CHAPTER 7

CONCLUSIONS AND IMPLICATIONS

'ALL HONOR AND GLORY TO THE DEAD!
ALL SYMPATHY AND COMPASSION FOR THE WOUNDED!' [1]

The commanders of both Armies were generous with praise for their medical departments. Rosecrans reported that 'our medical corps proved very efficient during the whole campaign, and especially during and subsequent to the battle. A full share of praise is due to Dr. Glover Perin . . . .' Bragg insisted that 'the medical officers, both in the field and in the hospitals, earned the lasting gratitude of the soldier and deserve the highest commendation.' [2]

Certainly an amount of praise was well earned. On both sides of the Chickamauga medical planning was occurring as the combatants maneuvered for position and an engagement. Then, when the fighting did begin, prompt medical support was provided to the wounded. And, while soldiers slept in the cold after the first day's fighting, litter bearers and surgeons worked long into the night finding, moving, and caring for their men and prisoners. All of this occurred on most difficult terrain in a land long void of much needed rain. Additionally, hospitals were fired upon, medical officers were wounded, and each commander's intentions were never really understood.

There are those, on the other hand, who highlighted the medical failures of the battle. A Union regimental commander reported that, on the 20th, 'neither surgeons, hospital corps, nor ambulances were to be found.' In the Confederate Army the shortage of food and supplies and the distances to the nearest railroad 'seemed to daze Dr. Flewellen,' who was reported to be 'watching General Bragg look at the army.' [3] At the very least, one has to wonder about the placement of the Union hospitals and the movement of the Confederate wounded from the commissary depots.

IMPLICATIONS

Whatever one's assessment of its quality, the medical support provided to the Armies of the Battle of Chickamauga provides a wealth of observations that can be applied to health service support to the U.S. Army in the 1990's. The following discussion builds on the preceding description of the battle's medical support in order to address a number of those observations.

PLANNING: Quality Health Service Support (HSS) is not the result of a surgeon's haphazard arrangements or his operating in a vacuum. Indeed, HSS requires significant leadtime and input if it is to be provided in a form that will be of benefit to the sick and wounded. To this end, the staff surgeon and his operational planners must be an integral element of the command's preparation for battle. Being an integral element to preparations, in turn,

necessitates that the surgeon and his staff have complete access to all portions of the planning cycle. If either the quality or quantity of data is deficient then, very likely, the medical support package will be deficient.

The mission statement, commander's intent, timelines and suspenses, and resources consumed and available are all important inputs to the HSS estimate of the unit situation. Without access to any one of these bits of information the HSS estimate will not be complete. Surgeon Albert Hart, for one, commented on the difficulties he and his brigade and division surgeons felt by not being privy to even the route of march for their units.

In the Army of Tennessee Stout understood that the command's mission would be to withdraw from positions around Chattanooga in order to find more defensible terrain to the south. He also knew that the timeline, in this case, was entirely in the hands of the Union Army. Armed with this information he had the opportunity to move his general hospitals as whole organizations, thus leaving Perin and his medical department only empty buildings. Meanwhile, Perin was conducting medical planning within the framework of his command's mission, timelines, and resources. As a result, the Army of the Cumberland began the campaign with medical supplies and ambulances sufficient to meet three months of field duty and an evacuation plan that took advantage of the rail lines to the northern hospitals.

TACTICAL COMPETENCE: The requirement for the HSS leaders to be included in the planning process introduces a second and related observation: the need to understand the battlefield and the unit's role on it. If they are going to serve as productive staff members, HSS leaders must have the ability to evaluate a given situation and apply the same operational skills and knowledge as the maneuver combat planner would. For example, Perin's critics, such as Duncan and Gillett, question his grasp of Rosecrans's command intent. The objective of the campaign, after all, was to take and hold Chattanooga. Why, they wonder, were seven of the ten field hospitals positioned south of the using units instead of between the Army and Chattanooga? By being located far on the right wing the hospitals were at risk of ending up in the exact situation they eventually found themselves. That is, on Sunday the 20th they became isolated from the Army and unavailable to serve the wounded.

Two possibilities are ignorance and astuteness. If Perin knew little of combat medical support the reader might accept that the hospitals were improperly located. In this context, only a command surgeon unaware of the commander's intent, terrain, and battle positions would place his front line hospitals in an exposed position. But Perin was not a novice to combat medical support; he knew well the need to properly position hospitals for the benefit of the wounded. It is just as probable that Perin used his knowledge of

combat to place the hospitals. Specifically, the Battle of Chickamauga was initially fought as a meeting engagement with both Armies moving for position when they ran into each other. In this case Perin may have preferred improperly positioned medical support to no medical support at all. Risk, after all, is as inherent in medical planning as it is in operational planning.

But to make this kind of risk-accepting decision, then and today, means that HSS leaders must have a complete grasp of operational concepts, capabilities, and concerns. This understanding is not limited to the nine categories of HSS. Rather, the HSS planner's skills must include such far-ranging topics as the principles of war, concepts of operational design, and an army's doctrinal tenets. In other words, the HSS planner must be able to speak and understand technical and operational language (Army talk).

CONTINGENCY PLANNING: Being involved in the planning cycle and having a full understanding of how the Army operates while in the field allows the HSS planner to react to events that might cause changes to the original plan. This means that the command surgeon and his planners are always looking beyond the current operation. Clearly, the Battle of Chickamauga demonstrates the need to plan HSS beyond the conduct of immediate tactical operations. Coordinating HSS just to meet the needs of the immediate operational plan is not adequate. Instead, the HSS leader

must also consider branches (what next) and sequels (what if) to the command's operational plan. Acceptable HSS planning, therefore, must consider actions to be taken when faced with either success or failure of the initial mission.

Surgeon Blair, of the First Division, XXI Corps, realized this when he noted that 'it is a wonderful undertaking to care for the wounded where the battlefield is retained but when the field is lost, it is incomparably greater.' [4] Had Perin fully considered the possibility of his Army losing control of the battlefield he may not have left the division hospitals on the right flank. Instead, he may have consolidated or evacuated the patients and moved as many hospitals as possible to a more tactically acceptable position during Saturday night's lull in the fighting.

The Confederates response to the outcome of battle seems to have obeyed, in at least one instance, the need for considering branches and sequels. By Monday morning, even with an inadequate number of ambulances, the wounded were being moved to the commissary depots. The Army had prepared for the shortage by planning to use empty supply wagons to move the wounded. Having access to those wagons was the end result of the interaction among some staff officers.

STAFF COOPERATION: Just as HSS personnel cannot plan in a vacuum, neither can they provide HSS without the support of the staffs from other functional areas. Backhaul of patients, protection of the medical facility, rations,

and transportation augmentation are examples of how HSS is assisted by other staff sections. Even at the very lowest levels of support a medical unit must rely on other staff sections to provide rations and protection.

Examples come from both armies. Stout ran into many problems with staff cooperation in moving his hospitals. In some instances a commissary officer had not been assigned to arrange for rations. In other locations quartermaster help was not quickly forthcoming. Meanwhile, Surgeon Perkins, of the Federal XX Corps, had not been coordinated with when it was decided to reduce the medical supply allowance to 500 pounds for the march south of the Tennessee River.

On the other hand, staff officers of both armies succeeded, either by design or accident, in providing the needed wagons to backhaul patients from the battlefield and subsequent hospitals. This example of staff cooperation meant that the wounded soldier arrived at a general hospital sooner, and with a better prognosis, than if only ambulances were used. Still, even with practiced staff cooperation and coordination, problems can exist if HSS needs are not truly understood by the non-medical staff officer.

UNITY OF COMMAND: Medical organizations must be owned and commanded by medical personnel. This applies equally to all HSS treatment, evacuation, and logistics units on the battlefield. Treating the injured soldier means more than just applying a bandage to a wound before

evacuating that soldier. Other concerns include assigning the right size and type of unit, knowing where the available hospital beds are located, moving medical supplies quickly to the requesting unit, and having immediate and unbroken access to evacuation assets.

Only the surgeon and his staff have the expertise to ensure that the correct HSS assets are properly located on the battlefield in order to adequately care for the sick and wounded of the command. Perin demonstrated this with the transformation of his Army's medical department from that which he found at Murfreesboro to that used at Chickamauga. Although the quartermaster department still owned the ambulances, they were required to respond to the needs of the surgeon. As a result, the ambulances were readily available and performed their assigned missions.

Unity of command also allows certain HSS-specific staff functions to be properly considered, planned, and prepared for execution. Among these are the following.

LEAVING PATIENTS BEHIND: As Rosecrans and the Army of the Cumberland discovered, the number of patients needing evacuation may well exceed the capability to evacuate. If this occurs in a retrograde or withdrawal the commander may be forced to leave the patients at the medical facilities on the battlefield. The surgeon's duty in this instance has at least three elements.

First, the surgeon must keep the commander and his staff apprised of the situation. It may be that, through staff knowledge and cooperation, backhaul vehicles can be found to move the wounded. If not, the commander should have as much advance notice as possible in order to make his decision. Second, the surgeon will have to arrange to leave sufficient medical personnel and supplies with the wounded to care for their needs. The difficulty with this decision is ensuring that the wounded are properly cared for while limiting the impact on the ability to provide adequate care for the remainder of the command.

Finally, the surgeon will have to alert his staff and subordinate surgeons. First, the medical personnel who will stay with the patients must be given enough time to make any personal preparations necessary. Surgeon Joseph Woods experienced this when 'it fell to my lot [to stay behind with the wounded] and with many regrets I divided my clothes sent away my horses and consigned myself to fate.' [8] It will also be their duty to choose which patients are evacuated on any available transportation and which ones will be left behind. The process of choosing patients to stay on the battlefield introduces a second HSS function lending itself to unity of command.

TRIAGE: Deciding which wounded will be treated immediately, which will be cared for next, and which will not be treated is never easy. Unfortunately, the decision

is predicated less upon the distress and discomfort of the patient and more upon the stark reality that supplies, time, and personnel are limited on the battlefield.

A dramatic example of the need for triage was seen with the Army of Tennessee problem of handling over 17,000 Confederate and Union casualties. Less evident, but just as realistic, is the frontline surgeon or medical aidman who is faced with two or more simultaneous casualties. At both ends of this spectrum is the requirement that medical personnel, and no one else, are responsible for selecting who will be treated and who will not.

These types of life and death questions are best argued within the HSS community among HSS professionals. In such an environment it is more likely that HSS issues, such as triage, will be made on merit rather than emotion. The accuracy of such a statement, however, is largely dependent upon the skill, knowledge, and training of the surgeon.

CONCLUSIONS

There are two significant results that arise from the reader's acceptance of the implications discussed above. First, the medical department of a military organization must have both the complete support and cooperation of non-medical leaders and commanders at all levels of the command. Second, military HSS personnel must be thoroughly trained in the combat-unique aspects of their profession. Additionally, neither of these issues can exist in an

environment where the other is missing. Command support provides the time and resources necessary to teach wartime skills in a setting of continuing peacetime requirements. This type of support develops well trained HSS personnel who demonstrate their willingness and ability to provide for the organization and its troops in combat. Such competence, in turn, increases the line leadership's willingness to support the medical department's doctrinal, tactical, and resource changes and refinements. The observations and implications of this study of the medical support provided to the Union and Confederate Armies at the Battle of Chickamauga are thus reduced to two great lessons.

The U.S. Army of 1990 has a lower ratio of combat experienced Army Medical Department leaders than at any time since, probably, before World War II. In such a situation history can serve as an important element in the education and training of today's and tomorrow's medical leaders. Let all understand that the beneficiary of this historical analysis, and its suggested requirement of complete command support and dedicated medical training, is the very essence of an army: the soldier.

ENDNOTES

CHAPTER 7

1. OR 30/1: Battle Report, Starkweather, 23 Sept. 1863, 302.

2. OR 30/1: Battle Report, Rosecrans, Oct. 1863, 62; Typical comments are seen at OR 30/1: List of Special Mentions, Rosecrans to [Thomas], 7 Jan. 1864, 89; OR 30/2: Battle Report, Bragg, 28 Dec. 1863, 36.

3. OR 30/1: Battle Report, Lane, 26 Sept. 1863, 480-1; Stout, "Outline" 72; Harwell Kate 152.

4. William Blair, Personal Note, n.d., Blair Papers, Indiana Historical Society, Indianapolis, IN.

5. Joseph Woods, Personal Letter, n.d., Woods Papers, Duke University, Durham, NC.