

YANKS IN THE KING'S FORCES: AMERICAN PHYSICIANS SERVING WITH THE BRITISH EXPEDITIONARY FORCE DURING WORLD WAR I

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In the summer of 1917, among the first Americans to enter into World War I was CPT Stanhope Bayne-Jones.¹ Reporting for duty at the 69th Field Ambulance in war-torn Belgium he began what he would later describe as “a great job - and rather lively.” For the next twenty days, Bayne-Jones was under fire at an advanced dressing station where he worked continuously among the wounded and dying of the British Expeditionary Force (BEF). He also contended with the continual danger of shell fire and poison gas. Recognizing the hazards he faced, Bayne-Jones later remarked, “I have not been as scared as I thought I would be,” although “the war is horrible beyond imagination.” Working with his British counterpart, he performed his duties under all the circumstances that came to characterize life in the World War I front lines. Additional duties, outside treating the wounded, consumed much of Bayne-Jones’ time, mainly preventative medicine measures that later became the focus of many American medical officers. He had to supervise sanitation, check personnel for venereal disease, and conduct sick call. Bayne-Jones was responsible for both keeping his men healthy and returning them to good health after sickness, disease, or wounds from combat. Bayne-Jones’ experiences are typical of what many American physicians would see during their World War I service with the BEF.

This article is an account of those United States Army medical officers who would serve in World War I with the Royal Army Medical Corps (RAMC). It is a story that needs to be told because the memory of these events has long since faded. These Americans were members of the first American military organizations to arrive in France as part of the United States of America’s commitment to the Allied war effort.

The first American military unit in France during World War I was Base Hospital No.4 (Cleveland), which arrived to cheering French crowds on 25 May 1917, nineteen days ahead of General Pershing and the nucleus of his American Expeditionary Force (AEF) staff.² These American physicians, nurses, and enlisted men would face the possibility of death and destruction months before the first American soldiers would see combat.

Medical personnel were the first to deploy and the first to suffer casualties. On 14 July 1917, CPT Louis J. Genella was hit in the head and face by shell fire while he was serving with the BEF in Flanders. His wounds were painful, but not serious enough to require evacuation from his unit. The first seriously injured American in World War I was a woman, Miss Beatrice M. McDonald, an Army nurse assigned to General Hospital No.1 (Presbyterian). She was hit by a shell fragment on 17 August 1917, while on duty at Casualty Clearing Station (CCS) No.61, and would eventually lose an eye.³ The Army's first officer killed by the Germans was 1LT William T. Fitzsimons, serving as adjutant of General Hospital No.11 (Harvard). 1LT Fitzsimons was in his tent on 4 September, 1917, when a German bomb exploded literally at the foot of his tent; he died instantly.



Panoramic view of General Hospital at Camiers, near where 1LT William T. Fitzsimons was killed on 4 September 1917.
(National Archives Photo, 111-SC-42344)

A second American medical officer's death occurred on 28 September 1917 when 1LT George P. Howe was killed by artillery fire while he was serving with the British 37th Division on the front lines; he is thought to be the first American officer killed in a combat unit engaged with the enemy.⁴ Howe's actions in combat greatly impressed the war-weary British military. He was recommended for the Victoria Cross, Britain's highest award for valor in combat. As an American, Howe was not eligible for the Victoria Cross, so the recommendation went to AEF General Headquarters for America's Distinguished Service Cross, an award that ranks just below the Medal of Honor. Howe's citation read:

During the operations of the Tower Hamlets Spur east of Ypres on 27th and 28th September 1917, this officer displayed the most conspicuous courage and devotion to duty in attending to the wounded of several different regiments under very heavy and continuous shell fire. He himself was wounded in the head early on the morning of the 28th, but refused to give in and continued to work at his Aid Post until killed by a shell when directing an officer, whose wounds he had dressed, to the Advanced Dressing Station. On many occasions during the period that he was attached to the Division this gallant medical officer earned the respect and admiration of all ranks for his consummate coolness and utter contempt for danger under fire. His cheerfulness under trying conditions was proverbial.⁵

It would be the night of 2 November 1917 before the first AEF infantry deaths occurred in the 2nd Battalion, 16th Infantry, 1st Infantry Division. This battalion was undergoing unit familiarization training with the French 18th Division, in the line near Bathelemont, when three enlisted men were killed and eleven were captured during a German trench raid.⁶

GENESIS

The circumstances that brought Bayne-Jones, Fitzsimons, Howe, and their peers to the BEF had their root when the Balfour Mission came to the United States in April 1917. This visit by the former British Prime Minister sparked the agreement that led to placing U.S. Army medical personnel in British units.⁷

At the outbreak of hostilities in August 1914, the British Royal Army Medical Corps had 1,279 officers, while the Territorial Force (analogous to the National Guard) had another 1,889 medical officers.⁸ While sufficient to meet the medical needs of the peacetime forces of the British Empire, and expanding to 11,385 officers in November 1918, the RAMC quickly fell behind the demands of an intensifying worldwide conflict.⁹ At the beginning of 1917, over half of British physicians were in uniform, severely

curtailing civilian healthcare. It was under these circumstances that the Balfour Mission arrived in the United States.

When the United States declared war on Germany and her partners on 6 April, 1917, America presented a new source of both personnel and materiel for the Allies. A year earlier the US government had established an Advisory Commission of industrial experts, organized with committees representing specific aspects of American industry.¹⁰ Representing medicine, surgery, and sanitation was Dr. Franklin H. Martin, a pioneer in American medicine and a founding member of the American College of Surgeons. As stated in his autobiography, Dr. Franklin H. Martin attended a formal White House reception in honor of the Balfour Mission. Dr. Martin recalled his conversation with Mr. Balfour: “As my name was mentioned, I was astounded to find the lapels of my coat grasped by Mr. Balfour, as he inquired, ‘You were introduced as Doctor. Do you happen to have to do with the enrollment of civil doctors for service?’”¹¹ A conversation ensued, with Balfour asking if Martin could provide between a thousand and twelve hundred physicians as soon as possible. Martin promised he could, saying he would be glad to be of assistance.

The next day Dr. Martin reported to Secretary of War Newton Baker that he had pledged the United States government to provide 1,000 American medical officers to serve with the British forces. Baker’s response to Martin on being informed of the commitment was “Doctor, go the limit!”¹² The die was cast that would send nearly 1,500 American Army medical officers to Europe to serve with the British Army, some until the end of the war. This American contribution would take the immediate form of six base hospitals, each with a complete medical staff, and over 100 additional medical officers were quickly dispatched to England.¹³

Pre-war American Actions

At the onset of World War I a group of Americans living in Paris took it on themselves to organize both a military hospital and a motor ambulance service in conjunction with the existing American-staffed hospital at Neuilly-sur-Seine. To support this, the French Government provided a school building, the Lycée Pasteur, which was then modified to accommodate 500-600 patients. In September 1914, this hospital accepted its first patient. The hospital was named the American Ambulance, “ambulance” indicating a French military hospital. Through the financial support of prominent Americans in the United

States, a second American Ambulance was established closer to the front, staffed with doctors rotating from the College of Physicians, New York.¹⁴

To sustain these first American institutions, selected American teaching hospitals were invited to provide medical personnel on a rotating basis, with the goal of each organization covering a three-month period. The first to respond was Western Reserve University (Cleveland) under the direction of Dr. George W. Crile. Crile's group entered service in France in January 1915, followed in April 1915 by a group organized from Harvard University by Drs. Harvey Cushing and R. B. Greenough. Service in France yielded these two groups a great deal of expertise in handling battlefield casualties. Even though the period of assignment was short, the long-term benefits would later prove to be invaluable.¹⁵

Personnel were very carefully selected for these early hospitals, and were well known to their respective medical establishments for their professional backgrounds. Crile's group included a chief surgeon, an associate surgeon, a neurologist, four residents, two nurse anesthetists, two operating room nurses and two researchers. In their three-month deployment, they treated French and British soldiers from fighting at Mons, Charleroi, and the Marne. By the end of 1915 Philadelphia and Chicago groups had enlarged the small cadre of American medical personnel with experience in treating the carnage of World War I.¹⁶

The American Red Cross had also become involved. The American Red Cross' charter at the outbreak of World War I included the responsibility of channeling volunteer aid to the sick and wounded of the armed forces in war.¹⁷ Within weeks of the outbreak of the war, the American Red Cross sent a ship to Europe laden with medical supplies and 170 surgeons and nurses who would provide medical relief to combat casualties of both sides.¹⁸ A year later the Red Cross was reorganized into two separate departments, functionally divided between civil and military relief. Part of military relief was serving as an auxiliary to the military medical services. In subsequent discussions with the Army Surgeon General it was decided that the Red Cross would organize base hospitals on military lines, with the staff enrolled in the medical reserves. All the personnel would be familiar with their organization, functions, and training, yielding better unit cohesion as well as speeding mobilization and deployment.

This action was in consonance with the earlier activities of Drs. Crile, Cushing, and J.M. Swan (all Medical Reserve Corps members) who had organized base hospitals under the authorization of The Surgeon General.¹⁹ The first director general of the Red Cross' Department of Military Relief was Army COL Jefferson R. Kean. It was on Kean's shoulders that the responsibility was placed to develop selected base hospitals that would support the Army. By February 1916, COL Kean began visiting medical schools, which were identified as being "desirable parent institutions for future base hospitals."²⁰ Eight base hospitals were soon established and organized.

In October 1916, the Red Cross selected the Lakeside Hospital Unit to demonstrate their mobilization concept. This was a fortunate selection. Crile had organized this unit, and not only he but many of his medical staff had served in France in 1915. Their success marked a milestone in the relationship of the Red Cross and the military. "It took the scheme of Red Cross military units out of the domain of theory into that of accomplished fact."²¹ Between October 1916 and April 1917 other medical institutions across the United States established base hospitals. Thirty-three base hospitals were authorized by the time of the American declaration of war in April 1917. In all total there were 50 Red Cross – Army Base Hospitals established by the end of the war.²² Six of the thirty-three were ordered to England in response to Balfour's request: Base Hospital No.2 (Presbyterian Hospital, New York City); Base Hospital No.4 (Lakeside Hospital, Cleveland); Base Hospital No.5 (Harvard University); Base Hospital No.10 (Pennsylvania Hospital, Philadelphia); Base Hospital No.12 (Northwestern University, Chicago); and Base Hospital No.21 (Washington University, St. Louis).²³

Concern about filling out the staff proved to be unfounded. Despite peacetime recruiting difficulties, patriotic excitement brought in medical professionals and cooks alike. To placate the teaching hospitals, the Army had pledged to rotate physicians back from France to sustain education, but it seems the Army made it as hard as possible for hospitals to accomplish this.²⁴

Base Hospitals Activities

Between 18 May and 3 June, the six American Base Hospitals landed at the ports of Liverpool and Falmouth, England. They were given a courteous welcome by the British Government, which made them feel appreciated. The majority of the officers traveled to London while the enlisted men were billeted in the RAMC training facility at Blackpool.

Once in England, contingents from the soon-to-be-augmented British military hospitals in France traveled from the continent to meet with the new arrivals and to assist them in their movement to France. Beginning on 24 May and continuing through 11 June, the six Base Hospitals transited to France to begin their service with the BEF.²⁵

The plan was to relieve the RAMC medical personnel at six British General Hospitals in France, and gradually assume the total responsibility for the hospitals. The British personnel would gradually withdraw, leaving a small cadre of liaison personnel to assist in administration. The Base Hospitals received new designations showing their hybrid role: in line with British nomenclature they were titled General Hospital, then parenthetically their American affiliation was noted, for example General Hospital No.1 (Presbyterian, U.S.A.) or General Hospital No.9 (Cleveland, U.S.A.).

When the six American Base Hospitals arrived in France in mid-1917 they found medical facilities that had been developed by the British over the past three years of the war.

General Hospitals were part of the casualty evacuation chain on the lines of communication. Hospitals were located on or near railway lines, to facilitate movements of casualties from the CCSs and on to the English Channel ports. Most of the hospitals rarely moved, that is until the larger movements of the armies in the summer and fall of 1918. Some hospitals later moved into the Rhine bridgehead in occupied Germany, and many were operating in France well into 1919.²⁶

When the RAMC began mobilization with the rest of the British Army in August 1914, two general hospitals mobilized with each division, later cut to one per division, and eventually hospitals were mobilized according to the hospitalization requirements in each theater of war.²⁷ By the time Americans arrived in France, the General Hospitals were clustered along the French coastline, in centers ranging from less than 1,000 beds to more than 20,000 beds. Centers with over 1,000 beds were located at Calais, St. Omer, Boulogne, Etaples (Dannes-Camiers), St. Pol, Cayeux, Abbeville, Le Treport, Dieppe, Buchy, Etretat, Le Havre, Rouen, Trouville, and Marseilles.²⁸ Most provided easy access to the English Channel for hospital ships to the United Kingdom and were on rail evacuation lines from the Western Front. Although the French city of Rouen was situated inland, its position allowed easy access to ships on the Seine River and the port facilities at Le Havre.



Panorama of the British General Hospitals at LeTreport, showing wards and operating rooms. (National Archives Photo, 111-SC-42339)

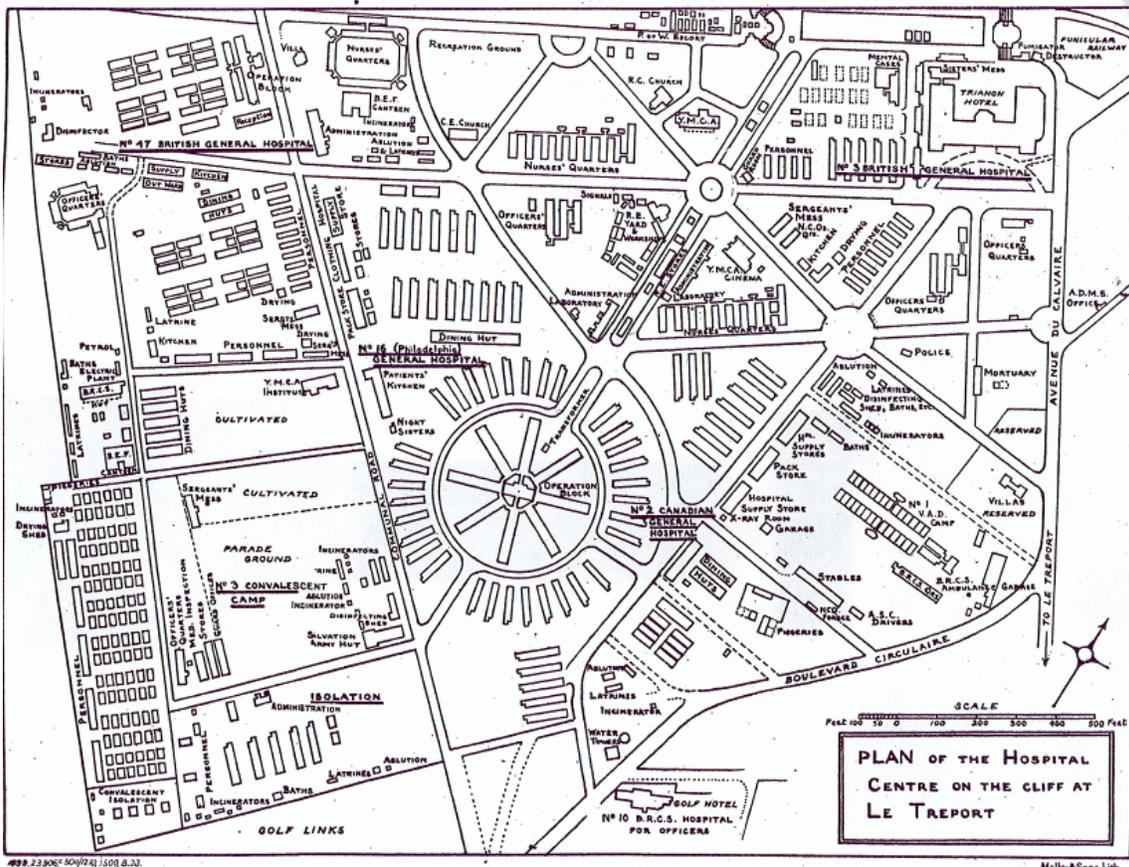
It was in these surroundings that the American base hospitals became operational in June 1917. As they arrived it was necessary for them to gain a quick understanding of both their facilities, and developments in treating the wounded. This had to be done quickly to free the RAMC personnel for deployment elsewhere. Usually, the RAMC officers would depart incrementally until the Americans were solely in charge of the hospital.²⁹ At first there was dual control in the hospitals, the British patients and RAMC personnel being under the command of RAMC officers, and the U.S. personnel (and patients) under the command of the U.S. commanding officer. From 1 August a single British officer was left to act as liaison officer, registrar, and commandant of RAMC personnel and patients under British military discipline, along with a quartermaster and necessary quartermaster's staff for handling British stores and equipment. (The British also left Other Ranks for labor duties.³⁰)



Unloading a convoy of wounded at Etaples, France.
(National Archives Photo, 111-SC-42343)

The transitions between the British and American personnel at all six locations were smooth and quite cordial. The facilities the Americans encountered were a mixed bag, since each had developed to meet the immediate needs of the war. Huts and tents had been erected to supplement hotels converted to hospital use. The French town of Le Treport was described as a “little fishing town and seashore resort” where the British had constructed a number of hospitals and other facilities. General Hospital No.3 was in a former hotel, while General Hospital No.16 (with a bed capacity of 2,232 patients) was “constructed entirely of huts and tents which were arranged in radiations extending in a half-circle from a center.”³¹ At Etaples, the Harvard unit summed up their new facility (General Hospital No.11) as an “ideal spot” on the coastline. Before the war it was a broad expanse of landscape covered with sand, sea-grass, and flowers; the hospital complex was well planned and methodically built, with six 2,000-bed General Hospitals each having its own section. Quarters were built for officers, nurses, and enlisted men; electric lights and telephones were installed, while patients went to ward tents of 48-60 beds each.³² (The tents allowed quick expansion in times of heavy casualties.)

The Harvard unit later moved to Boulogne and occupied the Casino Municipal as General Hospital No.13. The Casino offered excellent shelter with space for patients in its “brilliantly illuminated and gaily thronged halls, cafes, and ballrooms.”³³



From MacPherson, History of the Great War, Medical Services General History, Vol. II



Christmas 1918 in the orthopedic and medical wards, General Hospital No. 13 (Harvard), Casino Municipal, Boulogne, France. (Note American and British flags.) (National Archives Photo, 111-SC-44201)



General Hospital No.13 (Harvard), Casino Municipal, Boulogne, Pas-de-Calais, France.
A leave ship is entering harbor basin in background. (National Archives Photo, 111-SC-44196)



Heavy Surgical Ward, British General Hospital No.13 (Harvard), Casino Municipal, Boulogne, France.
(National Archives Photo, 111-SC-44198)

The first American unit to arrive in France, Base Hospital No.4, was impressed with what they discovered when they arrived at Rouen on 25 May, describing it in detail.

General Hospital No.9 BEF was centrally located in a group of large British Hospitals. This base had been well organized, carefully planned, and substantially constructed. No.9 contained about 20 to 30 wooden 'huts.' The floors were elevated from 12 to 20 inches from the ground and above them were the tight wooden sides with ample windows. Over all was a well shingled or composition roof. The medical and surgical huts each contained about 30 beds. There were two small rooms at one end for the seriously ill, and the nurses' office and preparation rooms were at the other end. Coal-burning stoves heated the wards, and coal oil Princess Stoves stood on a bench in the nurses' quarters and supplied heat for sterilizing and for brewing a 'spot of tea.'³⁴

The 9th General Hospital (Cleveland) experienced 16-hour duty shifts, daily admissions in the 700s, and around 100 operations daily, contrasting with a normal workload of 10-30 operations.³⁵ It would be still busier later. During the March 1918 German offensive this hospital completed 104 operations in one 24-hour period, and on 31 March admitted over 1,000 patients.



Operating Room, General Hospital No.18 (Chicago), Etaples, France.
(National Archives Photo, 111-SC-42336)

Once the American hospitals began their transition into General Hospitals it became very apparent that they were understaffed. Base Hospital No.5 absorbed forty American enlisted men, fifteen nurses and a few more physicians; General Hospital No.16 (Philadelphia) sent back to Philadelphia for 8 officers, 30 nurses, and 47 enlisted

men.³⁶ Eventually all six of the American base hospitals acquired the necessary staff for their new responsibilities.



British General Hospital No.21 (St. Louis), Rouen, France. Sand bags were used as protection against frequent German air raids.
(National Archives Photo, 111-SC-42300)

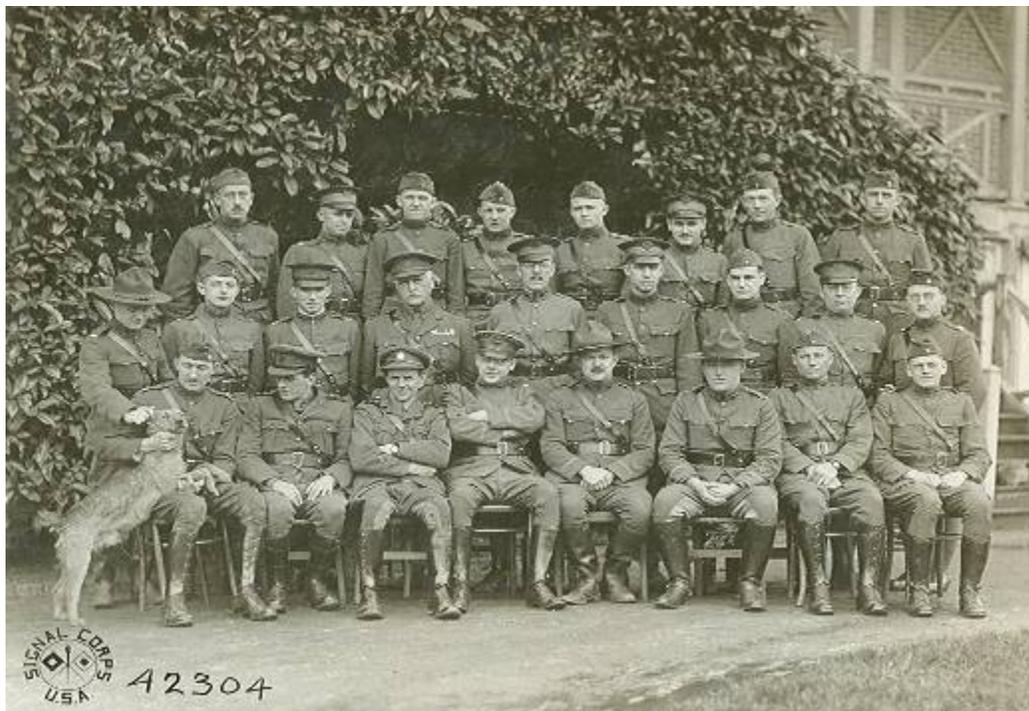


CPT Ronald F. Fisher, M.C., USA operating on a shrapnel wound in a soldier's neck. General Hospital No.12 (St. Louis) Rouen, France. (National Archives Photo, 111-SC-42279)

The Americans quickly established routines and began to treat the patients that arrived. COL Harvey Cushing, at General Hospital No.11, described the transition thus:

Beginning to take over ... We are effectively swallowed up in the British Army Machine, and already Base Hospital No.5 has completely lost its identity. ... Our young officers have taken hold valiantly, and the wards, with the nurses' help, are already improved in appearance. ... It seems small when compared to the 70,000-bed capacity of this district.³⁷

Working in the British General Hospitals saw some administrative friction as differences between the British and American regulations periodically became apparent. In June 1918, MAJ R. H. Harte, commander of General Hospital No.16 (Philadelphia), wrote to the Commanding General of American Troops with the BEF about problems of admitting American soldiers to the British facility. American procedures directed patients should keep their entire "kits" with them. Unfortunately for the British this meant that the American soldiers would keep weapons in hospitals and in the evacuation chain. British regulations prohibited soldiers entering medical facilities with weapons, holding that it violated the Geneva Convention. Major Harte recommended collecting and storing the equipment forward of the General Hospital.³⁸



American and British personnel (and mascot), General Hospital No.21, Rouen, France.
(National Archives photo 111-SC-42304)

By August 1917, the American-run General Hospitals were a fully functioning part of the British military medical establishment. After six months of duty with the British the BEF seemed quite pleased with the American efforts. A British inspection noted the Harvard unit had shown “much improvement” in adapting the Casino building and surroundings to hospital purposes, and “every necessary attention seems to have been paid to the question of discipline, uniform and general behavior of the officers and men both when on duty and otherwise. ... The relations with the British and Colonials continue excellent, and the supplies furnished by the British are fairly satisfactory.”³⁹

Surgical Teams at Casualty Clearing Stations

Once the original six Base Hospitals had arrived in France in June 1917, each underwent a period of familiarization and training. At the start it was recognized that these American medical personnel should gain some first-hand front line experience that would help them to understand the complexities of the medical situations they would face. Beginning in July and lasting through December 1917 the original American Base Hospitals sent surgical teams to provide assistance and at the same time to gain experience and an appreciation for the demands of wartime medicine.

These teams quickly found themselves in CCSs that were a few miles behind the front lines of the Western Front. Here medical officers attended to the routine tasks of dressing wounds, and also operated on the wounded to stabilize each man for the next stage of the evacuation process. The CCSs were organized in a manner that would “expedite and facilitate the movement of the seriously wounded.”⁴⁰ Two of the first American surgical teams to depart for the front left on 21 July from the 16th General Hospital (Philadelphia) located at Le Treport. They went to Flanders where they became part of CCS No.61 and CCS No.4, intending to stay at the CSS for approximately two months.⁴¹ The team at CCS No.4 operated on a total of 302 cases between 22 July and 18 September. At CCS No.61 the team spent a total of 76 days, performing 383 operations. Both of the CCSs were subjected to aerial bombardments in addition to the other hazards of forward duty. In this period each team gained a wealth of practical knowledge that would be beneficial in the coming months.

Each of the teams was relieved by new medical personnel from Le Treport, who then remained through December. Later Dr. John H. Gibbon from the 16th General Hospital (Philadelphia) described his thoughts on his time at CCS No.61. “The horrible

wounds, the suffering, the high mortality, tended to depress one and this was added to at night by the disturbing visits of the Hun planes. During our off hours in the day time, our only diversion was walking and, as the roads were bad and usually filled with motor trucks and artillery, there was no great pleasure in walking.”⁴² After their return from the CCS, the American base hospital medical personnel were able to better understand the conditions that combat soldiers had to tolerate. Further, these training experiences helped provide a cadre of personnel who would be able to serve as effective leaders and supervisors when called on after the arrival of AEF units in 1918.

Beginning in the summer of 1917 Americans were part of the rotation of supplemental personnel to the CCSs, teams of surgeons and operating room nurses. The teams improved their surgical techniques through experience and no group of surgeons burned out from constant work at a CCS. By 31 July 1917, many CCSs were almost multi-national: “In addition to nine British teams there were eleven from the USA, six from Canada, three from Australia, one from New Zealand and one from South Africa.”⁴³

CPT Edward B. Hodge wrote a vivid account his time on a surgical team.

Captains Hodge and Dillard, Nurse Stambaugh, and orderlies Clark and Mangin, received orders to leave Le Treport and help in the offensive begun that morning by the Germans. [They were assigned to CCS No.32.] There were 1,000 wounded waiting at the CCS. The word that night was that the Germans had made a big advance on a 50-mile front but would certainly be held on reaching the Somme if not before. ... Artillery fire was very heavy and almost continuous, but still distant. ... The Boche was still advancing steadily, the advance had not been checked at the Somme, gun fire was not so constant but nearer, a Divisional Headquarters had suffered a direct hit by a bomb in the night and many of the staff had been admitted to our CCS, among them the general commanding with a serious head wound. ... Many warnings had been coming in all afternoon of the increasing proximity of the enemy. The engineers had just reported the road mined and advised leaving in half an hour...at about 10 P.M. we pulled out. ... Many of the wounded spent the 21 hours it took to cover the twenty-odd miles to Amiens lying on stretchers on the open flat cars. Captain Dillard and Captain Hodge occupied the brakeman's box of a box car, getting an occasional nap by the roadside when the train made a particularly long stop. ... On arrival the wounded were transferred. ... All officers and men were kept on the platform in the station ready for orders to go up on the line again. ... Amiens had been bombed nightly since the start of the push. ... nearly everyone got some sleep, lying either on the baggage pile or on the concrete platform. ... Three teams, Canada, St. Louis, and ourselves, were taken by ambulance to Cerisy-Gailly on the Somme some miles away ... and attached to 41 Stationary [Hospital]. ... They were now acting as a Field Ambulance, terribly rushed and operating for hemorrhage only. We were all on duty most of the night and could see the whole battle line marked by burning dumps fired during the retreat. ... Going to bed at 9 A.M. ... we were roused at 11 A.M. by the news that we were to pack and be ready to move at 1 P.M. ... All the way, the road was filled with refugees on foot or on top of carts loaded with household goods. ... On arrival at 42 stationary hospital, we were given free foot until 9 A.M. next day. ... While walking along a broad boulevard about half way to our destination, more bombers came over and four bombs were dropped in our block. After we had extricated ourselves from the fallen glass and plaster and had taken account of stock, we found everyone had a wound in leg or foot. ... An ambulance took us

back to the place we had so recently left. ... The Chaplain gave up his room to the nurses, whose wounds were the most serious, and we found a room for Capt. Dillard in a ward. ... Next morning after getting the Adjutant's permission, we got the patients and luggage loaded and started to Abbeville. ... Finally appeared some of the well-known garage ambulances bringing the other teams and our orderlies back from Amiens in response to general orders for return of CCS teams to base.⁴⁴

As the war began to wind down in the late summer of 1918, the General Hospital surgical teams still found that they were needed as critical situations arose on the front. Departing from Treport, 1LT John B. Flick was to be one of the members of CCS Surgical Team No.48.

The attack on St. Quentin was already under way and by 10 P.M. were deluged with cases. We were alongside an anti-aircraft headquarters, and apparently beneath a favored air path of the Hun, for in the short space of time there we witnessed a number of air battles, and saw two planes brought down in flames ... we received orders to report to a hospital near Doullens. ... We were cordially welcomed, but again assigned to night duty. ... As there were only two teams, we worked on sixteen-hour shifts for the first few days. ... The pre-operative ward was always full; we operated only on cases that could not be transported without operation, and that were reasonable favorable. Most abdominals had to be left to their fate. The rush lasted about ten days, (Cambrai attack), the Hun bombs continued to interrupt our evening meal, but it never amounted to more than ducking lights. Occasionally he hit an ammunition dump and furnished excitement for the time being. ... work hours came and went, almost without our being conscious of a lapse. Rumors of the coming armistice already were rife. We treated on American boy who came in with a convoy made up of patients abandoned at a German advance hospital, captured by the British. He was from New York City, a youngster about nineteen. He had been captured the latter part of September while on a raid. The convoy was made up of Americans and British, some French, Italian and Russians. This youngster's general condition was wretched, as was the condition of most of these poor fellows. He was very septic and emaciated. He had had a disarticulation at the left knee-joint, the articular surface was covered with granulation and bathed in pus and he had a compound fracture of the other leg and several flesh wounds elsewhere. He said that the German hospital had been under-staffed and without adequate supplies; that the prisoners suffered from want of food and attention.⁴⁵

Individual Officers' Employment

After the arrival of the original six base hospitals, unassigned individual officers began to arrive in Europe. They were assigned to the RAMC facilities or the BEF in small groups as they arrived in the United Kingdom. They would be normally assigned to British military hospitals in the U.K., and after a period of familiarization with British medical procedures and administration, the majority of these officers would be sent to a BEF unit. This rotational cycle would continue until the Armistice.⁴⁶ For instance, a party of twenty orthopedic surgeons arrived at Liverpool on 28 May 1917 and was subsequently posted to various orthopedic hospitals around the United Kingdom.⁴⁷ The timing of an officer's arrival in Europe sometimes dictated the type of training he received prior to assignment in the BEF, or they might be needed for a front-line unit straightaway. Those who had not received specific military training in the US were sent to courses at the British Field

Service School in Leeds, a facility established for American medical officers who serve with the BEF. As described by one newly arrived young American medical officer, “instruction was given in sanitation, gas defense, transportation of the sick and wounded, methods of caring for new diseases, such as trench fever, trench foot, etc.; work at Casualty Clearing Stations [CCSs], trench sanitation.”⁴⁸ Additional, the RAMC training facility at Blackpool provided fundamental instruction to these newly arrived American officers.

From this experience the officers were then sent to their first assignment in the U.K. or on the continent. The current personnel situations and the state of the war usually dictated the assignments for an individual officer. After a major offensive on the Western front there was usually a greater need for officers in France due to casualties among the medical personnel. In times of relative inactivity officers could usually be placed in RAMC facilities in the U.K., which would eventually lead to a rotation to the combat units at the front. The quality and quantity of the training at these facilities would prove one of the best experiences that a young physician could get prior to his baptism of fire at the front. In September 1917, 1LT Christopher Gallagher was assigned to the Greylingwell War Hospital, Chichester, England to gain experience and training that would help him function later at the front lines. His fondest memory of that period was of the hospital Chief of Staff, a Dr. Maxwell, who impressed on him the process of learning about military medicine:

Doctors, on this service you are not going to see me do operations, then forget what you saw. You will DO the operations, then *remember* what you DID. ... I see and I forget. I do, and I remember. So I did, and did, and kept doing. Maxwell helped build up my confidence. Someday, men’s lives would depend on me.⁴⁹

A short time later Gallagher found himself a Regimental Medical Officer with the 2nd/4th Gloucestershire Regiment at the front. His first encounter with combat was a German attack, even before he could formally report to his new commander. Instead, he suddenly found himself entering a dugout marked with a red cross.

That Red Cross guarded the door to the seventh circle of hell. Before I even crossed the threshold, men were crying out to me for help. This would be my baptism of fire as a doctor. One step in the door and I heard a chorus of misery. ... Heading down the stairs I got assailed again by every kind of pitiful cry you could imagine. Everyone wanted help ... This was the descent into hell that Maxwell had told me about. No nervousness assailed me, no doubts nagged me. ... Maxwell’s teaching was there, in my head, and in my hands.⁵⁰



American Army physician treating a wounded soldier in the front lines, March 1918. (National Archives Photo, 111-SC-12151)

American medical personnel who found themselves assigned to the RAMC and the BEF could be placed anywhere across the spectrum of British wartime medical care. Each of these assignments was unique and each posed a challenge to the particular medical staff. American medical officers learned to be flexible and adaptable to an ever-changing set of circumstances. It should be noted that there was not a fixed policy of assignment for American medical officers to British divisions and medical units. In August 1918 the “number of officers of the U.S.A. Medical Corps with British divisions was 386, and of the RAMC 1,542. The U.S.A. Medical Corps officers, however, were very irregularly distributed in the divisions, the numbers varying from one or two in one division to as many as 12 or 14 in another. This was brought to notice on 11 August 1918, and steps were taken to distribute them more equally.”⁵¹

Many American physicians found themselves serving in the British military hospitals in the United Kingdom. It was here that they got their first experiences in the treatment of war casualties. It was also here that the American medical officers would sometimes return after a tour of combat duty with the BEF on the Western Front. Prior to World War I the British military had between 150 and 160 hospitals; by the time of the Armistice in November 1918, there were over 2,000 such medical facilities. The large

number meant there were specialized facilities for all medical fields, and physicians with particular expertise could be appropriately employed.

American physicians also served with the British Royal Air Forces. In a March 1918 letter to Major General John Biddle, who was commanding the American Base Section No.3 in London, the British expressed their difficulties in obtaining medical personnel for their new Royal Air Force; they wanted to obtain “the services of American Medical Officers at Air Stations in this country.” While the AEF staff was favorably disposed, since it would ultimately provide trained aviation medical personnel to the AEF, the lack of spare American medical officers forced a delay in agreeing.⁵² Later some of the American Medical Corps officers who arrived in England had been trained in aviation work at Mineola, New York and found themselves at the British Military Heart Hospital, Colchester, England. A request was made by the Medical Consultant of the AEF Air Service that a selected group of officers be placed at the Aviation Medical Laboratory at Issoudun. These officers had been “specially trained in the United States for service in the aviation research work which is being carried on in the AEF.”⁵³

The normal medical system utilized by the BEF differed only in detail from that of the American field medical organization. The American “medical array was more elaborate than that of the British, but for the man at the bottom – the battalion surgeon – there was, except for the presence of the assistant battalion surgeon, little practical difference in duties and dangers.”⁵⁴ When a British soldier was wounded in the front lines his comrades were not allowed to help him; he either made it to the Battalion Aid Post on his own or stretcher-bearers carried him. These posts were located at or very close to the actual front line, and many times stretcher-bearers had to wait until dark to provide assistance to the unfortunate men, or work at great risk to themselves. It was at the Battalion Aid Post that the wounded “Tommy” had his first encounter with a physician. Here the goal was to stabilize the injury, stop bleeding, splint fractures, administer tetanus antitoxin, and apply tourniquets. Once that had been accomplished the soldier was evacuated by stretcher-bearers to the Advanced Dressing Station that was operated by the Field Ambulances.⁵⁵ Each division had three Field Ambulances, each including two companies of stretcher-bearers and basic hospital capabilities.⁵⁶



American and British Officers attached to a British field hospital, 12 May 1918, Berthen, France.
(National Archives Photo, 111-SC-13828)

Once at the Advanced Dressing Stations (which were in “reasonable proximity of the front lines”) a greater range of medical tasks could be performed. Some emergency operations could be performed, enough to keep the man alive until he could get to the next stage of the evacuation process, the Casualty Clearing Station, roughly analogous to the American Evacuation Hospital. At the CCS, several miles behind the front but near transportation links for easy patient movement in and out, they could perform major operations and amputations as well as dealing with other medical conditions and diseases. As well as battlefield injuries, CCSs also treated venereal disease cases (18.1 per 1,000 casualties) and trench foot (12.7 per 1,000 casualties).

The CCS was the first large, well-equipped medical facility that the wounded man would visit. Its role was to retain all serious cases that were unfit for further travel, treat and return slight cases, and evacuate all others. It was usually a tented camp, although in the static trench areas the accommodation would sometimes be huts. CCSs were often grouped into clusters of two or three in a small area, usually a few miles behind the lines and on a railway line. A typical CCS could hold 1,000 casualties at any time.⁵⁷

The wartime locations of these CCS facilities can be identified today by some of the military cemeteries that dot the landscapes of northern France and Belgium. From the CCS the soldiers were moved by a variety of means, often depending on what was

available or the conditions of the weather, to the General Hospital. There wounded men would remain until sufficiently recovered to return to his unit, or be evacuated back to the United Kingdom for long-term treatment or recovery. At the General Hospital the soldier was afforded greater comfort and had the first real chance to regain his health. The decision to retain or evacuate a soldier to Britain rested with the medical opinions of the physicians at the General Hospitals. The patient populations of the General Hospitals fluctuated with the intensity of the combat, rising during or after a major operations. It was in this framework of the British military medical establishment that the American medical personnel were placed when they arrived in Europe in the spring of 1917. From that point on the newly arriving American medical personnel began to be employed on an individual basis, being assigned as needed throughout the BEF. Subsequently, an American medical officer could find himself at either a Field Ambulance (as part of a British division), or at a CCS. Working at the CCS, the American medical officer would be only a few miles from the Advanced Dressing Points, seeing serious surgical cases. This assignment put heavy responsibility and stress on these young physicians, but it also enabled them to learn medical practices at a faster pace and thus save lives in the variety of situation they were to face by the end of the war.

In The Front Lines

For many American medical officers, work at a CCS seemed to be the height of their medical practice. However, there were those physicians who were even one step further forward, at the front lines, under fire from the Germans. Work as a Regimental Medical Officer put physicians in harm's way, but provided them with a true sense of purpose for their medical practice. During combat the American medical officers established Advanced Aid Posts where the wounded British soldiers were collected. From there the men were brought to the Regimental Aid Post. American CPT Stanhope Bayne-Jones' service with the 11th Sherwood Foresters as a young medical officer during World War I was typical of this duty:

When shells began to fall, Stan lay in the mud while the ground leaped like the surface of a pond under rain. The mud was also thick inside the captured German bunker where he received the wounded; the flies on the walls swarmed over one another, while all about and overhead the earth was "beaten by huge steel flails" as the bombardment moved ahead of a German Counterattack. ... when the firing quieted enough to let the stretcher-bearers out, he triaged the wounded. As many as twelve men were needed to manage a single litter over the mucky, cratered ground. Not all the wounded could be moved, and the hard rule of triage was to save those who might survive and let

the others die. At that unearthly hour, in the stinking tunnel, Stan had to play God and decide who went and who did not.⁵⁸

It was here that physicians were in the greatest danger of injury and death. Often they would leave the semi-protection of their dugouts in order to treat an injured soldier. Charles H. Arnold was serving as Regimental Medical Officer with the 18th Lancashire Fusiliers. Early in the morning, Arnold was treating a badly wounded British officer who was lying on a stretcher. A German sniper saw this movement and put a bullet through Arnold's helmet, cutting his scalp. The same sniper shot a stretcher-bearer in the head before he was finally killed by British sharpshooters. Arnold had little time to worry about his own injury other than having the wound bandaged, but managed to retain his steel helmet with the two bullet holes as a souvenir of his close call. Arnold continued to work in his aid post and watched wounded and dead, both German and British, pile up outside his aid post, ultimately numbering over one thousand.⁵⁹

Another American, 1LT Bernard Gallagher with 2nd/5th Gloucestershire Regiment, was captured by the Germans in March 1918. Gallagher was put to work in a German Feldlazarett (military hospital) which was similar to a CCS. There he was responsible for 50 British soldiers (wounded prisoners) and also found himself working on wounded German soldiers who were brought in at all times of the day and night. For 1LT Gallagher his German medical work lasted for nearly three weeks. Gallagher could speak some German, so he was able to interact in a more personal way with his captors. His characterization of the German *doktor*, a Major, who commanded the Feldlazarett was such that he wished he could have known the man outside of the circumstances of the war. He was also impressed with the German military chaplains who in his words were "genuinely touched by the tragedy of all these needless deaths." At the end of his German medical experience, he noted "most of the Germans treated me with respect and courtesy."⁶⁰

American Units with the BEF

As the AEF built up with each passing month, agreements with both the British and French had entire American divisions training with the Allies. This allowed fresh units of the AEF to train and gain some front-line experience while retaining their distinct American identity. These AEF divisions could then be used with the British and French in the upcoming offensives or return to US control.

As an example, the 27th and 30th Divisions were the core of the U.S. II Corps that subsequently became a part of the British Fourth Army. The 30th had two phases of training to familiarize them with the British methods of trench warfare and military procedures, including familiarizing the divisional medical staff and units.⁶¹ Because an American division differed quite a bit from British divisions in doctrine, equipment, and organization, the intent was that each British divisional medical unit could train its American counterpart. It was considered essential that the American medical personnel train with the British transport and equipment since the Americans had arrived in France without any of their own equipment. The American litter did not fit British ambulances, and had to be replaced with British field stretchers. The Americans would be provided with British medical equipment in nearly every facet of their operations with the Fourth Army.⁶² The 30th Division medical officers would subsequently find themselves working with RAMC personnel from the 132nd and 134th Field Ambulances. Some of the Britons would later be cited in the Divisional General Orders for their particular meritorious service in actions with the 30th Division.⁶³



119th Ambulance Station, American 30th Division, British Fourth Army, 18 October 1918, Molain, France. (National Archives Photo, 111-SC-28454)

While the bulk of the fighting involving the Americans occurred on the Western Front, some British, French, and subsequently American units served in northern Italy during the war. Much of the fighting on the Italian Front from 1915 to 1917 had taken place in the mountains, but the enemy offensive that caused British, French, and American troops to be sent to Italy late in 1917 meant most subsequent fighting was in the plains. 1LT Edward H. Truex initially worked at the Italian naval base at Taranto, until in April 1918 he volunteered for assignment to the front. He was promptly working on British Ambulance Train No.30, which was moving the wounded from two CCSs to hospital facilities at Genoa, Italy, or Marseilles, France. As the Austro-Hungarians and Germans were preparing for a new attack in June, 1LT Truex was assigned to the British 48th (South Midland) Division on the front lines. Truex found himself going “over the top” as his unit counterattacked. Once the fighting died down, Truex was able to count 1,008 dead Austrians in front of his unit, which had also captured over 2,000 prisoners. He noted it was “terrible to look upon [the Austrian wounded], for added to their wounds was the emaciated condition of the bodies due to hardships and poor food. The Austrians were in the more desperate condition at this time, due to lack of all kinds of supplies.”⁶⁴ After the 48th Division was moved to the Western Front Truex was gassed while serving in the front lines in September 1918.

Another American physician serving in the Italian campaign similarly described his experience. While serving as the Regimental Medical Officer with the 10th Duke of Wellington’s Regiment, 1LT Norman R. Davis was one of the few Americans who saw combat in the mountains. He accompanied his battalion as they moved up into the line, then advanced to a plateau that was nearly 6,000 feet high. He was surprised to see the snowed-capped Alps were still far off in the distance. He overheard a nearby Tommy summing up the difficulty of fighting at this level: “If we have to finish this bloody war up here they will have to use aeroplanes and make aviators out of us infantry.” Davis completed his war service with the British, remaining in Italy where he was awarded the Italian Bronze Medal for Valor for his activities when the division crossed the Piave River in late 1918.⁶⁵

In his book The Lost Legion, Dr. W.A.R. Chapin describes a very unusual event for an unnamed American physician, part of his duties as a regimental medical officer. He was involved in the court martial and ultimate execution of a 19-year old British

private on the charge of desertion in the face of the enemy. On entering combat for the first time the youth heard the first shell explosion and left the front without permission. When returned to the unit by the military police he was not court martialed but only admonished. Again he went back to the front when the unit returned to combat, and again he left the unit when the first enemy shells fell nearby; this time he left the unit not once but twice. Finally he was imprisoned and the American was assigned to the medical board judging the youth's mentality. The board found the youth to be mentally fit, and he was condemned by the judge. The narrative resumed on the morning of the execution:

The firing squad came out in proper formation. The prisoner between two guards, an officer, perhaps someone else besides the doctor whose duty it was to pronounce him dead, and last but not least the padre. An open grave had been dug, but the clods of earth were mercifully hidden by the golden mist. He was left standing on the brink of his grave. The padre said a few words to him and he was alone. Alone on the edge of his grave. No words were said, the rifles were raised, a sharp report, a crumpling figure and he had fallen into his grave. The doctor's duty was to pronounce him dead. He had fallen so that he lay on his back, almost in the correct position to lie when dead, save his feet were caught a bit on the end of his grave as if loath to leave this field of gold. He was dead.⁶⁶

Chapin notes the American officer was not sure about the justification of the sentence.

There was even an American physician serving with Royal Naval Division that was part of the BEF, 1LT Royce Paddock, on duty with 148th Field Ambulance.⁶⁷

Another interesting service history was that of CPT Earl V. Morrow who spent over three years in the war zone of the Western Front. In June 1918 CPT Morrow was serving with the 87th Field Ambulance and requesting a reassignment to the AEF. Earlier when the war first began he had served in the French and Belgian medical establishments. He was held in high esteem by his peers and was being sought for assignment to the American 30th Division.⁶⁸

Besides the duties in working with patients at the BEF organizations in the evacuation chain, American Medical Corps personnel were also utilized in capacities that were intended to take advantage of their knowledge, skills, and expertise. This included teaching and sharing experiences in various capacities in a variety of locations. After the American medical officers gained their "frontline" experiences they found themselves involved in sharing that information with their peers representing the allied countries in the war effort. In early April 1918, COL George Crile from General Hospital No.9 (Cleveland) was assigned as the Director of the Division of Research for the A.E.F., with his duty station remaining at General Hospital No.9. This allowed him to attend the

Interallied Surgical Conference in Paris with medical personnel from Britain, Belgium, France, Italy, Japan, and Portugal. The conference covered the treatment of war wounds, including the use of local anesthesia in the handling of traumatic shock and amputations. His opinions and experience were so well respected that he prepared a book entitled Notes on Military Surgery that was intended for use as a war manual.⁶⁹ In March 1918, steps were taken to allow 46 American surgeons who were already stationed in England to take a specialized course in orthopedic surgery at two hospitals there based on the increasing demands for orthopedic work in both British and American hospitals.⁷⁰

Transfer to the AEF

As AEF units poured into France, efforts were made to take advantage of all training opportunities presented to the arriving American medical personnel. In January 1918, the AEF Chief Surgeon intended to utilize the expertise that had been developed by the men currently serving at the General Hospitals. They were picked for a one-month detachment, and the British medical authorities approved this request.⁷¹ Medical officers were allowed to switch to the AEF, if they asked, after a several-month stint with the British. Another proposal was to take any “spare” medical officers in the AEF and place them with the General Hospitals: “the assignments would serve two purposes, namely administering succor to the sick and wounded and at the same time give them an excellent opportunity to receive practical experience and training in this important line of work.”⁷² (This was suggested before the AEF had units in the line that needed surgeons.) Generally it can be said that once the floodgates of U.S. Army Medical Corps personnel had been opened in May 1917, they entered nearly every aspect of service within the British forces in Europe. By following the typical rotational policies of the BEF it is very easy to see that in a rather short period of time, the American physicians were able to gain a varied background of medical experiences. In a few instances it was possible for an American to serve in six or seven different organizations while assigned to the BEF. For example, in the course of his service, CPT James P. Austin served in the 22nd Northumberland Fusiliers; 104th Field Ambulance; the 43rd Casualty Clearing Station; 152nd Brigade, Royal Field Artillery; General Hospital No.9 (Cleveland); and General Hospital No.16 (Philadelphia). CPT Henry Dillard also served in six British units: 1st/6th Welsh Regiment; 2nd Field Ambulance; 32nd Casualty Clearing Station; 41st Stationary Hospital; General Hospital No.16 (Philadelphia); and the 1st Division, Army of the

Occupation in Germany.⁷³ Each assignment provided unique practical experience, although it has not been possible to trace all the physicians back to their positions in the AEF to determine where their experience was useful.

Some physicians had extraordinary backgrounds, as that of 1LT Arthur M. Zinkham. A graduate of the Georgetown University Medical School in 1906, he left the United States in 1914 and volunteered to serve in the Russian Army Medical Corps. From September 1914 until January 1916 he served at the Russian front and spent eleven months working in Kiev, Russia. He received a commission in the Medical Reserve Corps in April 1916 and entered active duty a year later. Shortly after he found himself in France by the end of June 1917, assigned to the 24th Field Ambulance. In August 1917, Zinkham was part of the Third Battle of Ypres, more notorious as Passchendaele. While working at an advanced dressing station on the Menin Road he was evacuating wounded when an artillery shell “struck between his Colonel and himself, killing the Colonel and wounding him in the back and breaking one rib. He carried on until relieved.” Zinkham was later reassigned to the AEF in January 1918 where he was eventually recommended for the Distinguished Service Medal for his work at Base Section No.2.⁷⁴

There are inevitably disciplinary problems and people ill-suited for the job assigned them. Such problems cropped up with the Americans with the BEF. In a Confidential letter to the Chief Surgeon AEF, dated January 21, 1918, the American Medical Corps Liaison Officer to the British War Office listed some troublesome men:

Lieut. Black – This Officer has been under arrest on charges of misconduct.

Lieut. Croop – This officer complains of the treatment he has received while serving with the British Forces in France. It is believed by the Liaison Officer that if this is true, Lieut. Croop is in all probability to blame.

Lieut. Gelineau – This officer has been reported by his Commanding Officer as being addicted to the too free use of alcohol.

Lieut. G.A. Noland – This Officer has been under arrest charged with conduct unbecoming to an Officer and a gentleman.

Lieut. H. Hutter – A communication has been received from a very reliable person in New York to the effect that this Officer while an interne of the Staff of Bellevue Hospital a year ago was a very ardent pro-German. This letter has been brought to the attention of the British Authorities who agree that it would be advisable to recall this Officer to the U.S. Forces.

Lieut. J.J. Parsons – This Officer is unable to do operative surgical work for the reason that he suffers from dermatitis of his hands when obliged to scrub them and immerse them in antiseptic solutions.⁷⁵

These are six of the hundreds then on duty. 1LT G.H. Richards, on duty with No.60 Field Ambulance, caused other problems in June 1918. In an April, 1918, letter to his sister in the United States, he wrote:

This is a hell of a life, but interesting, but I have seen and heard enough to suit me and I wish you could get this next part of my letter in the paper as it is true and a damn mean deceiving trick on the part of U.S. Government. The M.D.s who have been sent here as myself and lots of others who have been treated much worse than I with lots of them being killed were sent without knowing we were to serve with the English army. Now they are sending us all up to the front and making us take all the dangerous positions while the English doctors are allowed to stay at the base hospital and such safe places. I have made several applications to be transferred to the American army, but can not have it done because we are needed by the British. This is not so, because every place I have been there are more doctors than they can use except in a few places and it is due entirely to poor management. I am willing to take my chance with the Am. Army, but I did not join the English and think it is a very unjust thing to push us to the front as they do. If there is a dangerous post to be filled one of us has to fill it. The fellows are shifted from place to place, with no one taking any interest in us or our welfare. The American Army does not know anything about us nor do they seem to care. The fellows do not get their promotions simply because their Commanding Officers never get to know them and have no record of us until we do something we should not do, and that I expect to do soon if there is not a change in things. Nothing can be worse than this so I would put it to a test. The English are giving great medals for these retreats I don't know what they would give for an advance. Don't put that in your paper. If someone don't advance pretty soon I think we had better give it up as a darn big blunder as that is what this last retreat was.⁷⁶

Unfortunately for 1LT Richards the British censors opened his letter. Charges against him for violating the censorship regulations were considered, but later remitted when his chain of command noted

Lieutenant Richards' letter, written apparently to a member of his family, is objectionable in tone and manner and evinces an ill-disposed disposition. It is, however, to be doubted whether grumbling and complaining of this sort is a serious enough offense to be punished by court martial in time of war, when it is so difficult to bring officers to trial for more serious offenses.

Perhaps because "Lieutenant Richards is said to be professionally capable as a medical officer," the end result was a Letter of Reprimand in his record for consideration should he be eligible for promotion.

In some situations where single junior American medical officers were assigned to a British organization there were some complaints voiced about what appeared to be British officers "pulling rank." British physicians were commissioned as Captains while their American counterparts normally entered active duty as First Lieutenants. It is quite possible that some British personnel may have been rank- and class-conscious which could have been taken the wrong way by some Americans. Simply said, the idea of rank

having privileges has always existed, but perhaps some officers such as 1LT Richards were not able to deal with it when the situation arose.

Going Home

The majority of the officers serving with the British had been doing so since their arrival in Europe. As American units arrived, steps were taken to allow those who wished to be reassigned to AEF units. The determining factor for eligibility was the length of service with the BEF. This would help the AEF by providing a cadre of medical personnel who were familiar with the rigors, hazards, and realities of trench warfare. Some, however, desired to continue serving with the British army outside Europe. 1LT Stanley H. Osborn requested assignment to British forces in East Africa to study and perform epidemiological work. Other Americans with the BEF requested service with the British at Salonika, Greece. It is interesting to note that there was no objection to these assignments for the Americans other than the concern from a diplomatic objection “which might arise if any officers should be detailed with troops fighting against countries, with which the United States is not formally at war.”⁷⁷ As the U.S. had not declared war on Bulgaria or the Ottoman Empire, service at Salonika would have been problematic.

After the end of the hostilities in Europe the Allied combatants began to look forward to returning to the lives at home and put their war experiences behind them. This was a common feeling for all Allied personnel who wanted to get on with their lives, including Americans even though they had not been at war as long as the British or the French. American medical personnel on duty with the British began to plan for their return to the United States and a return to the medical practices they had left behind. For many was a sense of urgency about returning, driven partially by the great influenza epidemic that was raging throughout the world at the end of 1918. As the dust settled from the signing of the Armistice and the implementation of the Allied occupation of the Rhineland, clamor began to mount for a return to the United States. Letters requesting discharge began pouring in to The Adjutant General in Washington, AEF headquarters in France, and to the British military establishment. An example is Dr. John R. Wells’ letter to The Adjutant General, requesting that his son, 1LT Frank Wells, be immediately released from service with the BEF.

As an overworked country Dr. ... I wish to make an appeal for the early release and return to my aid, my son Lieut. Frank H. Wells, M.D. who is now serving with the 75th Field Ambulance, 1/8

Bn., Worcestershire Regt., BEF France and now stationed at Cambrai. He has been in service more than 18 months, having served last winter on the Italian Front and since Aug of 1918, has been in Northern France. His service has been entirely with the British Medical Corps, having been transferred from the Americans to the British ... after his arrival in London. His services are most urgently needed at home, owing to the Influenza Epidemic, because of the scarcity of Physicians in the County District. Hoping that my appeal may receive favorable consideration.⁷⁸

While many physicians had joined from patriotism, they were now facing hardships – mainly loss of their practice at home, but also family concerns – and sought discharge as soon as possible. 1LT Frank M. Pogue wrote to the AEF Chief Surgeon

Request to be discharged from the army and sent home at once. My reasons for making this request are: Physically am B11. This is on account of chronic bronchitis and asthma that I have had since having an attack of acute bronchitis at Ft. Oglethorpe, GA in February 1918. Was confined to hospital one month at that time and now I find this climate is seriously aggravating my present condition. Married, having a wife and two children dependent. This fact makes it doubly imperative that I do all possible to regain my health. Am 32 7/12 years of age. Have been in general practice for nine (9) years and as I left my practice with no physician's care, it is needing my services badly.⁷⁹

From his duty station with No.1 Ambulance Train, 1LT James W. Tipton wrote his British superiors:

I have just received an order from the Liaison Officer - US Army - London, in which he states American officers attached to British are to be given priority in demobilization - provided they have been over nine months in France. Sir I have been nearly eighteen months overseas - in England and France and want to return home as quickly as possible. Therefore I am writing you requesting you ... to forward my application for demobilization through the ordinary military channels. My father's health is not any good and consequently I am doubly anxious to return home.⁸⁰

Some American medical officers with the British expressed concern about their being “released” from their British units so they could apply for a discharge. In a letter to his British commander, 1LT E. Drew Silver wrote

I respectfully request that I be given my release from service with the British Army in order that I may apply for discharge from the United States Army. My reasons for desiring immediate release are as follows: I have a wife & child to support. I left a considerable civilian practice in Windsor, New Jersey, USA which my father has attempted to care for during my absence. ... He is an old man. ... His health has not been of the best for some years and he has undergone five serious abdominal operations in the past eight years. ... The result is that he has broken down from over-work during the influenza epidemic of this winter. ... I have served with the British Army since October 3-1917. Remained in England until Mar. 23-1918 and have since served in France with the 1/1 Northumbrian Field Ambulance, 8th Durham Light Infantry, 1/3 Northumbrian Field Ambulance and am now at #22 C.C.S.⁸¹

While physicians were more of a social and economic elite, they had many of the same concerns of the average soldier and officer of the AEF: to get home and pick up their lives. Yet not all American medical officers with the British forces wanted to return

home quickly, there were those who decided to take advantage of their presence in Europe for a variety of activities. Some sought professional development courses at some of the best universities in Europe, while others wanted to be tourists and travel throughout Europe. In April 1919 CPT Henry H. Slater found himself in Florence, Italy and requested continued service in Italy, asking for duty in the Army of the Occupation in Germany when finished in Italy. Interestingly, CPT Slater gave as his reason a fascination for the study of literature and foreign languages, and he wanted to take full advantage of being in Europe. He had “about five months’ study of French and since reporting here for duty three days ago have bought the necessary books and engaged a teacher for instruction in Italian.”⁸² As the Army needed some physicians to stay in Europe, and Slater had volunteered, he was allowed to stay until “your services are no longer necessary.”

CPT S.H. Richman, on duty with the 2nd Inniskilling Fusiliers, requested in February 1919 the opportunity to study medicine for three months at Edinburgh or London before his return to the U.S. This was an opportunity that had been extended to many of the American medical officers by the AEF Chief Surgeon.⁸³

EPILOGUE

The American medical participation with the BEF was in many ways very similar to the overall experience of service with the AEF. There were acts of supreme courage, heroism, and bravery under very trying circumstances while there were officers who failed to perform their duties. As with any armed conflict, the American involvement in the BEF was not without tragedy and sadness. Of the 1,649 American physicians identified as having served with the BEF at one time or another, 37 lost their lives either while serving with the BEF or as an immediate result.⁸⁴ Twenty-five stemmed from front line combat service: fourteen were killed in action and eleven died of wounds. Six officers died from non-combat reasons while assigned to the BEF; the final six died while assigned to the AEF. In contrast, the AEF had 28 physicians killed in action and 24 who died of wounds. From December 1917 through June 1919, ninety American medical officers died from disease, accidents, and other causes with the AEF; many of the disease deaths were likely from the influenza and related infections.⁸⁵

A quick analysis of the deaths in combat brings out some interesting points: of the 43 killed in action the majority were first lieutenants (21 in AEF, 12 in BEF), which

demonstrates that the junior officers were normally assigned to front-line duties.⁸⁶ Eight captains (five in the AEF, three in the BEF) died at the front, while two majors were killed with the AEF. The majority of the medical officers killed in action were in September (seven deaths) and October (nine deaths) 1918, corresponding with the heavy combat actions at St. Mihiel and the Meuse-Argonne. This contrasts with the plurality (five deaths) of American physicians killed in action with the BEF occurring in April 1918, as the BEF was blunting German offensives. Died of wounds are harder to correlate against battle activity because the death could take place months after the wound; the last to die as a result of combat actions was 1LT Ralph E. Powers, who died on 22 January 1919, from wounds sustained while serving with the 339th Infantry Regiment, American Expeditionary Forces, Russia.

The outstanding efforts exhibited by many of these men did not go unnoticed by their British superiors: 199 awards and decorations were presented to physicians for their service in the BEF.⁸⁷ The Distinguished Service Order was presented to three American officers.⁸⁸ The most frequent award to these officers was the Military Cross which was awarded to 173 American physicians.⁸⁹ Non-combatant awards were also given to physicians for their “ability and service” in situations that did not involve front line action. In this category were ten Medical Corps officers presented with the Companion of St. Michael and St. George, ten presented with the Companion of the Bath, and one who was presented with the Knight Companion of St. Michael and St. George.⁹⁰

Reviewing the citations, one finds names of some of the proudest British regiments: East Surrey Regiment; Gordon Highlanders; Manchester Regiment; Dragoon Guards; Durham Light Infantry; Essex Regiment. Certain phrases are seen again and again: “under constant enemy fire ... disregard to personal danger ... coolness under fire ... great initiative ... devotion to the wounded.”⁹¹ 1LT Harold S. Morgan can stand for many of these. On arriving in France in November 1917, 1LT Morgan reported to the 36th (Ulster) Division. He started with a Field Ambulance, then was sent to an advanced dressing station, and by the end of the year was made Regimental Medical Officer of the 9th Royal Irish Fusiliers. In March 1918 1LT Morgan found himself participating in the second battle of the Somme and the battle of Lys. In the German advance on Amiens the British forces fought a desperate rearguard action. Near him, Morgan saw three British battalions decimated with only a few men returning. In this maelstrom 1LT Morgan

functioned with fearless devotion and bravery, earning the Military Cross. His citation read

For conspicuous gallantry and devotion to duty during the retirement from Grand Seraucourt on the morning of March 22nd. This officer was retiring behind the rearguard, and on approaching Artemps was told that some wounded were still lying in Grand Seraucourt. Although he knew that the enemy was already on the outskirts of the village he returned at once with some stretcher bearers and succeeded in bringing out the wounded. He thus at the commencement of the operations set a splendid example to his stretch bearers of devotion and courage.

Within a month, Morgan was again on the battlefield, tending to the wounded with two stretcher-bearers when a shell fragment hit him on the leg. As the men were putting Morgan on the stretcher, another shell killed him and buried one of the other two men.⁹²

Another American who perished under similar conditions was CPT John E. Ray, who was posthumously awarded both the Military Cross and the American Distinguished Service Cross for his actions. CPT Ray was a member of the 119th Infantry, 30th Division, attached to the British Fourth Army. In September 1918, his unit began an attack at Bellicourt under heavy shell and machine gun fire. He set up his aid post behind the advancing lines, moving forward with the line, and treating both American and German casualties. He continued his treatment until he was severely wounded and had to be taken to the rear, where he died a few days later from his wounds.

1LT Abraham Haskell was assigned to the 50th Brigade, Royal Field Artillery, and his actions earned him the respectful nickname “the bloody Yank Medical Officer.” Haskell’s Military Cross citation brings out his bravery:

For conspicuous gallantry and devotion to duty. When in medical charge of the Fiftieth Brigade, Royal Field Artillery, on the 21st of March 1918, at Gouzecourt, this officer showed the greatest gallantry in tending to the wounded of batteries which were, at the time, under heavy hostile fire (shell) though he himself was suffering from the effects of gas. Again at Millencourt on the 27th of March, this officer with total disregard for his own personal safety tended unceasingly the wounded and also performed with the greatest coolness several difficult surgical operations where delay would have been fatal, though exposed to heavy shell fire all the time.⁹³

After the Armistice halted the fighting, Haskell met a German officer, who was opposite his position during the days of March 1918 when he had won his M.C. The German officer remarked about the deadly conditions at the front when he stated, “A lot of iron in the air, then it rained iron.”⁹⁴

LEGACY

If we are to use statistics to quantify the contributions of the American Medical Corps officers to the BEF medical system one only has to look at as being representative the numbers of personnel that passed through General Hospital No.16 while it was operated

by Base Hospital No.10 (Pennsylvania). From 13 June 1917 to 31 December 1918 this hospital “admitted 47,811 patients, of whom 22,431 were wounded and 24,222 sick. Of these 398 of the wounded and 140 of the sick died, making a total of 538 deaths. There were 3,736 surgical operations performed, the great majority for the removal of missiles or their fragments, but also a large number of amputations. The patients were chiefly, of course, members of the British Expeditionary Force, including British, Scotch, Irish, Australian, New Zealand, South African and Canadian soldiers, the total number of American soldiers being admitted being but 3,012, of whom 44 died.”⁹⁵ Those lives saved, the bravery awards earned, the experience carried to the AEF, the deaths serving under the Union Flag – those are the legacies of these nearly-forgotten men.

¹ Albert E. Cowdrey, *War and Healing: Stanhope Bayne-Jones and the Maturing of American Medicine* (Baton Rouge, 1992), pp.55-57.

² Harry D. Piercy, *History of the Lakeside Unit Of World War I*. p.4.

³ Robert U. Patterson, *Earliest American Battle Casualties in the World War*. Army Medical Bulletin No. 27, Volume 1 Supplement (Carlisle Barracks, 1932), pp.3-4. Patterson had been commander of General Hospital No.11 (Harvard) when the first Americans personnel were killed and wounded.

⁴ Dr. W.A.R. Chapin, *The Lost Legion: the Story of the Fifteen Hundred American Doctors who served with the BEF in the Great War* (Springfield, 1926), pp.41-42; Harvey Cushing, *From a Surgeon's Journal 1915-1918* (Boston, 1936), pp.200-203.

⁵ Letter, BG W.W. Harts to Commander-in-Chief, AEF, 9 June 1918. RG 112, Box 76, NARA. Howe was awarded the D.S.C. and it was later forwarded to his next of kin.

⁶ Society of the First Division, *History of the First Division during the World War 1917-1919*. (Philadelphia, 1922), pp.28-31. The 1st Division had been in France since 26 June. Pershing decided that small elements of units should be given the chance to “experience” combat and units were rotated in ten-day increments from late 1917.

⁷ Franklin H. Martin, *The Joy of Living: An Autobiography* (New York, 1933), Vol.2, pp.158-160. Balfour's visit to the United States occurred simultaneously with a French mission under M. René Viviani and Marshal Joffre, which arranged for U.S. medical assistance to France.

⁸ H.W. Wilson and J.A. Hammerton, Eds., *The Great War: The Standard History of the World-Wide Conflict*, 13 volumes (London, 1919), Vol.13, p.205. These volumes provide a vivid illustrated review of the British participation in WWI. Each of the volumes covers a specific period or aspect of the war. Volume 13 summarizes the war at its conclusion and provides a general index.

⁹ Ian R. Whitehead, *Doctors in the Great War* (Trowbridge, UK, 1999), p.83. In April 1918, the British Parliament would pass the Military Service Act, responding to the military manpower crisis. The Act expanded the age range for conscription to fifty-one, with doctors eligible to age fifty-five. Even after the arrival of the American doctors, there remained a severe shortage of qualified medical personnel in both the military and civilian sectors of life. Older doctors were not intended for front-line service, but to relieve younger men who would serve at the front.

¹⁰ Frederick Palmer, *Newton D. Baker: America at War*, Two Volumes (New York, 1931), Vol. I, pp.58-63.

¹¹ Martin, *The Joy of Living*, p.155.

¹² *Ibid.* p.158. Martin wryly noted, “it was much easier to obtain authorization of important matters than to get them executed.” He recognized he had to brief all the US government personnel involved with the request as soon as possible in order to make this happen. Additionally, Martin indicated that he was surprised that the French mission did not request doctors, even though he felt that the French had as a great a need for doctors as did the British. Their first requests were for ambulances with enlisted drivers.

¹³ MacPherson, *History of the Great War: based on official documents*, Vol.1, p.147.

¹⁴ Cushing, *From A Surgeon's Journal*, p.3; Colonel Joseph H. Ford, *The Medical Department of the United States Army in the World War*, (Washington, 1927) Vol.2, p.19.

¹⁵ Ibid. p.3.

¹⁶ George Crile, *An Autobiography*, (Philadelphia, 1947) Vol.1, pp.247-252. Crile, along with Cushing, would be very active in forming and organizing the first base hospitals. His 1915 experiences helped him avoid many pitfalls.

¹⁷ COL Charles Lynch, LTC Frank W. Weed, and Loy McAfee, *The Medical Department of the United States in the World War*, (Washington, 1923) Vol.1, pp.92-93.

¹⁸ American Red Cross, <http://www.redcross.org/museum/ww1a.html>.

¹⁹ Lynch et. al, *The Medical Department of the United States in the World War*. Vol.1, pp.92-93.

²⁰ Ibid. p.93.

²¹ Ibid. p.98.

²² Many were not activated until the spring of 1918. All served abroad except No.16, organized from the staff of the German Hospital in New York. Because of the Teutonic background of many staff it was utilized at home. Lynch et. al, *The Medical Department of the United States in the World War*. (Washington, 1923), Vol.1, p.102. On America's entry into World War I there was very strong anti-German sentiment across society. German language teaching in schools was halted, people thought to hold strong German sympathies were arrested, and German-American businesses went out of their way to "Americanize" their names.

²³ Ibid. pp.98-101. Units were keen to be the first Army units to go abroad, and to represent American medicine and nursing. Each was given a commander, adjutant, and personnel from the regular Army to facilitate their operation. Base Hospital No.4 under MAJ Crile was the first unit to embark, departing 5 May 1917, two weeks after mobilized. It landed safely in England on 17 May.

²⁴ Letter, COL J.R. Kean to AEF Chief Surgeon, 16 October 1917. Box 4947, Entry 2065, RG 120, NARA. The AEF Chief Surgeon, BG A.E. Bradley, forwarded this request to Pershing's HQ where it was approved with the stipulation that these requests for alternates would be handled only on a case by case basis. Pershing's Chief of Staff, MG James Harbord, rejected a uniform policy of alternates being approved for all officers who joined under this policy.

²⁵ MacPherson, *History of the Great War*, Vol.1, p.148.

²⁶ Chris Baker, <http://www.1914-1918.net/hospital.htm>, 11 August 2003.

²⁷ MacPherson, *History of the Great War*, Vol.1, pp.50-51.

²⁸ MacPherson, *History of the Great War*, Vol.2, p.76. There were eleven other hospital centers with capacities under 1,000 beds.

²⁹ Hoerber, *History of the Pennsylvania Hospital Unit*, pp.56, 59-60.

³⁰ MacPherson, *History of the Great War*, Vol.1, p.100.

³¹ Hoerber, *History of the Pennsylvania Hospital Unit*, pp.48-49. The hospital was adjacent to the beach which provided a morale-lifting view of the English Channel and the ship traffic going to England.

³² J. Philip Hatch, ed. *Concerning Base Hospital No. 5, A Book Published for the Personnel of Base Hospital No.5, France, 1917-18-19*. (Boston, 1919), pp.16-17.

³³ Hatch, *Concerning Base Hospital No.5*, p.27. Photographs show very little unused space in the Casino. One can imagine the thoughts running through the minds of these injured soldiers as they lay in their beds looking around at all of the ornate decorations in these large rooms.

³⁴ Piercy, *History of the Lakeside Unit Of World War I*. p.5.

³⁵ Ibid. p.6.

³⁶ Hatch, *Concerning Base Hospital No.5*, pp.19, 22; Hoerber, *History of the Pennsylvania Hospital Unit*, pp.69-70.

³⁷ Cushing, *From A Surgeon's Journal*, pp.111-112.

³⁸ Letter, MAJ R.H. Harte to Commanding General of American Troops with the BEF, 15 October 1917. RG 120, Box 75, NARA. There was no record discovered that would indicate if Harte's request was ever acted on.

³⁹ Letter, BG W.C. Langfitt to Commander-in-Chief, A.S.G.S., AEF, 22 January 1918. Box 4950, Entry 2065, RG 120, NARA.

⁴⁰ Paul B. Hoerber, *History of the Pennsylvania Hospital Unit (Base Hospital No. 10, U.S.A.) in the Great War*, (New York, 1921), p.137.

⁴¹ Ibid. pp.139-147. "Each of the first two surgical teams consisted of one operating surgeon, an anesthetist, a nurse and an orderly. Each team was assigned a table in the operating theater." Work was divided in such a manner that each team would work their shift and also have time off duty.

⁴² Ibid. pp.147-150.

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- ⁴³ Augmenting the CCSs for more surgery there had been tested in early 1917, and survival rates improved. Thus the British began moving surgeons forward from the stationary and general hospitals, resulting in fewer operations there and more being done at the forward CCSs. Whitehead, *Doctors in the Great War*, pp.200-201.
- ⁴⁴ Ibid. pp.158, 161-164.
- ⁴⁵ Ibid. pp.165-170.
- ⁴⁶ Ibid. pp.149-150.
- ⁴⁷ Ibid. pp.148-149.
- ⁴⁸ Chapin, *The Lost Legion*, p.33.
- ⁴⁹ Dr. Christopher Gallagher, *The Cellars of Marcelcave: A Yank Doctor in the BEF* (Shippensburg, 1998) pp.50-52.
- ⁵⁰ Ibid. pp.106-107. Gallagher was awarded the MC for valor during his tour in the BEF. Gallagher was captured on 28 March 1918 by the Germans. He was subsequently released in late November, 1918. While working in a German field hospital Gallagher saw the "Red Baron," Manfred von Richtofen, as he was visiting his injured men. A few weeks later von Richtofen was dead.
- ⁵¹ MacPherson, *History of the Great War*, Vol.2, p.101.
- ⁵² Letter, British Air Ministry to Commanding General, Base Section No.3 (London), AEF, 20 March 1918. Box 4969, Entry 2065, RG 120, NARA.
- ⁵³ Letter, LTC Thos. R. Boggs to Chief Surgeon, AEF, 29 September 1918. Box 4947, Entry 2065, RG 120, NARA.
- ⁵⁴ Cowdrey, *War and Healing*, pp.62-63.
- ⁵⁵ Gallagher, *The Cellars of Marcelcave*, pp.74-77.
- ⁵⁶ Cowdrey, *War and Healing*, p.55.
- ⁵⁷ Chris Baker, <http://www.1914-1918.net/wounded.htm>, 11 August 2003.
- ⁵⁸ Cowdrey, *War and Healing*. pp.58-59. Bayne-Jones was one of the medical corps officers who gained a very wide degree of experiences in World War I. He used this knowledge over the course of the interwar years to perform medical research in a variety of areas. Once World War II began, Bayne-Jones became director of the U.S. Army's medical research program.
- ⁵⁹ Chapin, *The Lost Legion*, pp.262-266.
- ⁶⁰ Gallagher, *The Cellars of Marcelcave*, pp.192-203. Gallagher in his book describes for the most part a very civil existence that he had with his German captors at the front. There were instances in which some German personnel (a doctor, a chaplain, and a medical orderly) were hostile and negative toward him. He felt that for the most part these people were good, kind individuals who were performing services for their country just as he was for the United States.
- ⁶¹ Elmer A. Murphy and Robert S. Thomas, *The Thirtieth Division in the World War*. pp.63-74.
- ⁶² MacPherson, *History of the Great War*, Vol. 2, pp.101-105.
- ⁶³ Murphy and Thomas, *Thirtieth Division*. p.336.
- ⁶⁴ Chapin, *The Lost Legion*, pp.289-294.
- ⁶⁵ Ibid. p.296.
- ⁶⁶ Ibid. pp.240-242. According to published accounts approximately 350 British and Commonwealth personnel, including three officers, were executed for desertion during the course of the war. The intent of the courts martial was to discourage other desertions. There were no recorded executions of AEF personnel for desertion, but there were executions for various criminal acts committed by soldiers. A book covering the British executions in detail is William Moore, *The Thin Yellow Line* (Conshohocken, 1999).
- ⁶⁷ Letter, COL J.F. Siler to Chief Surgeon AEF, 20 August 1918. Box 5064, Entry 2065, RG 120, NARA
- ⁶⁸ Letter, MAJ F.A. Besley to Chief Surgeon AEF, 11 June 1918. Box 5065, Entry 2065, RG 120, NARA.
- ⁶⁹ Crile, *Autobiography*, Vol.2, pp.334-337. One main reason that Crile remained at Rouen was the fact that General Hospital No.9 was composed of individuals from his own hospital in Cleveland.
- ⁷⁰ Letter, MAJ Joel E. Goldthwait to Chief Surgeon AEF, 20 March 1918. Box 4969, Entry 2065, RG 120, NARA.
- ⁷¹ Letter, BG A.E. Bradley to Director General Medical Services, BEF, 22 December 1917. Box 4947, Entry 2065, RG 120, NARA.
- ⁷² Letter, LTC H.L. Gilchrist to Chief Surgeon AEF, 15 October 1917. Box 4947, Entry 2065, RG 120, NARA. COL Gilchrist was the commander of the hospital.
- ⁷³ Medical Officer Roster, World War I Medical Corps in the BEF, 12 August 2003, Office of Medical History, Office of the Surgeon General, Falls Church, VA. Roster was prepared over a period of several

weeks from textual and photographic records (RG 120/111SC) from NARA and published sources located in the Office of Medical History. The roster identifies over 1,300 US Army medical officers who served with the RAMC in World War I, and their assignments.

⁷⁴ Letter, COL Henry A. Shaw to Chief Surgeon AEF, 16 August 1918. Box 4949, Entry 2065, RG 120, NARA.

⁷⁵ Letter, MAJ L.B. Rogers to Chief Surgeon AEF, 21 January 1918. Box 4969, Entry 2065, RG 120, NARA. Unfortunately records discussing the disposition of these officers were not located.

⁷⁶ Confidential Letter, Adjutant General, British Armies in France to Headquarters, American Troops with BEF, 9 June 1918. Box 75, Entry 2065, RG 120, NARA.

⁷⁷ Letter, LTC M.A. Delaney to Chief Surgeon AEF, 28 May 1918. Box 4950, Entry 2065, RG 120, NARA. No located records indicate any American officers serving outside of England, France or Italy with the British forces.

⁷⁸ Letter, Dr. John R. Wells, 5 February 1919. Box 4945, Entry 2065, RG 120, NARA.

⁷⁹ Letter, 1LT Frank M. Pogue, 14 February 1919. Box 4946, Entry 2065, RG 120, NARA.

⁸⁰ Letter, 1LT James W. Tipton, 9 February 1919. Box 4946, Entry 2065, RG 120, NARA.

⁸¹ Letter, 1LT E. Drew Silver, 14 February 1919. Box 4946, Entry 2065, RG 120, NARA.

⁸² Letter, CPT Henry H. Slater, to Chief Surgeon, AEF, 3 April 1919. Box 4948, Entry 2065, RG 120, NARA.

⁸³ Letter, CPT S.H. Richman to Chief Surgeon AEF, 18 February 1919. Box 4950, Entry 2065, RG 120, NARA.

⁸⁴ Chapin, *The Lost Legion*, p.389. Chapin's book only lists the names of those who had served in the BEF and died during the course of the war, not a breakdown of when or where these deaths occurred.

⁸⁵ Lynch, Weed and McAfee, *The Medical Department of the United States in the World War*, (Washington, 1923) Vol.1, pp.587-603. This volume gives a very detailed list (through 1 September 1919) by name of all Medical Corps officers who had died in World War I, including their assigned unit, date, and circumstances of death. The two differ but Chapin's appears to be the later one.

⁸⁶ The died of wounds numbers were also skewed to the lower ranks.

⁸⁷ Chapin, *The Lost Legion*, pp.389-408.

⁸⁸ This award was originally instituted in 1886 for officers who had performed distinguished or meritorious service during actual combat against the enemy. Each award of the D.S.O. included an announcement in the London Gazette of the citation. See also <http://www.firstworldwar.com/atoz/dso.htm>.

⁸⁹ The Military Cross was instituted in December 1915 with the intention to recognize gallantry of officers in combat that was not to the level of the Victoria Cross or the Distinguished Service Order. It was designated for officers between the ranks of Warrant Officer through Captain. See also http://www.worcestershireregiment.com/wr.php?main=inc/a_mc

⁹⁰ The Order of St. Michael and St. George was established in 1818 and is used to recognize individuals who have performed distinguished or loyal service in foreign affairs. The Order of the Bath was instituted around the 12th Century and was made a military order in 1725, thereafter being used to recognize service which merits particular honor or reward. See also www.royal.gov.uk

⁹¹ Letter, BG W.W. Harts to Commander-in-Chief AEF, 24 May 1918. RG 112, Box 76, NARA.

⁹² Robert J. Carlisle, *A Seven Year Record of The Society of Alumni of Bellevue Hospital 1915-1921 being the Year-book with Memorials of Those Who Died in the Great War*. (New York, 1922), pp.4-8.

⁹³ Chapin, *The Lost Legion*, pp.215-218.

⁹⁴ *Ibid.* p.218.

⁹⁵ Hoerber, *History of the Pennsylvania Hospital Unit*, p.64.