces. It took over responsibility for the Hesse, Saarland, Pfalz and Rhine provinces where it processed POWs, disarmed enemy forces and displaced persons.

As surgical consultant to a field army, McFee was to supervise the treatment and transportation of patients from aid stations through the evacuation hospitals. He had technical control of the Auxiliary Surgical Groups assigned to that army and in general was adviser to the army command surgeon concerning the treatment and transportation of surgical casualties. He functioned under the direction of the army surgeon. In an April 23-dated V-mail, McFee seemingly expressed some dissatisfaction with his new assignment: “I moved with the unit [2nd Evacuation Hospital] pretty deep into Germany, and was just getting settled there when I got orders to come to this army as consulting surgeon. ... It seems a little late for this kind of job because it looks like the war in Europe is nearing its close.” A May 1-dated V-mail states: “Have been kept pretty much on the move. The hospitals I have to visit are scattered over a rather wide area.” Coincidentally, he was living in an – unnamed – town not far from the Rhine along the route he marched on into Germany in December 1918. McFee was relieved from duty with the Fifteenth Army on July 10 and returned from overseas service on July 16. He was discharged from the Army on November 6, 1945.

After the war, Colonel McFee was awarded the Legion of Merit for meritorious service from October 1943 to February 1945. He received a letter of commendation from Major General Paul R. Hawley, chief surgeon to the U.S. Army European Theater of Operations. However, the extent of McFee’s service for the AMEDD might be best expressed in his own letter dated June 11 written from Germany: “In another month I shall have had a total of 5 yrs overseas service in the two wars. That should be enough for one lifetime.” McFee ultimately fell about 10 days short of five years overseas service.

After the Korean War began, McFee published an article in the March 1951 issue of *The Military Surgeon* with the title: “The Surgery of World War III.” Fortunately, his foresight did not come true as of yet.

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The author would like to thank Mary Alton (great-niece of William McFee), Wendy McFee (great-niece by marriage of William McFee), James Shetler and www.med-dept.com.



COL McFee after WWII, with ribbons for the *Croix de Guerre* with one star, Silver Star, Victory Medal with four battle stars, Army Occupation of Germany (all World War One ribbons), Europe, Africa, Middle East Campaign with five battle stars and the Legion of Merit (both World War Two ribbons). Author’s collection.



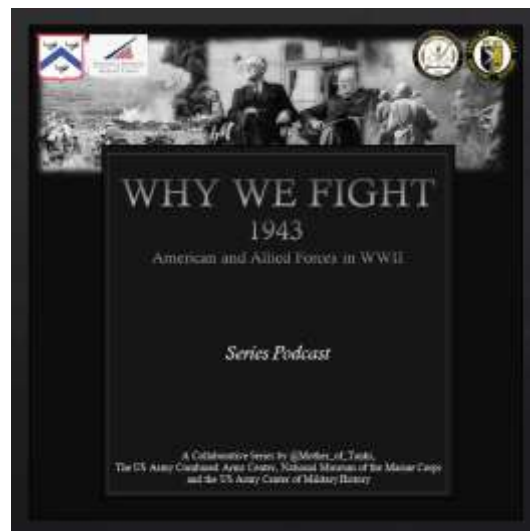
Even the portable surgical hospitals could not move fast enough to avoid paperwork. This is the 26th PSH in the South Pacific, probably in the summer of 1944. ACHH collection.

The Sicily Campaign and the AMEDD

In August the ‘Why We Fight 1943’ podcast (<https://www.motheroftanks.com/podcast> and through various podcast services) is running two episodes that feature the AMEDD.

Dr. Grant Harward will be discussing the 56th Medical Battalion and the various things they did.

Dr. Sanders Marble will be discussing Patton’s slappings of soldiers and the care provided for psychiatric patients.



MAJ Alexander T. Augusta, MC

George Wunderlich, AMEDD Museum

Dr. Alexander Thomas Augusta was a pioneer in medicine in the mid-nineteenth century. He served as a regimental surgeon, directed two Army hospitals, was a post-war hospital director for refugees and former slaves, faculty member of a medical school and was one of the founders of the National Medical Association. Despite many legal and social barriers, Alexander Augusta fought for every opportunity to learn and pursue his medical professional despite being born in a state that legally prevented him from being taught to read and write.

Augusta was born as a “free person of color” in 1825 in Virginia. Due to the Nat Turner slave rebellion in 1831, new laws were passed in Virginia, and across the South, to prevent the education and strictly restrict the free movement of all Blacks, free or slave, in an attempt to prevent future rebellion. From the perspective of a slaveholding society, the ability to read and communicate across any distance was seen as a threat to the life and property of the slaveholders. Despite the legal challenges, Augusta found a tutor and learned to read and found that medical texts were of particular interest.

In 1847 he moved from Norfolk VA to Baltimore MD but found that his pursuit of a medical education would not be possible there. He then went to Philadelphia hoping to attend the University of Pennsylvania. His application was denied, stating he was not prepared. He did find a professor who would begin a more formal education process during which he learned chemistry among other topics. In 1850 he and his new wife went to the gold fields of California where he worked as a barber and saved money for his next move.

From California the pair moved to Toronto Canada where Augusta was able to enroll as a medical student at the University of Toronto’s Trinity College. While studying medicine he also ran a small shop where he acted as both a pharmacist and chemist. He advertised the application of leeches, filling prescriptions, and the pulling of teeth. In 1856 he graduated from Trinity with a degree in medicine and soon was appointed to run the Toronto City Hospital. He built his private practice while running the hospital and served as president of the Provincial Association for the Education and Elevation of the Coloured People of Canada. Although he was developing deep bonds with the people of Toronto, he was also a keen observer of the events in the United States as the American Civil War began.

The Emancipation Proclamation took effect on January 1, 1863. Not only did it declare freedom for all slaves living in the areas held by the Confederacy, but it also allowed for the enlistment of Black soldiers. Six days later Augusta wrote a letter to Abraham Lincoln and Secretary of War Edwin Stanton offering his services to the Union Army as a surgeon for the newly raised United States Colored Troops regiments. Once he had received confirmation that he had an appointment to take the examination to become an Army surgeon he left Canada and traveled to Washington DC. The acceptance that he had found in Canada was not to be repeated in the United States. The racism he had left behind was still very much in place upon his return.

Just before his examination date he was informed that he would not be allowed to sit for the examination. The reasons given were his race and his ten years of residency in Canada. Although the Army was enlisting Black soldiers, it was not accepting Black officers. Also, the claim was made that since he had lived in Canada his acceptance would violate Great Britain’s neutrality. This claim had not prevented the enlistment of both soldiers and officers who were British citizens including several white surgeons who came from Canada. Augusta would have to approach Lincoln again to have the decision reversed and he was finally allowed to take the examination and was recommended for appointment as a surgeon on April 1, 1863.

He was officially appointed as surgeon of the 7th U.S. Colored Infantry and received his commission as a Major on April 14th making him the first Black commissioned officer and the first Black surgeon in the U.S. Army. Despite his rank and qualifications, the white surgeons protested his assignment of his command wrote to the War Department, the White House and members of Congress stating that having a Black man in



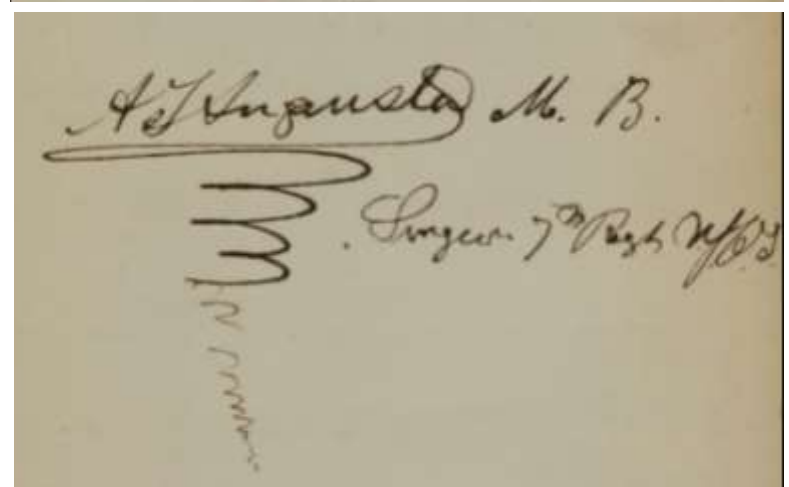
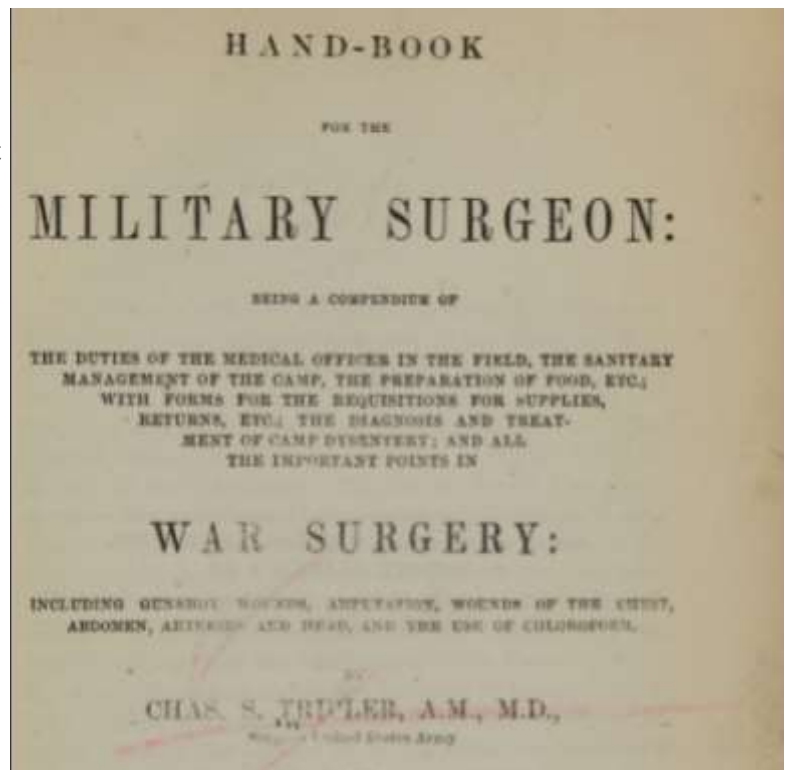
Alexander in uniform as a lieutenant colonel. Courtesy Oblate Sisters of Providence via National Park Service.

authority over them was “humiliating” Since surgeons were difficult to recruit it was decided that rather than risk the resignation of these officers, they would instead transfer Augusta to the newly founded hospital at Camp Barker. This facility served Black soldiers, civilian refugees and Army contract laborers and teamsters. In this new position Augusta became the first Black hospital director in the United States. He was transferred to Baltimore in 1864 where his services were needed in the medical examination of newly enlisted Black troops. In both positions he earned the respect of military leadership and was promoted to the brevet rank of lieutenant colonel at the close of the war. He also received an invitation to visit the White House with his assistant Dr Anderson Abbott, one of at least seven Black surgeons to come into Army service after Augusta, to meet the President and First Lady on February 23, 1865.

Dr Augusta continued his service for the government when he was given responsibly for the Lincoln’s Freedmen’s Hospital in Savannah GA by the Bureau of Refugees, Freedmen, and Abandoned Lands. In addition to his medical duties, he was responsible for overseeing the distribution of food, clothing, fuel, legal aid, and education to both former slaves and poor whites. He continued in this position until he returned to Washington, DC in 1868 to begin his own medical practice.

In 1869 was hired by the new medical college of Howard University. He would now become the first African American professor in the United States. His work teaching anatomy and diseases of the skin would have been nearly impossible to anticipate two decades before when he left his home in Virginia to pursue an education that he could not receive in the United States. When he was denied membership in the District of Columbia Medical Association he would assist in the creation of the National Medical Association which was open to all race and is still operating today.

Alexander Augusta died at the age of 65 in Washington DC. In a final first, he became the first Black officer buried at Arlington Cemetery in 1890. His legacy in medicine, medical education and fighting racial injustice are certainly remarkable not simply noteworthy because of the great number of “firsts”. The professionalism and dedication to service in the face of bigotry and discrimination and his dedication to bettering the life of all citizens is an example of service worthy of admiration.



Augusta bought a copy of the standard textbook in military medicine, Charles Tripler’s *Handbook for the Military Surgeon*. He inscribed it A T Augusta, MB, Surgeon 7th Regt USCT. He took his role as an Army doctor seriously, and his work and talents were recognized by brevet promotion.
 Courtesy National Library of Medicine

Yellow Jack Charles Franson and Paula Ussery, AMEDD Museum

On August 15, 1914, the Panama Canal opened with the transit of the SS *Ancon* through the locks. The dream of connecting the Atlantic and Pacific had finally been realized, resulting in a savings of 2,000 nautical miles.

Lauded as a great feat of engineering, it was also a triumph of medical science, with the AMEDD playing a crucial role. France, America, and Britain were all vitally interested in shortening transit time between Atlantic and Pacific. The French attempted to construct a canal in the 1880s but diseases, especially malaria and yellow fever, which cost 20,000 lives in nine years brought the project to a halt.

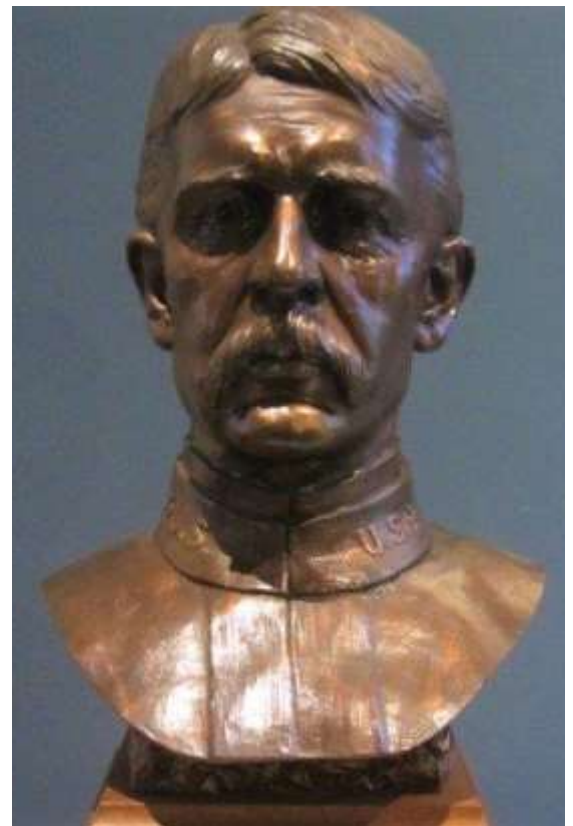
In 1903 America signed a treaty with the Republic of Panama granting a strip of land 10 miles wide to build a canal. Construction began on the canal in 1904, but tropical diseases, including yellow fever and malaria once again began taking a toll on the workers. By 1906, roughly 85% of canal workers had been hospitalized with either malaria or yellow fever. If the project was to continue, a solution had to be found.

The incapacitating nature of yellow fever had been dramatically demonstrated during the short Spanish American War in which disease casualties outnumbered combat deaths by 6 to 1. After a serious outbreak in Havana in 1900, the Army appointed a Yellow Fever Commission, consisting of four members, with MAJ Walter Reed as the chairman. The team conducted its research there, testing the various theories about the transmission of the fever, and each was studied thoroughly. The importance of controlling yellow fever lay in its ability to infect and kill those who were nonimmune. Many of the residents of Panama and other tropical countries had contracted light cases as children and therefore were immune. For the French, British, or Americans however, it was an epidemic disease.

Although Carlos Finlay, a Cuban physician had advanced the idea that the disease was spread by mosquitos, the idea was not widely accepted. One prominent idea championed by Italian physician Giuseppe Sanarelli, was that it was caused by *Bacillus icteroides*, which was found in patients suffering from yellow fever.

Reed and Acting Assistant Surgeon Aristides Agramonte, a Cuban physician, researched various theories. Their research concluded *B. icteroides* was related to another disease, and the presence in yellow fever cases was a coincidence. Another theory pointed to direct transmission from an infected person, or via “fomites”, that is contact with objects such as clothing or bedding which had come in contact with an infected person. However, a prisoner in the local stockade had yellow fever while confined with other soldiers, yet none of the other prisoners became ill.

Walter Reed felt that Dr. Finlay’s mosquito theory had great merit, and the *Aedes aegypti* mosquito had been isolated as the vector, but proving it in an environment where the disease was endemic posed problems, such as locating a “clean,” or uninfected control group. This issue was solved by using volunteers selected from soldiers recently arrived, as well as the members of the team themselves. Major Reed had two screened enclosures built. The first test was to have healthy nonimmune volunteers sleep on the body fluid-stained bedding of former yellow fever patients. After twenty days none of the volunteers had con-



Walter Reed and three contract surgeons composed the Yellow Fever Board that discovered that mosquitos were the carrier of this disease. Reed became world famous almost immediately because of the global impact of that research. Sadly Major Reed died only two years after this great triumph of medical science.

tracted yellow fever. The second trial had volunteers separated by screening live in the vicinity of yellow fever infected mosquitoes. Again none of the volunteers contracted yellow fever. In the third test, a volunteer was bitten by a yellow fever mosquito and contracted the disease. While Dr. Reed was on leave in the U.S., Commissioner Dr. Jesse Lazear, conducted experiments on himself and Commissioner Dr. James Carroll, resulting in active infections. While Carroll recovered from his bout of yellow fever, Dr. Lazear contracted a severe case, and died.



William C. Gorgas who conquered yellow fever in Cuba and Panama was selected as Army Surgeon General in January 1914. He had planned to retire in 1917, but America's entry into WWI postponed this and he did not retire until October 1918.

Having evidence that yellow fever was caused by mosquitoes, the next step was to eradicate it from the Canal construction area. To eradicate yellow fever and control malaria, Surgeon William Gorgas received his orders as Chief Sanitary Officer for Panama in April 1904. Gorgas was selected due to his success at in Havana, Cuba, which had been a hot bed of both yellow fever and malaria. Due to the lack of support from the Panama Canal Commission and the overwhelming weight of the rules and regulations set up by the commission, Gorgas began his sanitation work on a small scale. When all of the Commissioners were replaced in the spring of 1905, Gorgas was given free reign over the public sanitation issue. His area of responsibility was much greater than in Cuba as the Canal was almost fifty miles long. Along its length were twelve thousand people scattered in a string of villages. Introduced into this were thousands of American yellow fever non-immunes who came as workers on "the big ditch."

Gorgas divided the 500 miles of the canal area into 17 districts, each with a chief inspector responsible for cutting brush, digging drainage ditches, fumigating buildings, erecting screening, and oiling standing water. Additionally, running water systems were built in several cities, eliminating the need for household rain barrels. This denied mosquitoes a breeding site in the vicinity of human hosts. Gorgas also set up a patient care system: 21 dispensaries along the canal route, and distributed one ton of quinine to prevent malaria annually. Both workers and Panamanian citizens were eligible for this prophylaxis.

The statistics illustrate his remarkable success. In June 1905 there were 62 known cases and 19 deaths; By December there were no reported cases. Incidence of malaria dropped significantly. In 1906 there were 831 reported cases per 1,000 employees, in 1908 282 per 1,000, and by 1913 there were only 76 known malaria cases per 1,000 employees.

Sources

- William C. Gorgas, *Sanitation in Panama*. New York: Appleton, 1915.
 H.A. Kelly, *Walter Reed and Yellow Fever*. New York: McClure, Phillips & Co., 1906.
 "William Gorgas, Soldier of Public Health" by Jonathan Leonard, *Bulletin of PAHO*, 1991
 Enrique Chaves-Carballo, "Clara Maass, Yellow Fever and Human Experimentation," *Military Medicine*, Vol 178 May 2013.
 Paul S. Sutter, "The First Mountain to be Removed" Yellow Fever Control and the Construction of the Panama Canal," *Environmental History* 21(2) April 2016 Apr; 250–259.



The French used a railroad to assist in the construction of the canal, as did the Americans. (Above) Due to the tropical climate, the railroad ties were made of Lignum Vitae, an especially dense and moisture resistant wood. This piece is only 10" x 5" x 7" but weighs 14 lbs 5 ounces. (Below) A section of the French inverted-U shaped rail. Common in Europe, it was not widely used in the U.S.



New ACHH Archival Donations:

Personal copies of service records, a scrapbook, and oral interviews on cassettes belonging to World War II nurse 1LT Miriam Laycook, ANC

Collection of Army publications donated by CSM (Ret) Clark J. Charpentier

Collection of books on military nursing and the Army Nurse Corps, newspapers and magazines about Desert Shield/Desert Storm, and VHS tapes on the history of Army Nursing donated by COL (Ret) Kim Smith

Two World War II ration books issued to Evelyn and Earl Franks and donated by AMEDD Museum volunteer Jed Elrod

Captured enemy weapon certificate, Camp Barkeley Christmas menu, Army Exchange Ration Card-ETO, and a black and white photograph belonging to T/5 Cleveland Lavergne

Six binders of articles, memos, and photographs documenting the work conducted by BG (Ret) Russ Zajtchuk and COL (Ret) Joan Zajtchuk on AMEDD telemedicine and advanced technologies



1LT Miriam Laycook, ANC

New to the Research Library:

Jill L. Newmark. Without Concealment Without Compromise: The Courageous Lives of Black Civil War Surgeons. Carbondale: Southern Illinois University Press, 2023.

— 27 July 1775 —

Army Hospital Trains

Hospital trains were first used in war in 1854, and the first U.S. use was in 1861. The Army used them in every war from 1861 to Korea, and had them in the inventory into the 1970s. They're back in use in Ukraine, presumably for military patients and certainly for the evacuation of civilian patients.

Left: a Civil War hospital train, with hospital steward.
Below: a 1950s hospital train unit training on loading casualties into boxcars for an improvised hospital train.



JAMA Network Open has an article on their use in Ukraine at <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2806503>, and a quick overview of Army use from the Civil War to the Cold War here <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2806512>.

A photogallery of Army hospital trains through time is on our Flickr site, <https://www.flickr.com/photos/armymedicinehistory/albums/72177720307953153/with/52862826074>



Excerpts from *Combat Readiness Through Medicine at the Battle of Antietam* Scott C. Woodard

As the anniversary of the battle of Antietam comes around, a recent book helps us understand medical care at the battle, and how that has affected the AMEDD.

Scott C. Woodard, George C. Wunderlich, and Wayne R. Austerman, *Combat Readiness Through Medicine at the Battle of Antietam*, Borden Institute, Fort Sam Houston, Texas, 2022.

Excerpt 1: Preface

This book focuses on the medical aspects of the single bloodiest day in combat for the United States of America. It was here that the Medical Director of the Army of the Potomac, Major (Dr) Jonathan Letterman, solidified his emerging plan to decisively combat battlefield mortality and marks the beginning of true combat readiness through medicine. It is from this crucible that the AMEDD began its path toward a world-renowned reputation for rendering aid to those most dear to the combat mission—the soldier. It is from this battlefield that we see the human dimension and usefulness of Dr Letterman’s plan for future generations in joint interoperability, standardization, and evidence-based medicine.

Participants can further examine the story of battlefield medicine in the rich outdoor classroom of western Maryland by using the 2007 US Army Center of Military History (CMH) *Staff Ride Guide: Battle of Antietam* by Ted Ballard. This publication serves as the core text to help participants understand the contextual, operational, and tactical overview of the battle. Traveling back in time, participants begin the staff ride at D.R. Miller’s Cornfield and Dunker Church in Sharpsburg, Maryland, where major action took place. After that, they will encounter division-level battlefield hospitals, travel through the corps-level evacuation and treatment route, and then complete the journey in Frederick, Maryland, at the general hospitals and at the National Museum of Civil War Medicine.

This study may be used in conjunction with the CMH guide, or it may be used separately as a focused analysis of military medicine. Additionally, the points of interest, or stops, may be grouped into the physical battlefield (Chapters 1 through 3), division-level hospitals (Chapter 4), and the large rear-area hospitals and National Museum of Civil War Medicine (Chapters 5 and 6). Each of these groupings may be studied together or separately from one another.

Excerpt from Chapter 2: Direct Action and Battlefield Hospitals



Figure 2.17 Union Viewpoint. The Federal troops’ view looking northwest from their position against the Confederates, who were entrenched near the Sunken Road out of frame on the left. The flow of the wounded traveled down to this lower elevation during the battle.

Dr Letterman's Plan at Work

It was in this field, north of the Confederate line at the Sunken Road, that the evacuation and treatment plan developed by Major (Dr) Jonathan Letterman proved its worth. By the afternoon of 17 September 1862, the medical officers were executing this plan that was rehearsed and developed for evacuation and treatment of the wounded. Field hospitals were initially set up in the barns and homes around the battlefield just below the crest where the Confederates were bearing down on the Federals. It became fairly obvious that these hospitals were deadly close to the actual fighting. So, the Medical Department of the Army of the Potomac began to move the larger field hospitals back toward Antietam Creek and beyond. Field dressing stations were established downhill from the fighting along the natural flow of the wounded away from the front. Here, soldiers were quickly treated with bandages and administered tourniquets. They were then evacuated by foot using litters or by hoof using ambulance wagons. From this stage in the battle, patient evacuations were coordinated for movement to fixed facilities across the creek, such as the Philip Pry House (Chapter 4, Stop 1) where Dr Letterman was busy organizing the medical department. The surgeons and hospital stewards at the Pry House had previously trained with Dr Letterman before the Maryland Campaign in the quest to be ready for the fight. This medical readiness emphasis was now paying off. Using the Ambulance Corps, patients were quickly and effectively moved from the dangers of the intense fighting in front of the Sunken Road to higher levels of care. This "quick win" in this portion of the battle foreshadowed the success and importance of Army readiness for future combat operations ...

The natural drift of wounded soldiers found their way to the Roulette Farm by following the lower elevation away from the Bloody Lane. Participants can look northwest and see the Roulette Farm (Chapter 2, Stop 4). The barn is in the forefront and the spring house is on the right. The home beyond the barn on the left is where the family hid inside the shelter of the basement during the battle. The white barn on the far ridge is part of the Mumma Farm. During the battle, this abandoned homestead was a pillar of black smoke that was seen for miles. As wounded soldiers sought shelter from the clash of arms, the Roulette Farm seemed to be in a perfect location for obtaining relief. The gradual descent made for an easy downhill path away from the open battlefield.

Excerpt from Chapter 3: Last Push



Left: Figure 3.5 Union Soldier at the Rock Wall. An unknown U.S. soldier stands along a rock wall near the Burnside Bridge where many Union soldiers are buried.

Below: Figure 3.6 Burnside Bridge—November 2017. George Wunderlich, AMEDD Museum Director, shares the scene with the wood and rock that bore witness to the battle. Federal graves were moved continuously until September 1867 when the Antietam National Cemetery was officially dedicated. It holds mostly Federal troops; Confederate troops were reinterred and buried at other locations

Parade of the Maimed

As the fighting for the Burnside Bridge raged on from about 10:30 am to noon, the rookie Union troops of the untried 35th Massachusetts Infantry were held in reserve in the cover of a cornfield not far from the brigade field hospital. Their position lay athwart the path taken rearward by many of the wounded as they sought medical aid.



The beleaguered wounded methodically trotted and felt their way past the untested newbies. It was a

parade of the maimed—bloody rags, stumps where legs had been, ripped flesh that once held sleeves. The New England troops were “front row” to a cornfield that ate soldiers and spit out their dying bodies. The tunnel of death from which they emerged would soon swallow them up whole, and some with pity, would be spit out.

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Interested in more? Common Access Card (CAC) holders may request a copy of *Combat Readiness* at no charge through the following URL - <https://medcoe.army.mil/borden-combat-readiness-antietam>

— 27 July 1775 —

56th Medical Battalion in Sicily

Grant Harward, PhD, U.S. Army Center of Military History

The 56th Medical Battalion was one of the most combat experienced AMEDD units of WWII. The 56th Medical Battalion (Corps) was activated on 10 February 1941 at Fort Lewis near Tacoma, Washington. It was an “all-purpose” medical battalion attached to a corps, not assigned as an “organic” medical battalion to any single division. Consequently, it provided support to whatever corps units needed additional medical assistance – be it infantry, airborne, or armored. The 56th earned the nickname “the D-day medics” because it had participated in more major operations than the average medical battalion. (“D-day” was a generic term for the start date of a major operation that only later became associated with the Normandy landings.) It was part of four amphibious landings: French Morocco (Operation TORCH), Sicily (Operation HUSKY), Anzio (Operation SHINGLE), and southern France (Operation DRAGOON). After landing on beachheads, the 56th advanced inland behind the front evacuating casualties, operating holding and convalescent hospitals, running the first hospital train overseas, bolstering hospital ship platoons, and even functioning as an evacuation hospital. By Victory in Europe Day, it had advanced across southern Germany. The 56th Medical Battalion was inactivated on 31 October 1945.

As the AMEDD prepares to fight Multi-Domain Operations in which a near peer enemy may challenge the U.S. military in land, sea, air, space, cyberspace domains, it merits looking back to the 56th Medical Battalion to see what lessons can be learned from the past to apply to the future. WWII was the last time the U.S. faced enemies capable of challenging it in multiple domains on the battlefield.

In Sicily (9 July-17 August 1943) the 56th participated in an opposed landing “under artillery fire, strafing, and bombing by the enemy.” The 56th assigned detachments to support the 3d Infantry and 82d Airborne Divisions. It operated a holding station for air evacuation in addition to transferring patients to ships for sea evacuation.

10 July 1943:

Units of the 56th Medical Battalion ... landed on RED, GREEN, YELLOW, & BLUE beaches in the vicinity of LICATA, SICILY. The landing was made under artillery fire, strafing, and bombing by the enemy. The first units being litter bearer squads and forward Battalion C.P. landing at 0645. ... The Litter Bearer Sections on each beach established liaison with the Battalion Aid Stations of the 36th Engineer Regiment, and kept in contact with the Battalion C.P. throughout the day by telephone communication. They continued to aid the Navy Shore Parties in evacuation of beach casualties to Naval Craft for evacuation to the Near Shore (Africa) for the next 24 hours. ...

The trucks carrying the equipment of the 1st Platoon were not unloaded from LST's until about 1800. During this operation, the truck carrying the surgery was unloaded in about 7 feet of water, and this equipment, vital to the operation of the station, was recovered through the efforts beyond the normal call of duty of Lt. CAUGHEY, Cpl Anderson, Cpl Bess, and Pvt Reppert. Some of this equipment was damaged beyond ser-

viceability, and several items were lost.

At 2100 the 1st Platoon Clearing Station was established ... By 2400, four patients had been admitted, one being an American Soldier, and three British Sailors. [Clearing companies had around 120 cots, but could be expanded, 12 officers and 120 enlisted men. They were intended for low acuity medical and surgical support, and normally divided into two platoons. They are analogous to the Medical Company Area Support.]

Equipment and one-half of the Clearing Station personnel of the 2nd platoon aboard the LST's bound for RED beach could not be landed because of a rough sea. The other half...were able to land and proceeded toward LICATA ...

11 July 1943:

[The 56th provided vehicles to support 3d Medical Battalion.] The 2nd Platoon equipment arrived about 1600 and immediately ... set up in conjunction with the 1st Platoon and by 2400 this date, 143 Army, 15 Navy, 1 English, and 34 Enemy soldiers had been admitted to the station. The 2 Surgeries were operating continuously, and the two Surgical Teams attached were of much assistance and proved their worth. We were fortunate in having two excellent teams attached under the able leadership of Major HATT and Major PEYTON.

During this 24 hour period, 106 American Soldiers, 11 American Navy men, 3 English, and 22 Enemy wounded soldiers were evacuated to the Near Shore by the Navy.

During this day, the 10th Field Hospital set up just West of LICATA and a message was sent to the 3d Medical Battalion to evacuate their patients directly to the 10th Field Hospital as the 56th Medical Battalion Clearing Station was filled.

12 July 1943:

All the litter bearer sections rejoined the 56th Medical Battalion this date after giving a very creditable account for themselves. During this 24 hour period, there were 104 American Soldiers, 2 Navy men, 1 British, and 37 Enemy soldiers admitted to the Clearing Station. 96 American Soldiers, 6 Navy Men, 2 English, and 29 Enemy soldiers (all wounded) were evacuated to Navy Craft for transportation to the Near Shore.

13 July 1943:

Because of the near proximity of an ammunition dump, railroad now in use for handling ammunition, and a food and gasoline dump, the Battalion Commander issued Verbal Orders that the battalion would move to a new location. [It did explode later.]...

Admissions to the Clearing Station on this date included 72 Americans and 26 Enemy soldiers. Evacuation totaled 108 Americans and 22 Enemy soldiers. All were evacuated to Naval Craft.

14 July 1943:

[Most of the remaining personnel of the 56th landed, and a provisional clearing platoon went into reserve.] 55 American and 41 Enemy soldiers were admitted to the station this date. 45 American and 22 Enemy soldiers were evacuated. 25 of these being by air transport furnished by an [Royal Air Force] squadron. The remainder went to the Navy. This marked the first air transport of wounded from this sector.

15 July 1943:

Verbal Orders were received from the Division Surgeon to move a Clearing Platoon to the vicinity of NARO ... The 2nd Platoon of Company D and Company B were sent on the mission. ...

A message from the Division Commander stating recommendations for decorations would be made within 48 hours. In response to this message, Lt. CAUGHEY, Cpl Anderson, Cpl Bess, and Pvt Reppert were recommended for decorations.

Admissions for the day included 63 Americans and 25 Enemy soldiers. Dispositions for this day were 65 Americans and 23 Enemy soldiers to the Navy for evacuation ...

16 July 1943:

[Minor command changes were made and an ambulance section was moved.] 140 Enemy casualties were ad-

mitted and evacuated. 17 of these (seriously wounded) were evacuated by the 267th Air Transport Squadron R.A.F. and one American plane a B-26 [bomber, used as an emergency transport] #118326.

17 July 1943:

The 1st Platoon of Company D and collecting elements of Company C were attached to the 82d Airborne Infantry Division ... They joined this unit at 1600 in LICATA and proceeded to the vicinity just West of AGRIGENTO.

The Battalion C.P., Provisional Clearing Platoon, and Company B ambulance section moved to LICATA Airport and established a Clearing Section ... at 1900. [This was analogous to a medical air staging facility.]

Four American and three enemy soldiers were admitted on this date, and four Americans and three enemy [delivered to the] Navy.

18 July 1943:

Surgical Team from 3d Surgical Group attached to the Provisional Clearing Platoon... [The last of the battalion's vehicles arrived.]

Admissions: 7 American soldiers and 7 enemy soldiers. Dispositions: 7 American, 1 English, and 3 enemy soldiers ... From this date through 23 July 1943, the 2nd Platoon, 56th Medical Battalion evacuated patients to the 10th Field Hospital and the 11th Evacuation Hospital. [This was the start of a normal chain of evacuation from frontline to hospital rather than to North Africa.]

NOTE: There were a total of 6 deaths in the Clearing Station; 1 American, 1 English Navy, and 2 Enemy on July 10th and 11th. One American and one enemy on 13 July 1943.

19 July 1943:

Message received at 0100 from Captain JACKSON, Commanding Officer of Company D, said that the 2nd Platoon expected to move to a location North of FAVARA soon, continuing to service the 30th Infantry. This Platoon had 14 admissions for the day, one of which was a battle casualty.

[Despite a request from 82d Airborne, for multiple ambulances, there was only one available.] ... During this 24 hour period the 2nd Platoon of Company D admitted 21 American, 1 British, and 4 enemy soldiers. Evacuations for the period were; 3 Americans and 1 enemy soldier.

20 July 1943:

...Message sent at 1205 to Provisional Platoon to move to vicinity 10th Field Hospital North of AGRIGENTO and evacuate to 10th Field Hospital and PORT EMPEDOCLE.

Message received from 1st Platoon Co D attached to 82nd Airborne Division said they were expecting to move forward and requested additional evacuation [assets] from 56th Medical Battalion. 56th Medical Battalion unable to evacuate 1st Platoon Company D per VCOG 3rd Infantry Division (Reinforced) and they were so advised. Their evacuation to be accomplished by 7th Army.

Headquarters, Battalion Supply, and Provisional Platoon moved to vicinity 10th Field Hospital north of AGRIGENTO ... established at 1800.

Admissions for the day were 19 Americans. Evacuations were 16 Americans.

21 July 1943:

Message received from Division Surgeon at 1130 to move Headquarters, after 1700, to vicinity South of ALESSANDRA coordinating move with 10th Field Hospital, also moving North.

Verbal Orders received from Surgeon 7th Army to move Provisional Clearing Platoon with collecting element to AGRIGENTO Airport to handle evacuation by air and be attached to Headquarters and Headquarters Company 7th Army. [The 802d Medical Air Evacuation Squadron was now handling the air evacuation flights back to North Africa.]

[Most elements of the battalion moved forward.] Admissions to the 2nd Platoon of Company D for the 24 hour period were 11 American and 4 Enemy. Evacuation were 20 Americans and 2 enemy.

22 July 1943:

[The northward movement continued for most of the battalion.] ... Admissions for the day for this platoon were 6 American and 5 enemy. Evacuations were 10 Americans and 6 enemy.

23 July 1943:

Nothing of note. 17 U. S. Soldiers and 3 Italian soldiers admitted to 2nd Platoon Clearing Station. 14 U. S. evacuated and 4 enemy evacuated. Mostly minor ailments.

24 July 1943

Battalion Headquarters, Headquarters Detachment, and ambulance dispatching point moved to vicinity 2nd Platoon of Company "D", one mile South of MISILMERI and established at 1030. ...

The Provisional Collecting Clearing Platoon consisting of the station sections of the three collecting companies and four ambulances of the collecting platoon of Company "A", was operating at the AGRIGENTO airport. This platoon was attached to Headquarters and Headquarters Company, 7th Army. Operations of this platoon consisted of holding patients for air evacuations and loading them aboard planes for evacuation to the near shore.

The 1st platoon of Company "D" together with Company "C" collecting elements was attached to the 82nd Airborne Division and operating a collection clearing station for this division. [Airborne divisions had fewer medical assets, and thus needed additional medical support if combat was prolonged.]

The 2nd platoon of Company "D" was operating a clearing station one mile South of MISILMERI serving the 30th Infantry Regimental Combat Team.

Company "E" collecting platoon was operating an ambulance dispatching point in the vicinity of battalion headquarters, operating four company "A" ambulances and eight Company "B" ambulances serving the 3rd Infantry Division (Reinf.).

[The 56th was still missing elements designated for the second and third follow-up landing echelons.]

25 & 26 July 1943

Nothing of note. Operations continued.

27 July 1943

Battalion headquarters, Headquarters Detachment, 2nd platoon of Company "D", and Company "B" ambulance dispatching point were moved into the POLICLINICO in PALERMO establishing at 1300.

All headquarters concerned were advised of new location and a message was sent to Surgeon, 3rd Division advising him that the Clearing Station could take 100 patients, the facilities of the 91st Evacuation Hospital being limited. [7th Army had advanced rapidly and cleared the western end of Sicily. The 56th was more mobile than a hospital, and was able to follow the advancing troops.]

28 July 1943

On this date the units of the 56th Medial Battalion formerly with the 3rd Infantry Division(Reinf.) were relieved from attachment and reverts to 7th Army control.

The 7th Army Surgeon assigned the 56th Medical Battalion(-) to:

(1) Evacuate II Corps rear elements to PALERMO. Lieutenant Dalzell with eight ambulances and one 3/4 ton weapons carrier and transportation NCOs were ordered to PETRALIA to report to II Corps Surgeon.



Elements of the 56th at Agrigento airfield, 25 July 1943. Air evacuation was still unusual, attracting more photographers than other activities. U.S. Army photo.

(2) The 2nd platoon of Company "D" continued operations in PALERMO as a holding platoon for air and water evacuation to Africa. 56th Medical Battalion ambulances remaining in PALERMO evacuated clearing platoon and assisted evacuating the 91st Evacuation Hospital.

29 July 1943

Three ambulances and one 2½ ton truck with four enlisted men landed at PALERMO. Remainder of 2nd Follow-up landed at LICATA.

30 July 1943

56th Medical Battalion transportation landing at LICATA was mostly filled with 128th Evacuation Hospital equipment and Lieutenant Moore was instructed to take this equipment to CEFALU leaving Company "A" transportation with Company "A" at AGRIGENTO.

31 July 1943

Transportation and driver personnel arrived in PALERMO from CEFALU making 56th Medical Battalion transportation complete except for one command and reconnaissance car stolen in Africa prior to embarkation.

1 August 1943

Enemy made air attack on PALERMO harbor area. No casualties or damage to this battalion.

Company "B" headquarters and ambulance section (complete) was ordered to proceed to vicinity CEFALU to be attached to 128th Evacuation Hospital for rations and duty ... Four Company "A" ambulances were attached to Company "B". Company "B" was also ordered to lead hospital train at CEFALU each day and furnish medical personnel on the train. This train made one round trip each day between CEFALU and PALERMO during the remainder of the Sicilian Campaign. Capacity of the hospital train is approximately 300 patients. Company "B" established in the vicinity of the 128th Evacuation Hospital ...

2 August 1943

Nothing of note occurred. Operations continued.

3 August 1943

Portion of Company "B" ambulance section at PETRALIA moved to vicinity of SPERLINGA.

4 August 1943

Provisional Collecting-Clearing unit moved 100 men, tentage, and essential equipment including one ½ ton [command and reconnaissance] car and one water trailer, by air from AGRIGENTO to TERMINI airport. Remainder of the personnel, transportation, and equipment followed overland. The Provisional Collecting-Clearing unit returned to control of the 56th Medical Battalion upon arriving at TERMINI.



Elements of the 56th at Termini airfield. U.S. Army photo.

5, 6, & 7 August 1943

Nothing of note. Provisional Collecting-Clearing unit at TERMINI continued as a holding station for patients being evacuated by air to AFRICA.

8 August 1943

[Various battalion elements moved, but there were no notable activities.]

9 August to and including 17 August 1943

No changes during this period. Operations continuing. Sicilian campaign ends on 17th. Strength of this battalion during the campaign was 35 offices and 409 E.M. and 9 officers and 9 E.M. attached from the 3rd Auxiliary Surgical Group.

Also featured are articles about heroic units such as the 56th Medical Battalion and medical Soldiers from the 3d Infantry Division in World War I. The 56th saw extensive combat during World War II providing support to the 3d Infantry Division and 82d Airborne Division during four amphibious landings: French Morocco, Sicily, Anzio, and southern France. Recognized for their work during the Battle of the Marne (July 1918), nine medical personnel from the 3d Infantry Division earned the Distinguished Service Cross, and another nine earned the Silver Star. In 2018 Fort Stewart recognized their bravery with the dedication of both the Marne Medics Troop Medical Clinic and the Creighton Lane Dental Clinic.

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Photos of artifacts, with an explanation

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Material can be submitted usarmy.jbsa.medical-coe.mbx.office-of-medical-history@army.mil Please contact us about technical specifications.

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