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**The Coat of Arms Display Symbolism**

Heraldry

Distinctive Unit Insignia (DUI) are metal heraldic devices worn by soldiers to clearly indicate organizational affiliation. While unit crests may change with every assignment, regimental affiliation remains the same.

Heraldry has been defined as “picture writing with every symbol having definite significance.” The most important decorations and missions are shown in the design of the devices. Coats-of-Arms were worn by ancient clans to “spur their members to greater military achievement”, and to “bolster esprit de corps” and provide a unity of purpose. In the beginning, these designs were embroidered on a coat worn over the armor which gave the name “Coat-of-Arms”. Later, designs were added to the knight’s shield and the helmet crests. In the Middle Ages men wearing armor needed to be able to recognize “friend” or “foe” in the chaos of battle, and the symbolism was chosen to further intimidate enemies. These symbols need to face the “honorable” position of going from left to right to show they are in a position of advancing forward. A complete Coat-of-Arms consists of a shield, a torse, a crest, and a motto.

The crest is named after the Latin word “cresta” which is the tuft on the head of many types of birds. A crest is always placed on a wreath of six skeins or twists as a “torse,” originally a piece of cloth knights used to attach their crests to their helmets. When placed on the flag, the Regimental Distinctive Insignia is known as a “shield,” and can be two metals and eight colors with a variety of partition lines, with additional symbols placed between them. Additionally, all colors and symbols must be clear when reduced in size for other distinctive insignia.

Mottoes are even older than the Coat-of-Arms, and many started out as war cries. Mottoes are chosen as sincere expressions of an idealistic nature. The motto should be in a scroll below the shield, but not on the shield itself.

The AMEDD

Since 1775 a Hospital Department existed to support the Army, but the Act of April 14, 1818 created the Army Medical Department as a permanent and continuous Department. According to McCullough, Ashburn and Caples, the AMEDD Coat of Arms was most likely created in 1818 and follows European heraldry concerning colors and symbols. In 1986 the Army Institute of Heraldry approved a crest for the AMEDD Regiment.

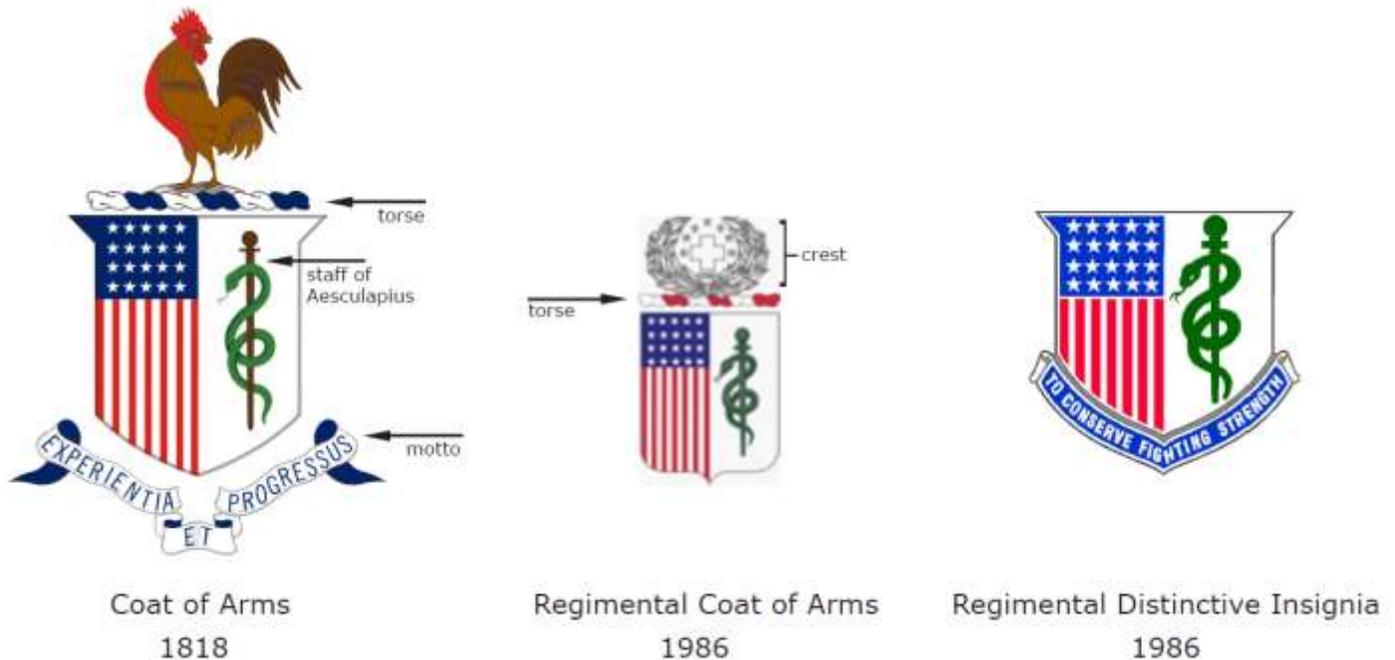
The rooster is associated with the ancient Greek and Roman god of healing and medicine, Aesculapius. He was the son of Apollo, and both Apollo and Aesculapius are mentioned in the Hippocratic Oath. The ancient Greeks believed that the rooster’s crowing at dawn drove away evil disease-spreading demons. Roosters were also sacrificed so their entrails could be examined for medical diagnoses. Roosters were sacrificed to show gratefulness to Aesculapius for treatments received, and ancient Greek healers were customarily paid with poultry.



The AMEDD’s 2014 Coat of Arms

Aesculapius's staff with a snake is also a symbol traditionally associated with medicine. Snakes have been symbols of wisdom, longevity, rejuvenation, ability to cure, and of convalescence, largely based on snakes' ability to shed skin. The color green was associated with the Army Medical Corps starting in 1847, and so the snake on the Coat of Arms is green.

The design of a shield is a historical choice; the twenty stars represented the twenty states in the Union in 1818 and the red and white stripes represent the stripes of the American flag.



The torse on the Coat of Arms shows alternating blue and silver colors which were the colors of the Army at that time. The torse on the 1986 Regimental Coat of Arms shows alternating maroon and white; in 1901 the AMEDD adopted the color maroon as representing the color of blood.

The crest on the Regimental Coat of Arms (as seen on the Regimental Flag) shows a wreath made of laurel, and a cross below an arc of seven stars. The Latin motto *Experientia et progressus* is meant to convey the steady and unflinching progress of the Army Medical Department since 1775. It also has been translated as "Let's do it better" or "Try and do it better." The motto "To Conserve Fighting Strength" was first adopted by the Medical Field Service School in 1921, and this was adopted for the RDI since it reflects the AMEDD mission.

One of the oldest Distinctive Unit Insignia in the U.S. Army is the Army Medical Department Coat of Arms. It helps us appreciate our ancestry when we remember that the Medical Corps was established in 1775, the Enlisted Corps came into being in 1887 (as the "Hospital Corps"), the Army Nurse Corps was established in 1901, the Dental Corps in 1911 and the Veterinary Corps in 1916. The Medical Service Corps forebears were established in 1917, the Medical Specialist Corps in 1947, and the AMEDD Civilian Corps in 1996. All military members of these corps are able to proudly wear the AMEDD Regimental Distinctive Insignia on their uniform, and the civilians can wear a miniature version of the insignia on their lapels.

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## FROM THE ARCHIVAL RESPOSITORY – NEW DONATION

### Short Snorters

On 13 April 2015, the ACHH Archival Repository received a rare glimpse into the life on MG Norman T. Kirk, Army Surgeon General from 1943-1947. His granddaughter drove from Boston to Fort Sam Houston, Texas with five boxes of photos and documents for donation. Within the great collection was a letter-size envelope with the inscription, “foreign money” but upon closer examination the item was something different.

There were five different currencies of foreign countries and on those bills were signatures. These are known as “Short Snorters.” **What are short snorters?** The tradition of the Short Snorters is said to have started in the 1920 by Alaskan bush pilots. Passengers and pilots traveling together would sign a banknote as a memento of their trip. This tradition carried over into World War II in which the flight crew and passengers would sign each other’s banknote to convey good luck to soldiers.



**How did they get the name “short snorter”?** Much like a challenge coin in the Army, if you signed the bank note and could not produce it upon request by another person on that flight, you owed them a dollar or a drink. The small amount of the alcohol was referred to as a short snort.

During World War II, Kirk visited the various theaters of the war. During some of his flights he participated in the short snorter tradition by signing and passing around a banknote.

Examining the signatures from the MG Norman T. Kirk collection, the following notable signatures are visible:

Henry L. Stimson, Secretary of War (1940–1945)

Dwight Eisenhower

John C. H. Lee, Deputy Commander of US Forces in the European Theater

Robert C. Richardson Jr., Commanding General of the Hawaiian Department/Military Governor of Hawaii

Raymond W. Bliss, future Surgeon General of the Army 1947-1951

Kester L. Hastings, future 35th Quartermaster General of the Army

H.T. Burgin, Chief Hawaiian artillery command

Paul R. Hawley, Surgeon for the European Theater of Operations

Robert G. Fergusson, Aide to MG Burgin and future commander of US Forces in Berlin

Earl Maxwell, surgeon United States Army Forces in South Pacific Area  
 Commodore John H. Magruder, Jr., USN  
 Elliott Cutler, Chief Consultant in Surgery in the European Theater of Operations  
 Harvey Bundy, Special Assistant for Henry Stimson and father of McGeorge Bundy  
 William H. Kyle, Henry Stimson's aide

## Introducing Bob Hope

Robert L. Ampula

Administrative Officer, US Army Medical Department Regiment

Bob Hope's USO shows are legendary among America's armed forces. Hope, along with his band and a rotating cast of patriotic entertainers, performed for American troops for half a century. His first USO show was 7 months before the start of US involvement in World War II and on his final tour he entertained troops in Saudi Arabia in 1990 during Operation Desert Shield. All of his shows brought a bit of home and some normalcy to American troops and allowed them a temporary escape from the daily rigors of life while deployed. In war zones, the shows also briefly allowed soldiers to forget the horrors and chaos of combat. Bob Hope hosted his first Vietnam Christmas show in 1964 and dutifully continued them each year until 1972. In December, 1967, Chu Lai, South Vietnam was the recipient of one stop on that year's Bob Hope Christmas show.

On the day of the show, troops lucky enough to attend piled into the area where the show was held and eagerly awaited the arrival of Bob Hope. The band had just finished playing a song, when out from the dark recesses of the stage strode a thin young soldier clad in jungle fatigues; he walked to the microphone and introduced Bob Hope to the throng of troops. As he walked off the stage, Hope grasped his hand and gave him a long hand shake. That soldier was a medical aidman with a cavalry platoon, SP4 Michael D. Esmond. Michael was given the honor of introducing Hope because of heroic actions he performed on 27 September 1967 for which he received the Silver Star. Hope said of Esmond, "You'll never catch him with a picket sign."

Michael D. Esmond was drafted into the Army in September of 1966 out of Philadelphia, Pennsylvania and trained as a 91B Medical Specialist. He arrived in Vietnam in August of 1967 and was assigned to a cavalry unit of the Americal Division. A little more than a month after his arrival in Vietnam, PFC Esmond went to the aid of sixteen soldiers who were pinned down by enemy fire in a rice paddy. Paying no heed to his own safety, and while under constant fire, he helped all the infantrymen out of the area to a place of relative safety. There he treated their wounds and evacuated the more seriously wounded. After the evacuation was completed, his vehicle moved to an area where the rest of the troop was under intense automatic weapons fire. Upon arrival, the enemy started a grenade attack that wounded the troop commander. Without concern for himself, PFC Esmond leaped from his vehicle and ran approximately 100 meters to treat the wounded commander, all while he was under heavy machine gun fire. As he was completing his treatment of the troop commander, another cry of 'medic' was heard. It came from a vehicle carrying the platoon's infantry squad which was hit by grenades. Five soldiers were wounded in the attack on that vehicle. Once again, without hesitation, PFC Esmond answered the call and started for the vehicle, which was 75 meters away. After only a few yards he was knocked to the ground and wounded by an enemy gre-



Bob Hope before the 1967 Chu Lai show.  
 Courtesy Esmond family.

nade. Despite his wounds, he got up and proceeded to the aid of his wounded comrades. After treating the 5 wounded, the vehicle in which he was originally riding was hit by grenades and machine gun fire wounding his platoon leader and machine gunner. Ignoring the grenades and machine gun fire, Michael braved his way to the vehicle and treated both men. Assured there were no additional wounded that needed attention, PFC Esmond then treated his own wounds. His heroism was why he was selected to introduce Bob Hope.

“You’ll never catch him with a picket sign.”

- Bob Hope

In February 1968 Esmond would receive a Bronze Star with “V” device for his actions on 9 November 1967. He would also earn his second Purple Heart during that action. On that day his troop was assaulting a fortified enemy position. During the initial action, PFC Esmond observed that a tracked vehicle had been hit by a recoilless rifle round with the crew all wounded. Immediately PFC Esmond ran across 100 meters of open terrain through intense enemy fire to aid the wounded. While administering aid to the more seriously wounded, he was himself painfully injured by fragments from a mortar round. Disregarding his own suffering, he treated each man and assisted in the evacuation of the seriously wounded. Only after being assured that all the wounded were evacuated did he accept treatment for his own wounds.

Michael left the Army in August of 1968 but remained in touch with many of the medics with whom he served in Vietnam. He routinely attended reunions and was active in the VFW. His training and experiences as a medic in Vietnam made him want to continue helping people. He subsequently attended school at Temple University on the GI bill and became a physical therapist. Michael married and raised three successful children. While he did not talk to his children much about his experiences in Vietnam until much later in his life, he proudly displayed his medals on the wall of his home and often talked fondly of the Bob Hope special.

Years later, Michael was asked to participate in a tribute to Bob Hope and his Christmas specials. You can see Michael at the 4:17 and 8:20 marks of this 10 minute video tribute to Hope <https://www.youtube.com/watch?v=ppA4qYF7ARo> The entire 90 minute television special of the 1967 Christmas tour that aired in January 1968, and includes all the stops on the 1967 tour can be viewed here <https://www.youtube.com/watch?v=8oy5rLICSk0> . Mike is seen at the 24:55 mark introducing Bob Hope.

Sadly, Michael passed away on October 14, 2013 and is buried at Washington’s Crossing National Cemetery in Washington’s Crossing, PA.



SP5 Esmond receives the Bronze Star, February 1968. Courtesy Esmond family.

## The Evolution of Medical Chevrons, 1851-1903

LTC (Ret) William K. Emerson

The first US Army hospital stewards were simply soldiers assigned to assist in a hospital or help an army physician. Post surgeons, with the agreement of the local unit commander, had soldiers assigned to medical duties. There was no special pay for hospital stewards until 1838 when congress authorized enlistment of men as stewards. Hospital stewards were classed as privates but for a while they drew 15¢ extra a day to recognize their special duties. These soldiers were the first men enlisted for the Medical Department in the 19th Century although there were no formal selection criteria. Some men appointed as stewards were druggists or otherwise had a modicum of medical training although most had no special skills. Musician Augustus Myers and dragoon Private James Bennett, are examples: they were simply appointed from the ranks but obviously had shown enough potential to be recognized.

The army further recognized the position in 1840, stating such men were “indispensable for troops on the march.” At the same time, stewards serving with more than one company received pay and clothing allowance equal to an infantry first sergeant while stewards serving with more than 4 companies had the pay and allowances of a sergeant of ordnance. Even so, the army failed to prescribe any special trim for stewards during this time so presumably they wore privates’ uniforms. In 1842 Congress prohibited enlistment or reenlistment of men to serve as stewards, so the status of those already in service was in limbo for several years. Given this lack of formal status, the 1847 regulations do not mention hospital steward uniforms.

Until 1851 stewards had no special insignia and wore the uniform of their assigned regiment. General Order No. 53, published in the fall of 1851, described chevrons for hospital stewards. This was the first time in many years the War Department had authorized insignia for enlisted men who were specialists. The Uniform Board that met early in 1851 had not considered insignia for hospital stewards. Joseph Eaton, an assistant surgeon from 1821 until his death in 1861, expressed his views to the 1851 Uniform Board. He noted that while the hospital steward enlisted as a private, “the regulations place him in a respectable and responsible situation....and they give him the pay and rations of a Sergeant...” After 1851 regimental commanders could not appoint hospital stewards; the Secretary of the War approved all hospital steward appointments, and assigned them to posts and not to units.

In a special meeting, board members promptly recommended a unique chevron for hospital stewards. In the nineteenth century the British and French alternatively influenced US military fashions. At this time the French styles were in vogue and so the new chevron for hospital stewards was similar to the French army’s upper arm oblique chevron for quartermasters. The new design elegantly incorporated a two-inch yellow caduceus on a “half chevron of emerald green cloth,” with 1/2-inch green edges, separated from the rest of the chevron by 1/2-inch yellow stripes.



Right: Civil War hospital stewards at Petersburg. Courtesy Library of Congress.

Left: A scarce gold-embroidered hospital steward chevron worn on the 1872 style dress uniforms until 1887. Author’s Collection.



The general design of the 1851 hospital steward's diagonal-pattern chevron continued unchanged through 1887. Even so, details changed.

For wear on service uniforms the yellow edge changed to chain stitching when the army began to use that manufacturing technique in 1872. The chevron was 1-3/4 inches wide and 9 to 10 inches long with a two-inch

long hand-embroidered caduceus. Hospital stewards wore the chevrons in pairs so they ran at an angle approximately 30° below the horizontal, with the top of the caduceus facing up and to the rear. When the War Department started to issue gold lace chevrons for dress uniforms in 1884 and 1885, hospital stewards' chevron replaced the yellow thread with gold.

In 1878 Congress created three classes of hospital stewards, first, second, and third, with different pay but the same insignia. The army allowed only one first class hospital steward at each post and in 1884 limited the total number of stewards to 140.

Brigadier General Robert Murray became Surgeon General in November 1883 and immediately began to request that Congress create a formal Hospital Corps for enlisted men. During Murray's tenure second class hospital stewards became known as acting hospital stewards and in June 1885 they were directed to wear the new red cross armband on the left coat cuff. The army had first prescribed the brassard in August 1884 for the left arm above the elbow for wear by all Geneva Convention neutrals, in addition to any chevron of rank. Local post commanders were empowered to appoint a soldier an acting hospital steward, and "if they are competent" they could later be promoted to hospital steward.

In early 1887, shortly after Murray's retirement, Congress formed a Hospital Corps of hospital stewards, acting hospital stewards, and privates. From then on hospital stewards had to meet many special requirements including serving at least one year as an acting hospital steward, passing an examination including principles of minor surgery, and "possess a thorough knowledge of the regulations of the Medical Department" as determined by a board of medical officers. These were the first formal qualifications for hospital stewards.



An 1887-1901 acting hospital steward chevron for blue service uniform. Author's collection.

When Congress created acting hospital stewards in 1887 the army gave medical NCOs distinctive chevrons. This resulted in two new point-down chevrons—one for hospital stewards that replaced the old half-chevron and one for the new rank of acting hospital steward. For daily wear cloth chevrons were three green V's with white trim and a red Geneva cross. Hospital stewards had a single arc above the cross while acting stewards did not. Dress uniforms carried chevrons of the same design but with gold lace bars on green cloth, with the usual red crosses.

It is questionable how often stewards wore these gilt chevrons as Hospital Corps members were not to march in reviews, parades, or similar functions. When post

personnel formed for a parade the one or two Hospital Corps members not on duty at the hospital were at the parade wearing their white ward uniforms in case soldiers needed medical assistance. In 1896 the Quartermaster General realized that Hospital Corps members did not use their dress uniforms because of this practice. As a result he withdrew dress uniform authorizations and issued additional white ward clothing, which in turn eliminated Hospital Corps gilt chevrons. In August 1896 the army discontinued dress uniforms for the Hospital Corps and directed the surplus gold chevrons be turned in. Those chevrons were sold at public auction in Philadelphia a few months later, making them scarce today.

The red cross armband had several titles and was worn by a variety of soldiers from 1884 through 1902. Between 1887 and 1901 Hospital Corps privates wore the white Geneva cross armband as their rank insignia, much to the chagrin of some soldiers. One soldier, who signed himself as "Too Conspicuous" in 1891, wrote a letter to the Army and Navy Register newspaper. While saying that on the field of battle the brassard couldn't be better, he



Between 1887 and 1896 hospital stewards wore gold lace chevrons of this design on their dress uniforms. Acting hospital stewards omitted the upper arc. Author's collection.

held that as part of the dress uniform, “in garrison it does not enhance the neatness of the dress one iota.” He then noted that on a recent practice march to Spokane, members of the corps were greeted by comments such as, “What’s the matter with your sore arm” and the like. He ended with a plea to make “some reform” and to



Members of the Fort Leavenworth Hospital Corps detachment, January 1897. Hospital Corps privates wore the armband with red cross to show their position even though their service uniforms also had trouser stripes and cap insignia showing they were members of the Hospital Corps. Many privates sewed their armbands onto their coats rather than simply pin them on. Courtesy Frontier Army Museum.

company-level commander, with the concurrence of the post surgeon, designated four privates to receive at least four hours of instruction each month in litter bearing and first aid. These soldiers wore the solid red armband on the left arm above the elbow to show their status. The army required bearers be men who could qualify as Hospital Corps privates so they could transfer to that corps if they desired.

In the late nineteenth and early twentieth centuries, medical officers wore a Maltese cross on their collar. The Surgeon General saw no reason why officers and soldiers performing the similar duties should wear different insignia. Accordingly in February 1901 a white-edged green Maltese cross replaced the red Geneva cross on chevrons.

The army severely limited each enlisted rank in each branch. For example the Regular Army did not have Hospital Corps corporals until 1903. Before 1901 a Hospital Corps soldier was a private, an acting hospital steward, or a hospital steward. The army’s trend toward chevrons for specialists resulted in the adoption of just a white-edged green Maltese cross as the sleeve insignia for Hospital Corps privates in February 1901. Previously they had no sleeve insignia.

wear the armband only in the field.

In February 1888, three years after hospital stewards stopped wearing the brassard as their insignia of rank, the army briefly directed that it be worn by company litter bearers on the left cuff. After this short use the army brought out a solid red armband that was used until 1899. This was for infantry, cavalry, and artillery enlisted men designated as company litter bearers. Each com-



A 15-inch long red wool armband for a company litter bearer, 1887-1899. These fastened with three japanned hooks to one of the two sets of corresponding eyes (the second set is underneath). Author’s collection.



Left: Chevron for a hospital steward, 1901-1903. In April 1903 the army changed the title of hospital stewards to sergeants first class, Hospital Corps. Author’s collection.

Right: A chevron for a Hospital Corps private adopted in February 1901. At the start of the Spanish American War the army began to use khaki uniforms and chevrons on a matching background. Author’s collection.



The army had allowed lance corporals for many years. The rank of lance corporal, an “acting corporal,” was first mentioned in 1820 when three officers were to meet “on the first day of every other month” to consider those soldiers who should be appointed a lance corporal. While the army provided no additional pay, regulations did call for lance corporals to be announced in orders, demoted only by a court, and to have “a distinctive badge” although that detail was not further explained. Early in the nineteenth century such appointments were important since regulations stated, “As far as practicable, the selection of corporals will be made from lance-corporals.” Regulations further noted that the position of lance corporal in the army was created as a “system for encouraging good conduct.” It would be 1890 before the army officially recognized the position of lance corporal with a chevron.

A Headquarters of the Army general order of November 1901 stated, “To test the capacity of privates of the Hospital Corps for the duties of noncommissioned officers, the Surgeon General and chief surgeons may appoint lance acting hospital stewards, who will hold appointments not to exceed three months and will be obeyed and respected as acting hospital stewards....” The November general order announced the lance acting hospital steward chevron was a single “V” in green cloth with white trim and a Maltese cross in the angle.

Hospital Corps corporal chevrons are known, but such chevrons must be allotted to some state militias. It would be 1910 before National Guard organizations had to be the same as the Regular Army. In April 1903 the War Department finally changed Hospital Corps enlisted rank titles to align with those of other branches. Hospital stewards became sergeants first class; acting hospital stewards became sergeants; lance acting hospital stewards became lance corporals. Only the names of these ranks changed—there was no change of chevrons.



Lance acting hospital stewards received chevrons in November 1901. A soldier was appointed to that position for three months to test his ability as an acting hospital steward. In 1903 acting hospital stewards became sergeants of the Hospital Corps and lance acting hospital stewards became lance corporals of the Hospital Corps.  
Author's collection.

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## Creating The MASH

Sanders Marble, Office of Medical History

In World War I, the Army created Mobile Hospitals to provide forward surgical care for the seriously wounded. The Army's interest was two-fold: it would save lives, and it would also speed return-to-duty for patients. After WWI, there was a short debate about whether to keep those specialty hospitals, which might benefit only 1% of patients, but the Army decided to keep them. They were retitled Surgical Hospitals, but none were organized or equipped until World War II. The Army's early ground campaigns in WWII, in North Africa and the Pacific, quickly showed the problems of the surgical hospitals. They were too large for Pacific islands, and Portable Surgical Hospitals (with only 20 men and man-portable equipment) were created. The 48th Surgical Hospital was deployed to North Africa, but proved a disappointment: with 400 beds it was too large to support one division, but if it was far enough back on the line of evacuation to utilize all its beds it was too far back to benefit patients needing prompt surgery. The theater surgeon, COL Frederick Blessé, extemporized a solution. He took a 100-bed platoon from the existing Field Hospital (which was a fully-functioning low-acuity hospital with organic transportation) and added surgical teams from Auxiliary Surgical Groups. The augmented platoons had everything they needed: surgeons; pharmacy, X-ray, and laboratories to support both pre- and post-operative care; doctors and nurses for post-operative care, and vehicles. They were also the right size to support an infantry division, and they were usually sited alongside the division clearing company – before helicopters, the key concentrating point in the chain of evacuation.

While the augmented field hospital was filling a vital role, it was still an improvisation and the Army sought a better way to perform the mission. There were several studies and proposals for surgical hospitals that would culminate in August 1945 with the MASH. Blessé (by now a brigadier general) had recommended the expedient in May 1943; in April 1944 he left the Mediterranean and became the Army Ground Forces Surgeon, in charge of organizing, training, and equipping units that would serve in forward areas. From that influential position, he



An operation at a Portable Surgical Hospital in Pacific theater. National Archives



An operation at the 11th Field Hospital, Sicily, 16 July 1943. National Archives

continued seeking a permanent organization. As

early as July 1944 he solicited opinions from the theater surgeons on a fifty-bed surgical hospital, and circulated a proposal in August. That proposal failed, but by mid-June 1945, Blessé had a new proposal for a sixty-bed surgical hospital, with surgeons assigned rather than attached from auxiliary surgical groups, nurses, x-ray capability, and its own trucks for full mobility. Blessé overcame opposition by Army Service Forces, largely by citing detailed personal discussions with most of the senior medical officers in Europe.

Initially, assigning rather than temporarily attaching surgeons proved the bone of contention. The civilian surgeons temporarily in uniform preferred augmenting surgical teams; these allowed elite surgeons to go where the action was and not waste their time and talents. In contrast, the Army saw no point in having a unit that was not mission-capable at authorized strength: a surgical hospital

without surgeons was a waste of all the other personnel and equipment and could represent false security if a commander saw that he had a surgical hospital without realizing it needed augmentation. Assigning instead of attaching the surgeons would solve that and avoid administrative problems. An initial meeting with colonels on June 14 only established the areas of dispute, and the next day the brigadier generals met to settle the matter. There was no question that a mobile surgical hospital was desirable, and the same points were again raised without resolution, except it was clear that the Medical Department was annoyed that Army Ground Forces was taking the lead. The Medical Department was given more time to consider the matter. The general surgery consultant, Lieutenant Colonel Michael DeBakey, used the time to solicit letters of opposition, getting Col. Edward Churchill (surgical consultant in the Mediterranean Theater, and a professor at Harvard Medical School) to oppose it. On August 11, the decisive meeting was held, chaired by Major General Russell Maxwell, a neutral referee from the General Staff, and Blessé carried the day. The AMEDD opinion was essentially unanimously against the proposed organization, with DeBakey giving most of the views against. However, Blessé had partially preempted the meeting by talking with Surgeon General Kirk, who thought the organization “desirable.” DeBakey sadly noted his “distinct impression” that the MASH would be approved as written, and it was published on 23 August 1945. DeBakey was still bitter the next spring, writing Churchill “this is an example of official blindness to facts bathed in the bright light of experience.” In light of his sustained opposition, it is unclear that how DeBakey came to be credited as the father of the MASH.

Whether or not the surgeons liked it, they would now be assigned to the MASH. The new unit would have six surgeons, five physicians for post-operative ward care, a radiologist, two anesthetists, twelve nurses, three administrative officers, and ninety-five enlisted men for 60 beds. Thus was the AMEDD’s most famous type of unit created, designed by a doctor but opposed by the AMEDD and the surgeon who would later get credit for it.

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This is extracted from Sanders Marble, “Forward Surgery and Combat Hospitals: The Origins of the MASH,” *Journal of the History of Medicine and Allied Sciences*, 69/1 (January 2014), 68-100.



BG Frederick A. Blessé  
US Army Military History Institute



A MASH in Korea. National Archives.

## Giants of AMEDD history

*First in a series of biographic sketches of people who have made significant contributions to Army Medicine*

Just as learning a patient's medical history is an important step in understanding their current condition and creating an effective treatment plan, the Army Medical Department's history is a necessary component in understanding the source of our corporate values, the successes and failures of our past, and identifying the decisive points that have led to improved support to our patients, our Army, and our nation. Without a sense of our history, all problems seem novel, as do the solutions we devise, without sense of whether those solutions have been tried before, whether they succeeded or failed, and why, if they succeeded, they were subsequently abandoned. The sum of our collective effort is reduced to individual experience.

If you are reading this, then you are amongst those who understand that the study of history broadens our experience beyond what we can hope to encounter on our own. It is not, however, enough to be satisfied with our own recognition of this fundamental truth. We must lead others to this realization by sharing our history, and our pride in the accomplishments of our organization. Leaders, mentoring their subordinates, should encourage historical study as a means of self-development.

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### John Shaw Billings, 12 April 1838 – 11 March 1913

Lewis Barger, Office of Medical History

Hospitals of the Army Medical Department frequently memorialize AMEDD members who have made significant contributions to medicine, played a major role in the leadership of the department, or have performed noteworthy acts of valor. Jonathan Letterman, Walter Reed, William C. Gorgas, Merritte W. Ireland, George M. Sternberg, and William Beaumont are well-known for the contributions they made to Army Medicine. During World War II, the general hospital at Fort Benjamin Harrison was named for LTC John Shaw Billings, whose name should be as familiar to members of the AMEDD as Reed and Beaumont. William H. Welch called Billings' work "probably the most original and distinctive contribution of America to the medicine of the world." Just over a century after his death, though, Billings' contributions go largely unremembered within the AMEDD.

Many of Billings' lesser achievements were still significant. While working in the Surgeon General's Office, Billings mentored and encouraged a former Census Bureau employee, Herman Hollerith, who developed machines to compile census data. Hollerith's machines were used to automate census data tabulation for the first time in 1890. Later Hollerith's company merged with three others to form the company that would eventually be named the International Business Machines Corporation, IBM. Billings laid out the design criteria for the Johns Hopkins University hospital and established the principals for operating the Johns Hopkins medical school. When Abraham Flexner released his groundbreaking report on medical education in the US, Johns Hopkins was held up as the ideal which all other medical schools should emulate; the original hospital building at Johns Hopkins now bears Billings' name. After his Army retirement, Billings orchestrated the reorganization of separate libraries into the New York Public Library system and designed the central library building, serving as director until his death. Billings' most important work, though, took place while he was librarian of the Surgeon General's Library.



John Shaw Billings. National Library of Medicine.

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Billings joined the AMEDD during the Civil War. He was appointed an Assistant Surgeon in April 1862 and successively commanded several hospitals in Washington, DC and Philadelphia before being assigned to the 11th Infantry Regiment in the Army of the Potomac shortly before the Battle of Chancellorsville. Billings later described his service as a surgeon as “a postgraduate course in surgery... a long, weary course.” In December 1864, after being appointed to positions of increasing responsibility, he was reassigned to the Surgeon General’s Office as a staff officer and the librarian, initially taking charge of about 2,300 volumes. Librarian was initially only one of Billings’ responsibilities, which included collecting and collating data from the field, resulting in two substantial publications: *A Report on Barracks and Hospitals, with Descriptions of Military Posts* (1870); and *A Report on the Hygiene of the United States Army with Descriptions of Military Posts* (1875).

The Surgeon General’s Library was established in 1836, part of an initiative to procure up-to-date medical texts and send them to the Army’s surgeons who were mostly posted to remote locations, had no colleagues to consult, and lacked reliable reference materials. By the beginning of the Civil War the Surgeon General’s Library had accumulated 600 or so items but would expand significantly by the end of the war. The vastly expanded Medical Department needed more books; the Surgeon General and his staff needed reference material; and research material aided the production of the *Medical and Surgical History of the War of the Rebellion*. Billings saw potential for creating more than the existing hodge-podge collection of medical texts, journals, and monographs and convinced Surgeon General Joseph Barnes they could create a comprehensive repository of medical information – a national medical reference library. Winning Barnes’ approval, Billings began identifying publications to acquire. With a limited budget, Billings solicited donations from publishers and institutions, and enlisted the aid of Army and civilian physicians throughout the country and abroad to build the collection.

In 1872 Billings prepared a one-volume catalogue of the library’s books and pamphlets, listed alphabetically by author and including a subject index. Two years later he began preparing indices for the journals, creating individual cards for articles that listed a full citation as well as categorizing the article under a broader subject heading. The following year, 1875, Billings sent a sample of the entries he had prepared, from Aabec to Air, to the Government Printing Office, producing a *Specimen Fasciculus of a Catalogue of the National Medical Library*. It was a deliberate, significant step towards publishing a full catalogue of the library’s holdings. He had produced more than a simple inventory, though. The *Specimen Fasciculus* included two types of headings in its listing. Author headings listed the author and all of the author’s books or monographs; journal articles were not indexed by author. Subject headings listed all works, including journal articles, which focused on a particular subject. Subject entries were organized anatomically, and cross-referenced, enabling a physician researching the literature to identify monographs and journal articles related to the subject of his inquiry. All of the entries, both authors and subjects, were included alphabetically rather than printed in separate sections for authors and subjects. Thus, shortly after the entry for “*ABBOTT (Samuel Warren)*” which listed only Abbott’s thesis, the entry for “*ABDOMEN*” began, running on for about 13 pages. Abdomen was divided into 23 subcategories (*Abscess of, Anatomy and physiology of, Bandaging, etc.*), each of which included (as applicable) cross references to other entries, a list of monographs on the subject, and a list of pertinent journal articles. Just one of the subcategories, “*Abdomen (Diseases of)*,” included a cross reference to the subject heading “*Digestive Organs (Diseases of)*,” followed by listings for 36 monographs or volumes and 21 journal articles.

*Do some research:*

<http://indexcat.nlm.nih.gov>

Developing subject classifications as a means of organizing information was not a new idea, but neither was it standardized. The *Specimen Fasciculus* came off the press the same year that Melvil Dewey first proposed his decimal system for organizing library collections and 21 years before the Library of Congress classification system was implemented. Billings also was not original in wanting to create a bibliography of the published literature. Instead, Billings’ great contribution lay in the scope of the work he proposed, tied to his

continuous enlargement of the library's holdings. A comprehensive catalogue to that ever-growing collection, systematically indexed by subject and author, could provide the whole profession with information about the body of published work, otherwise unobtainable to most practitioners. The catalogue of the library's holdings was the exportable companion resource to the physical collection, not just for the Army's few doctors, or those who could travel to the library, but for the world's doctors, researchers, and medical educators. Billings, in his preface to the *Specimen Fasciculus*, identified the most difficult task for the individual doctor: that of knowing what had been published in the rapidly proliferating number of medical journals. Billings aimed to solve that problem with the catalogue.

All medical writers know that the most valuable part of medical literature consists of the records of cases and original observations, and that, for the present century, the greater part of such records are contained in periodical publications. These are difficult to obtain and preserve, occupy a large amount of space, and, even when accessible, require much time and labor to consult. It is not very difficult, although rather expensive, for a physician who is interested in a particular subject to obtain all the really important monographs relating to it; but that which he cannot obtain, and which he must look to large public libraries to supply, are the journals and transactions containing the most valuable data for his purpose. (*Specimen Fasciculus*, page iv)

Billings received permission to move forward with creation of the catalogue, which he estimated would require five volumes, each of about 1,000 pages. The first volume, A. – Berliński, of the *Index-Catalogue of the Library of the Surgeon-General's Office, United States Army* was published in 1880. For comparison, the subject heading "ABDOMEN" increased from 23 to 32 subcategories and from 13 to nearly 27 pages. The subcategory of "Abdomen (*Diseases of*)" expanded its cross references to "Digestive organs, Intestines, Peritoneum, etc., *Diseases of*; Portal vein (*Inflammation of*)," added 12 more book and monograph listings, and 24 additional journal articles, reflecting the continuing increase in the library's holdings. Billings estimated that the library held about 80,000 volumes and pamphlets in 1875, a number which increased to about 100,000 before the first volume of the *Index-Catalogue* was published and would total about 300,000 by 1895 when the last volume of the first series was printed.

Billings' initial estimate of five volumes was low. Between 1880 and Billings' retirement from the Army in 1895, 16 volumes were published with nearly a million entries. Yet even as he was preparing the first volume Billings recognized the *Index-Catalogue* would never keep up with the new journals the library was receiving. In fact, each volume of the *Index-Catalogue* was out of date nearly as quickly as it had been published, and as soon as one series of volumes was completed, a new series would have to be started, adding new publications.

## Abdomen.

See, also, Pelvis; Peritoneum; Viscera.

DRIESSEN (P.) \* Exhibens et icono illustrans nervos musculorum abdominalium et superficiei inguinis. 4°. Groningæ, 1775.

GAZZA (F. N.) \* . . . II. Quello est la disposition des aponévroses de la paroi antérieure de l'abdomen? . . . 4°. Strasbourg, 1838.

GLISSONIUS (F.) Tractatus de ventriculo et intestinis. Cui præmittitur alius, de partibus continentibus in genere; et in specie, de iis abdominalis. 4°. Londini, 1677.

HOOPER (R.) Anatomical plates of the thoracic and abdominal viscera, . . . 3. ed. 12°. London, 1809.

KAUFFMANN (J. E.) \* De præcordiis. sm. 4°. Erlangæ, [1753].

LUDWIG (C. F.) Icones cavitatum thoracis et abdominis a tergo apertarum. fol. Lipsiæ, 1789.

LUDWIG (C. G.) De situ viscerum in infimo ventre nonnulla proponit. 4°. [Lipsiæ, 1755.]

VON LUSCHKA (H.) Die Lage der Bauchorgane des Menschen. fol. Carlsruhe, 1873.

PLEENN (J.) \* De mechanismo musculorum abdominalium. 4°. Halæ Magdeb., [1736].

SYLVIUS (F. de le Boc). Dictata ad Casparis Bartholini Institutiones anatomicas. Liber I. De infimo ventre.

In his: Opera omnia. fol. Genevæ, 1681. pp. 675-682. Not otherwise published.

Abdomen. Dict. de méd., Par., 1822, i, 102-223.—Axenfeld et al. Abdomen. Dict. encycl. d. sc. méd., Par., 1859, i, 72-194.—Béclard & Berard. Abdomen

In all, sixty-one volumes were published with a total of nearly 3.8 million entries between 1880 and 1961 when publication of the *Index-Catalogue* ceased.

While the *Index-Catalogue* proved to be an immensely important tool for surveying the material published on a given subject, it suffered from the amount of time that it took to prepare each volume. In any volume, only a fraction of the entries would have been published in the preceding year or two while the growing number of medical publications produced a similarly burgeoning number of backlogged entries awaiting publication. By 1920 the backlog had grown to a million and was expected to reach two million in 1951. In 1950 the decision was made to stop producing the *Index-Catalogue*. The library's staff continued to produce volumes with previously indexed material, but the last volume of Series 4, Mh-Mn was published in 1955. A special three-volume series of monograph entries was produced between 1959 and 1961, completing the publication of the *Index-Catalogue*.

To address the problem of keeping physicians abreast of the latest literature, Billings began preparing what was originally intended as a supplement to the *Index-Catalogue*, the *Index Medicus*. This would eventually eclipse the *Index-Catalogue* in importance and become a stand-alone publication in its own right. *Index Medicus* was published monthly and was printed in partnership with various civilian publishing companies which bore the cost of printing. Instead of the Author-Subject listing found in *Index-Catalogue*, *Index Medicus* only had subject headings, facilitating quick arrangement of material for publication. The last issue of the year included an alphabetical subject index and list of authors, with twelve issues completing a volume. *Index Medicus* was never intended to enable a physician to search the full body of literature – that was the purpose for the *Index-Catalogue*. *Index Medicus* kept physicians apprised of the most recent medical literature, and for that reason strived to maintain the shortest possible interval between the appearance of an article in a journal and its inclusion and publication in the *Index Medicus*.

Eventually, though, the sheer number of new publications overwhelmed the staff at the library and a backlog began to accumulate. Beginning in 1920 the *Index Medicus* switched to a quarterly publication schedule and in 1927 merged with an American Medical Association publication to create the *Quarterly Cumulative Index Medicus*. For five years the library continued to provide indexed material, then the AMA completely took over the *QCIM* and the library focused on producing the *Index-Catalogue* until 1960 when librarians of what was by this time the National Library of Medicine returned to publishing the *Index Medicus*. In 1964 NLM contracted for the creation of an early digital database, the Medical Literature Analysis and Retrieval System (MEDLARS). The following year, the database was searched 1,800 times. By 1971, that number was over ten times that amount. By today's standards those numbers seem low, but this system predated the internet, and searches could only be performed on terminals with a direct connection to the NLM computer. MEDLARS transitioned into MEDLINE, NLM's digital database of indexed publications and in 1996 the introduction of PubMed made the MEDLINE database freely accessible to anyone with an internet connection. Billings' vision of providing medical professionals with a simple way to stay current with medical literature and to look back at the body of medical literature on a given subject has been realized to a degree that even he could not have imagined when he began.

Given the magnitude of Billings' contribution to medicine, why then is his name unknown to most members of the AMEDD? We can point towards a number of reasons. First, the medium in which Billings worked has been largely supplanted by other forms of information storage and retrieval. Although he initiated the project, it has evolved beyond what he originally conceived. Professional articles now include abstracts, keywords, and metadata that simplify placing them into an automated database. While Billings was the progenitor, many people have contributed to create the system now in place.

Secondly, the Surgeon General's Library became the National Library of Medicine. Billings' vision for a "National Medical Library" eventually proved to be more than the Army needed or something it could afford. By the 1950s many people insisted that the library was a national resource that must be maintained, but few were willing to find space in their budget to do so. In 1956, Congress transferred the library to the National

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Institutes of Health in the Public Health Service, formally establishing it as a national library. Billings' portrait hangs in the library's main reading room, but few members of the AMEDD go to the library or even know that it once was operated by the Army Medical Department.

Third, the better recognized names mentioned at the beginning of this article were, or continue to be, associated with well-known hospitals or other Medical Department institutions. Letterman and Walter Reed Army Medical Centers and Gorgas Army Hospital have closed recently enough that people still remember them, or know people who served in them. Sternberg General Hospital in the Philippines has been closed for a longer period, and his name is fading from our collective memory. Ireland's and Beaumont's names continue to be memorialized at Fort Knox and Fort Bliss, respectively. Billings Hospital, on the other hand, was open for only a few years, closing shortly after World War II. We are only likely to encounter Billings' name if we take an interest in our own history..

It is this last point that bears the greatest consideration. There is no shortage of biographical material for John Shaw Billings, and much is available on the internet. That which has not been rendered in digital form can easily be found through online searches of IndexCat, the online successor to the *Index-Catalogue*, and PubMed. The problem, though, is the same that faced Billings as he attempted to catalogue the important medical knowledge of his time. The ever increasing number of new publications eventually overcomes the medical practitioner's ability to master them, and the effort to remain current eventually makes studying history appear to be an unaffordable luxury. This is unfortunate. Individuals like John Shaw Billings serve as our exemplars. We should take pride in his achievement, for we are in the same long line of individuals that together form the Army Medical Department. We should also be encouraged by Billings' example, and urged to excel, as he did, as we strive to sustain and improve the quality of Army Medicine today and in the future.

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## **Conference Call for Papers and Panels "A Medical History of the Vietnam War"**

On March 10-12, 2016, the Vietnam Center and Archive at Texas Tech University, USUHS, and the Army ACHH will be co-sponsoring a conference on the medical history of the Vietnam War. This two-day conference will be hosted at the Doubletree Hotel, San Antonio, Texas.

Presentations on all facets of medicine and healthcare related to the Vietnam War are welcome to include historical understandings of military medicine as practiced by all participants and in all geographic regions, the repercussions of the war on the practice of medicine, medicine in various campaigns, medical care outside of Vietnam, effects on the home front, postwar medical issues, mental health issues, and related topics.

Conference organizers welcome both individual presentation proposals as well as preorganized panel proposals that include two to three presentations. Conference sessions will follow the standard 90 minute format to include one hour for presentations and 30 minutes for questions and discussion. Presentations by veterans are especially encouraged as are presentations by graduate students. All of the conference organizers are partners with the Department of Defense's Vietnam War Commemoration. In keeping with that partnership, there will be a dignified event to thank veterans for their service.

**Proposal submission deadline is October 31, 2015.** Please send a 250 word abstract and separate two-page CV/resume to [steve.maxner@ttu.edu](mailto:steve.maxner@ttu.edu). If submitting a panel proposal, please include separate abstracts for each proposed presentation and CVs/resumes for each speaker.

Thank you for your interest in participating in this conference.

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## Leather Elbow Patches on Desert Camouflage: The History Collectors

Scott C. Woodard, Office of Medical History

Two historians from the US Army Medical Department (AMEDD) Center of History and Heritage recently deployed to Kuwait and Afghanistan where they conducted oral history interviews, and collected documents and artifacts capturing the military medical transition in the Central Command Area of Operations. United States and North Atlantic Treaty Organization (NATO) allies have transitioned from offensive and stability operations to a training, advisory and assistance role. This mission preserved that story.

Official Army history is often written 20 – 30 years after the event. Just like intelligence data is collected before it is analyzed, history is often gathered and archived for later analysis. Army historians are able to quickly gather timely primary source information by conducting oral history interviews with actual participants in a military conflict. The soldier does not have to spend hours writing memoirs or filling out reports. These recordings are transcribed and cataloged for future research and writing. Documents related to the mission or “soldier life” are obtained for the Office of Medical History Archives, and equipment and supplies are gathered for display at the AMEDD Museum.

Sanders Marble and Scott Woodard from the Office of Medical History completed deployment training at the Continental United States Replacement Center at Fort Bliss, Texas and traveled to Camps Arifjan and Buehring in Kuwait for the first leg of their mission. Here they interviewed soldiers involved in missions ranging from the strategic coordination and planning of surgical assets within theater to conducting tactical-level environmental sampling in support of Operation Inherent Resolve.

### Unit Interviews in Kuwait:

3d Medical Command (Deployment Support) Operational Command Post (Forward)  
 Army Central Command - Surgeon's Office  
 223d Medical Detachment (Preventive Medicine)  
 21st Combat Support Hospital  
 581st Area Support Medical Company  
 Area Support Group-Kuwait

The next phase of the team’s mission was in Afghanistan where they witnessed the transformation from Operation Enduring Freedom to Operation Resolute Support. Travel included Bagram Airfield, North Kabul International Airport, New Kabul Compound, International Security Assistance Force Headquarters, and the Afghan National Army Medical Command Depot. Here the stories ranged from details of the interworking of NATO and the Afghan Ministry of Defense from the senior American doctor in country to the personal experiences of a newly graduated licensed practical nurse in a forward surgical team.



Medical Logistics Warehouse Receiving and Distribution Point, Camp Arifjan, Kuwait

### Unit Interviews in Afghanistan:

Task Force 31 Medical/31st Combat Support Hospital  
 Combined Joint Special Operations Task Force-Afghanistan  
 Combined Joint Task Force 10/Regional Command-East  
 172d Medical Detachment (Preventive Medicine)  
 379th Blood Support Detachment  
 257th Medical Company, Dental Services  
 72d Medical Detachment, Veterinary Service Support

51st Medical Company (Logistics)  
 182d Medical Company, Area Support  
 911th Forward Surgical Team  
 United States Forces-Afghanistan  
 Joint Theater Trauma System  
 International Security Assistance Force Joint Command  
 North Atlantic Treaty Organization Special Operations Command-Afghanistan  
 International Security Assistance Force, Medical Institutional Advisory Team  
 International Security Assistance Force, Ministerial Medical Advisory Team  
 Afghan National Army Medical Command  
 International Security Assistance Force Multinational Medical Facility Role III  
 528th Combat Operational Stress Company  
 United States Army Medical Center-Southwest Asia  
 45th Sustainment Brigade (Central Command Materiel Recovery Element)

Dr. Marble gave two presentations on World War I Army medicine to hospital staffs in Kuwait and Afghanistan and Mr. Woodard presented the history of forward surgery culminating with the mobile army surgical hospital.

In all, representatives from all of the AMEDD Corps were interviewed in addition to Civilian Corps, US Air Force, US Navy, United Kingdom, Afghan Army, and contracting personnel. In gathering the medical story, there are gems that need to be preserved. While collecting history, we are able to gain insight into the decision process made to equip the MV-22 Osprey with medical equipment because UH-60 Black Hawk air ambulance helicopters on hand could not fly distances required for patient evacuation. We get answers from a medic or surgeon who answers the question, "How do you deal with the blood and chaos?" Inherent in the transition in Afghanistan is the retrograde of medical equipment and supplies. We get answers as to where, how, and why certain dispositions are made. Other times we will even have tales and comparisons told of humorous or sad stories from previous combat deployments. Sometimes the historian is actually a part of history when the artifact collected was used during a witnessed mass casualty.

Have you told your story and/or donated an interesting item from your experience? Contact the AMEDD Center of History and Heritage and help preserve our collective heritage – it's free.



Convoy briefing, New Kabul Compound



Combat medic ambulance platoon members, 182nd Area Support Medical Company (l-r) SPC Timothy James, SGT Justin George, SGT Barry Lima, Jr. Immediately after this photograph was taken, incoming indirect fire impacted across from the airfield to the left of the soldiers. Bagram Airfield, Afghanistan

## ***Skilled and Resolute* Book Review**

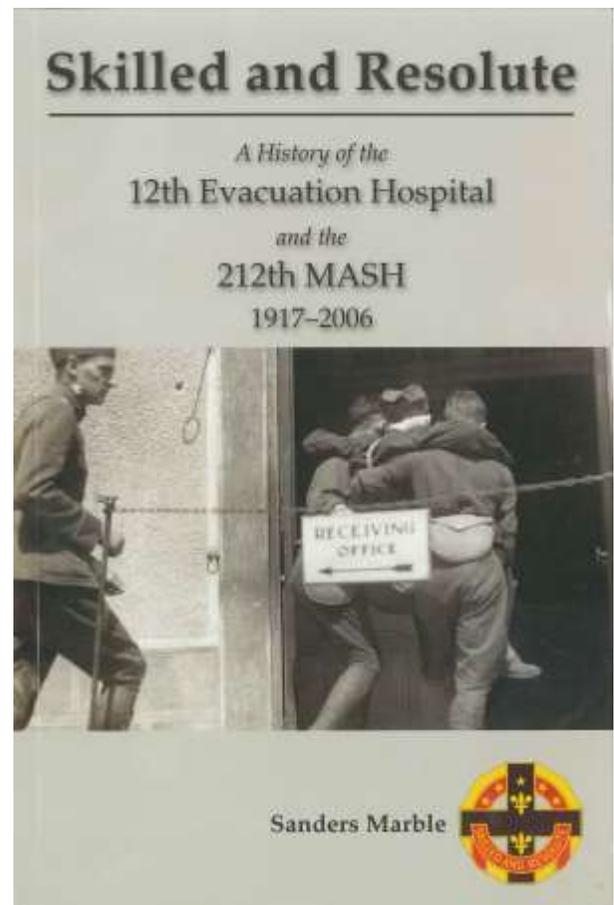
COL Betsy Vane, Army Nurse Corps Historian

*Skilled and Resolute* chronicles the history of the 12th Evacuation Hospital which then became the 212th MASH and covers the years from 1917-2006. The book encompasses ninety years of “who we are” and “what we do” as health care professionals on the battlefield, and with humanitarian and peacekeeping missions. The chapters are supplemented with excellent maps, diagrams, photos, abbreviations and acronyms and a list of all oral histories.

*Skilled and Resolute* is chronologically organized encompassing service in WWI, WWII, The Vietnam War, Operation Desert Shield/Desert Storm, the Balkans, and Operation Iraqi Freedom. Marble outlines the chapters in a clear narrative style while he explains the strategic and technological importance of a mobile hospital. Additionally, he ties in the socio-political and environmental contextual elements with the type of trauma care available at each time period, and has blended official interviews, books, and files with many oral history accounts to help readers better understand the progress made by the AMEDD’s oldest mobile/deployable hospital unit.

Perhaps the books’ strongest feature is the detailed descriptions of mobile medical care that transformed with each conflict. Much change over ninety years with regard to military force structure and doctrine, along with medical military technology and advances. Over the years, military medical capabilities have increased so that more lives can be saved on the battlefield. Understanding that context while seeing the details of life and medical care throughout those times provides a fascinating picture of military innovation, leadership, and caring and Dr. Marble expertly weaves numerous eyewitness accounts into the chapters, providing welcomed additions and a virtual account of the challenges and successes of providing medical care in this mobile environment. This book addresses how education, training and experience can help staff’s actions remain within the commander’s intent and in support of the overall objectives while remaining flexible and responsive for quality patient care solutions.

*Skilled and Resolute* remains the motto of the U.S. Army’s oldest deployable hospital and illustrates how it gave the best care for its time and remains effective today no matter the mission or the locations. This book is highly recommended for those studying the best way to provide quality medical and surgical care to warriors and other designated patients as soon as it is needed whether in combat, peacekeeping or humanitarian environments. In approximately 250 pages of *Skilled and Resolute* we can walk alongside these caregivers and reflect on their life, times, challenges, and successes. Dr. Marble reminds us that much of this practical information can help health care providers of today, not only in appreciating AMEDD history and heritage, but in planning and responding to current situations.



## The Hospital Steward of the American Civil War: Pharmacist, Hospital Administrator, or Nurse?

William T. Campbell, Ed.D., RN, Salisbury University

### Part I

In any US Army General Hospital during the American Civil War one would find an assortment of medical staff and support workers. There would be a Surgeon, and some Assistant Surgeons and Acting (Contract) Surgeons. Assisting them would be detailed male nurses, primarily convalescent or invalid soldiers, and female nurses who were usually volunteers, or religious sisters, or a paid Dix nurse. In addition there would be an assortment of orderlies, attendants, ward masters, cooks, laundresses, matrons, guards, and lastly the sole Hospital Steward. If there were more than 150 beds there was a second Hospital Steward and a third if it was over 400 beds, but that was few enough stewards; they were undermanned and always overworked. Stewards worked not only in hospitals but were also assigned to combat regiments and ships, so they were found assisting the surgeon with the regiment on the march, in camp, on the battlefield, and on board naval ships.

Finding a good steward was not easy; few men had the technical knowledge of pharmacy from civilian life. Pharmacy was not seen as a science until 1868 even though the Philadelphia College of Pharmacy had been educating these men in civilian life since 1821. At the time of the Civil War pharmacists were commonly seen as the druggist/chemist and often the hospital administrator. He was the druggist or chemist who worked in the civilian apothecary shop or hospital dispensary. He compounded prescriptions – even making the drugs from raw materials – rather than simply filling prescriptions from big bottles of pills. The term Hospital Steward was replaced with Pharmacist in the Army in 1902. If assigned to a hospital he was also the hospital administrator. He functioned as the clerk, the chief operating officer, and even the chief financial officer, with day-to-day oversight of the Hospital Fund. These men were in great demand in both the military and in civilian life. Their demand was so high that the commonwealth of Virginia petitioned the Confederate Congress that civilian druggists or chemists not be allowed to volunteer or be drafted as they were needed in the community. There were only 45 pharmacists in the entire commonwealth and during the war they were needed not only to compound and distribute medicines, but with the blockade in place they were also needed to manufacture medicines.

Many of these men have interesting and unique stories to tell. Hospital Steward W. Moore Smith (59th and 71st Pennsylvania Infantry) served at Gettysburg and faced the care of overwhelming casualties. Hospital Steward Perry W. Bahl (16th Ohio Infantry) was wounded at Fort Gibson, Mississippi, one of many medical personnel injured during the war. Pvt. Harlan Goodell (7th Massachusetts Light Artillery) was discharged for disability, but stayed on and volunteered as a hospital steward/nurse/clerk at Higgins Hospital at Fort Monroe, VA. Stewards had non-clinical duties familiar in the Army today: Steward William A. Bulkley, at Satterlee Hospital in west Philadelphia, found himself detailed as the unit postmaster, and Steward Theodore St. Clair (also at Satterlee Hospital) was ordered to be the Inspector of Police.

Some considered steward to be a desirable position. Charles F. Beal, Acting Assistant Surgeon at Dunbarton Street Hospital in Georgetown, Washington DC, tried to explain to his father in a letter dated 1 January 1863 that he had resigned his surgeon's position and applied to be a Hospital Steward in the Regular Army. He said the position was very difficult to obtain and he had gathered recommendations from three surgeons in preparation for his application. Hospital Steward R. C. Underwood, born in Georgia, enlisted in the US Regular Army and served in the post hospital at Fort Delaware, on Pea Patch Island in the Delaware River. While safe from the battles he still did not survive the war, dying of consumption (tuberculosis) while on Pea Patch Island and is one of 135 Union soldiers buried at Finns Point, NJ. Steward M. B. Summer



Steward Bahl, 16th Ohio Infantry.  
Author's collection.

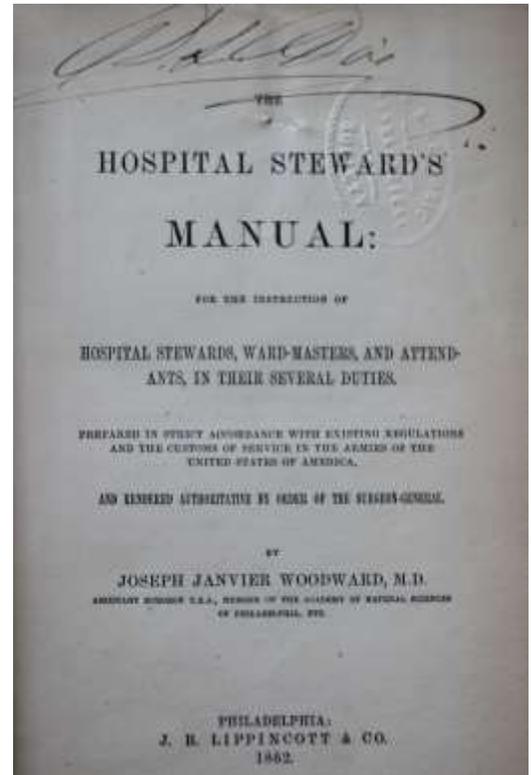
(13th South Carolina Infantry, CSA) was captured near Gettysburg on 5 July 1863 at the Samuel Lohr Farm Hospital. He also did not survive his days of imprisonment on Pea Patch Island, dying of smallpox on 13 September 1863 and is one of 2436 Confederate POWs buried in a mass grave at Finns Point. Many others, with equally interesting stories, remain nameless.

The first authority and primary reference on hospital stewards was written by J.J. Woodward, *The Hospital Steward's Manual: For the Instruction of Hospital Stewards, Ward Masters, and Attendants in their Several Duties*. Dr. Woodward was an Assistant Surgeon in the US Army, and was requested to write the manual by the Army Surgeon General. Woodward laid out the medical qualifications of applicants: “must have...sufficient knowledge of...pharmacy to take charge of the dispensary, acquainted with minor surgery, ... application of bandages and dressings, extraction of teeth, application of cups and leeches, ...knowledge of cooking.” One should note that the qualifications are much broader than pharmacy. The manual not only included the roles and responsibilities of the hospital steward, but also contained additional chapters to discuss hospital attendants and nurses.

The Hospital Steward was selected and appointed to his position and title. In contrast male nurses were usually temporarily detailed without change in rank or title from inexperienced enlisted men. The steward had to apply for his position using an official application process. Woodward suggested they be “18-35 years old, able-bodied, free of disease, honest and upright,” of “good intelligence, having a knowledge of English, able to spell and write correctly,” and “industrious, patient, and good tempered.” There was a competitive exam to take. Stewards were screened for previous experience and having worked as a druggist, chemist, or apothecary clerk in civilian life was a huge plus. Previous experience even as a medical student was greatly beneficial. After the exam, interviews, and references, the appointment had to be confirmed by the Secretary of War. Once the process was successfully completed the hospital steward became a NCO, although the rank structure was far more function-oriented than today. Woodward explained that he was “equal to Ordnance Sergeant” and “next above First Sergeant.” The appointment was permanent for the duration of the war and the steward could not be returned to regular duty – they were part of the Medical Department. This was certainly a benefit to the Medical Department as the men who gained experience would be retained.

Woodward’s manual also described the uniform and symbols of position and rank. The uniform, color code, and insignia were distinctive and certainly distinguished this position from the rest of the medical staff.

- \* dress sword was the NCO sword, not the Medical Staff (doctor’s) sword.
- \* dress sash was red worsted wool, not red or crimson silk (artillery) and not green silk (surgeons).
- \* insignia was the half chevron of caduceus and snakes worn on the upper sleeves.
- \* dress hat could be adorned with a feather or plume, an eagle pin on the right side, a gold laurel wreath on the front with a silver US (not MS for Medical Staff), and a green and buff hat cord.
- \* undress uniform (for fatigue purposes or hospital work) included the blouse or sack coat with the same distinctive half chevron on the upper sleeves. The pants were the sky blue enlisted infantry trousers with a 1½ inch wide crimson stripe down the outer seams. The red/crimson strip (and wool sash) did not mean artillery as a branch of service, but rather meant NCO.
- \* cap was the enlisted man’s regulation forage cap.



The roles and responsibilities of the Hospital Steward were numerous and varied depending on his duty location. In the hospital and acting as the pharmacist, he compounded (measured, weighed, mixed, rolled, cut, polished) prescriptions as written in the prescription book by the surgeons, rather than just filling them from a bulk supply. Everything was manual. He also verified that the medication was actually administered although he was usually not the person who gave it. As hospital administrator he was responsible for inventory and ordering of medical supplies, hospital supplies, record keeping, and overall hospital administration. His inventory of records was never ending. It included the Steward's Weekly Report, an enormous spread sheet manually recorded. On it were recorded the number of beds, linen, clothes, dishes, and even spittoons. In the field and on the march his dispensary had to be mobile and he learned to quickly assemble and disassemble it. Much of his time was spend in packing precious glass bottles of medications. Dr. Jonathan Letterman, Medical Director of the Army of the Potomac, even specified the hospital steward to carry the hospital knapsack for the surgeon when on the march.



(Above) Stewards and surgeons at Harewood General Hospital, Washington DC. National Archives.



(Right) Stewards on campaign, outside Petersburg, 1864. Library of Congress.

In addition to the roles and responsibilities previously mentioned, Woodward listed one other responsibility. The hospital steward was to be the nursing supervisor for the male detailed nurses (enlisted men) but not for the female nurses! He stated: "enlisted men are under the orders of the surgeon... look up to [him] as their commanding officer... [and] are also under the orders of the hospital steward, to all whose lawful commands they must yield prompt obedience." The supervisory role was echoed in the South where the regulations for the Confederate Medical Department stated "the cooks and nurses are under the orders of the stewards." The term "nurses" was not defined as to male or female, but one must remember that the South was very slow to accept the use of female nurses during the war. In contrast, regarding the female nurses, Woodward stated "she should heartily co-operate with the steward, and strictly obey the orders of the medical officers." It would appear from this wording that while all Union female nurses were under the orders of the surgeon (and for some also the supervision of Dorothea Dix) they were not under the orders of the Hospital Steward.

To gain insight into the roles and responsibilities of the hospital steward I have located seven first person accounts by and about hospital stewards. These sources, which are all available in print today, give us glimpses into the lives of these individuals during the Civil War years. Primary sources often allow us to see what the individuals are actually doing especially if their performance differs from the official manual. In Part II we will review and compare those seven primary sources, what the seven men themselves said, and answer the question: Pharmacist, or administrator, or nurse?

## What is an Artifact?

AMEDD Museum Staff

To stand in the presence of an artifact that was a participant at a historical event is to stand in the physical presence of history. Artifacts teach on an intellectual level but also through the senses. Each museum teaches history through the preservation and interpretation of the artifacts that it collects.

But what exactly is an artifact and how does a museum decide what artifacts should be collected and preserved? The Army Museum System’s definition of an artifact is ‘any object that has been designated by the appropriate authority as being historically significant because of its association with a person, organization, event or place or is a representative sample of something used by the Army.’ These objects can be very old, such as an 18th Century fleam or contemporary uniform items. Large items such as vehicles can similarly be designated as artifacts.

The AMEDD Museum has a unique mission among the Army Museum system because this museum is the only one that “collects, preserves, and interprets historically significant property related to the history of the Army Medical Department from 1775 to the present.”

The AMEDD Museum artifact collection is organized around several interpretive themes including: accomplishments of the Army Medical Department, the history and traditions of the Department, patient evacuation, echelons of care, the advancement of medical technology and the organization and expansion of the Army Medical Department.

Within the collection are the tangible reminders of service above self, such as the surgical tools of Dr. Thomas Hewlett, who continued to serve as a Medical Corps officer while a prisoner of war of the Japanese. Three of the instruments were made for him by his fellow prisoners, from their eating utensils.



Surgical instruments, some of them improvised, used by CPT Thomas Hewlett, MC, while a prisoner of the Japanese .

Some artifacts that illustrate the echelons of care span from the Revolutionary War, with a beam from a hospital at Valley Forge, Pennsylvania to a GWOT operating room exhibit from the 555th Forward Surgical Team.

The artifact collection covers both CONUS and OCONUS



LT Gayle O'Rear's jungle hat from Vietnam

materials and uniforms and medical equipment are the two largest components. Among the uniforms is a personalized Jungle Hat worn by LT Gayle O'Rear during her year-long deployment with the 67th Evacuation Hospital from March 1970-March 1971. She pinned unit crests given to her by her patients to her hat and sewed a “Snoopy” applique to the top.

The organization of the Army Medical Department and the creation of its seven uniformed corps, are represented by a collection of official Corps Chief portraits either painted in oil or official photographs. Two of the oil portraits currently on exhibit are COL Emma Vogel, first Corps Chief of the Army Women's Medical Specialist Corps and COL Othmar Goriup, the first Medical Service Corps chief.

Patient evacuation artifacts range horse drawn ambulances to the first motorized ambulance to the era of vertical evacuation with a Korean War H-13 Sioux and a Vietnam War UH-1 Iroquois Huey.

The unit heritage of the AMEDD is illustrated by a stunning collection of distinctive unit insignia collected by MG Floyd Baker during his service. It contains just over 1000 pieces that are on exhibit at the exit of the current operations area of the museum.

Like most museums the AMEDD Museum does not have sufficient space to have an in depth treatment of the entire depth of this amazing story. In order to expand our interpretation the museum staff organizes at least one temporary exhibit per year and periodically introduces "new" artifacts into the two core galleries.

Come and visit this amazing story-of those who have and are currently serving America by saving lives.



Official Portrait of COL Othmar Goriup, Chief of the Medical Service Corps, Sept 1947-Sept 1951



Part of the hospital section of the Malinta Tunnel, beneath Corregidor Island. During the 1920s a tunnel complex was excavated to complement coastal fortifications. A substantial portion of the tunnels were earmarked for hospital use. When Corregidor was besieged by the Japanese in 1942 around 1,000 patients plus medical staff were crowded into the hospital section of the tunnels.

For more see

[http://history.army.mil/html/books/010/10-24/CMH\\_Pub\\_10-24-1.pdf](http://history.army.mil/html/books/010/10-24/CMH_Pub_10-24-1.pdf)

## Generations of Hospitals

Fort Riley was established in 1853, and the AMEDD had a temporary hospital, with a permanent hospital open by 1865 and a stone building in the 1880s as the Fort Riley Station Hospital. That building was used (although with additional buildings as needed) until the 1950s when the new building was dedicated as Irwin Army Hospital on 7 February 1958. In its turn, that building has lasted almost 60 years; a new Irwin Army Community Hospital is being built. All images courtesy Fort Riley Museum and Irwin Army Community Hospital.



(Left) In 1853 the first hospital at Ft Riley was already abandoned and derelict.

(Below) 1865 photo of the frame building used as the hospital then.



(Right) The 1880s hospital, still in use in the 1930s, based on the cars.

(Below) Irwin Army Hospital in the 1960s.



(Right) Architectural conception of the Irwin Army Community Hospital currently under construction.

## 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 (initially we will try a 500 word minimum), which must have sources listed if not footnotes/endnotes

Book reviews and news of books about AMEDD history

Technical requirements:

Photos will need to be at least 96dpi; contact us about file format. Text should be in Microsoft Word (.doc or .docx) format. Please do NOT send text with footnotes/endnotes in .pdf format.

Material can be submitted to [usarmy.jbsa.medcom.mbx.hq-medcom-office-of-medical-history@mail.mil](mailto:usarmy.jbsa.medcom.mbx.hq-medcom-office-of-medical-history@mail.mil)

## AMEDD Center of History and Heritage

*Director, Mr Robert Driscoll*

*AMEDD Museum* [ameddmuseum.amedd.army.mil/](http://ameddmuseum.amedd.army.mil/) 210-221-6358

*Office of Medical History* [history.amedd.army.mil](http://history.amedd.army.mil/) 210-295-0977

*Office of the AMEDD Regiment* [ameddregiment.amedd.army.mil/](http://ameddregiment.amedd.army.mil/) 210-221-8160

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