

A Military Encyclopedia

Based on Operations in the Italian Campaigns, 1943-1945.

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Chapter Twelve

MEDICAL

Section 1. Hospitalization and Evacuation Report

A daily Hospitalization and Evacuation Report was required by the Army Surgeon from all Army hospitals, and by Corps and Division Surgeons from all clearing stations under their control. This was an operational statistical report, which provided daily data regarding casualty admissions and dispositions by type, number of vacant beds, number of non-transportable casualties, and communicable disease data. In consolidated form, these reports were both operational and historical in application, becoming the official record of hospitalization and evacuation performed by the army medical service. These reports became the basis of experience analyses for the purpose of evaluating effectiveness of hospitalization and evacuation facilities, and were used as reference data for operational planning. Weekly statistical Health Reports, MD 86 ab (required by theater and War Department) did not provide these types of data in sufficient detail.

Section 2. Communicable Disease Report

A special communicable disease report containing the patient's name, organization, the definite diagnosis and whether diagnosed by the unit dispensary or Army hospital was found necessary. It was submitted daily to the Army Surgeon's Office by all Army hospital installations. Existing standard statistical reports from Army hospitals did not show incidence of communicable disease by individual units within the Army. Information obtained from the special communicable disease reports was tabulated in order that any unusual incidence occurring in any unit could be easily detected and quickly investigated.

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Section 3. Special Medical Hospitals

The need in a field Army for hospitals restricted in their activity to the diagnosis and treatment of medical cases was proved. The present Field Hospital with augmented staff of specialists in medicine proved satisfactory. There was need for one such hospital for each two and one-half divisions assigned to an army. Evacuation hospitals were not suitably staffed to answer the need.

Section 4. Functional Reorganization of Two Medical Battalion

Because of an urgent need for additional hospital beds in the Fifth Army, two Army Medical Battalions were functionally reorganized to provide four 250-bed hospital installations. This was accomplished without a change in the total number of grades or ratings in the battalions since proportionate numbers were placed on detached service with the Medical Clearing Companies from the Medical Collecting Companies.

The ambulances of the Medical Collecting Companies of the medical battalions were utilized to evacuate division, corps, and army hospital installations as the need arose. Wherever possible, the ambulances not on a specific detail were pooled for immediate call to any of the hospital installations for the evacuation of casualties.

The four 250-bed hospital units (each representing an augmented platoon of the Medical Clearing Companies) were used as adjuncts to the Army Evacuation Hospitals, thus increasing their bed capacities, or as distinct hospital installations. In the latter case, two of the hospitals at one stage operated as a Gastro-Intestinal and Psychosomatic Center to investigate thoroughly the large number of patients with functional bases for their complaints. At other times they acted as general medical units. Of the remaining two, one was used as a Neuropsychiatric Hospital and the other as a Venereal Disease Treatment and Diagnostic Center.

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Section 5. "Holding" Hospitals

"Holding" hospitals were formed from either field hospital platoons or clearing company platoons, augmented by additional equipment, for the purpose of "holding" patients awaiting air evacuation or hospital ship evacuation. It was always endeavored to transport patients directly from the evacuation or field hospitals to the plane or ship without a prior unloading at the holding unit. However, when inclement weather or other conditions altered the scheduled arrival of the planes or delayed the loading of the ships, it was necessary to "hold" patients until the loading on to the plane or ship could be accomplished. These "holding" hospitals were placed in close proximity to the air-strips or water areas. An important function of these installations was to provide these patients with hot rations whether they were "held" or not. In stabilized situations these functions were taken over by the Base Section.

Section 6. Army Venereal Disease Treatment and Diagnostic Center

In order to cope efficiently with the problem of uniformly treating the large number of cases of venereal disease, it was found desirable to establish an Army Venereal Disease Treatment and Diagnostic Center. This center comprised a mobile section of a medical laboratory (one officer and five enlisted technicians) and a 250 bed hospital unit (improvised from an Army Medical Battalion Clearing Platoon).

The treatment of VD in such a center proved most efficient from every angle. It also proved to be the most practicable means of providing quality care in quantity, and served as a helpful guide for the care of venereal disease patients in all Army medical installations. During the fall and winter months, when the refrigeration of Penicillin was not a problem, the treatment of gonorrhoea at Division Clearing Stations proved practical.

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Section 7. Neuropsychiatric Hospital

A 250 bed hospital unit was established as a Neuropsychiatric Hospital. This relieved the several evacuation hospitals from the necessity of treating neuropsychiatric casualties. It also provided uniform practices in the management of these cases.

The handling of such cases in evacuation hospitals where all types of casualties were treated tended to fix the anxieties of the psychiatric casualty and to predispose him to believe that his illness was of an organic nature. Often the diagnostic procedures and treatments had to cease when urgent needs for surgical beds required that such patients be evacuated to base installations.

At the Neuropsychiatric Hospital an attempt was made to minimize the hospital atmosphere and to foster the notion that it was a modified rest center. There were no nurses, pajamas, sheets, mattresses, pillows or pillow-cases. Patients slept on regular cots. Bathing facilities were provided. The idea of returning to duty was constantly kept before the patient as the terminal point of his stay in the installation. Officer patients were kept in the same wards as the enlisted men and were often helpful in returning enlisted casualties to duty. The number of psychiatric patients leaving the Army area was reduced, and the period of hospitalization shortened. An additional important function of this unit was the preparation of psychiatric opinions on disciplinary cases.

Section 8. Division Psychiatric and Division Rehabilitation Center

It was shown that if the treatment of neurosis was undertaken at an early hour in close proximity to the physical conditions against which the soldier reacted there was a greater chance of the soldier recovering rapidly and returning to combat duty. Treatment within the Army area also reduced the replacement problem.

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The treatment of these cases in the division was directed by the Division Psychiatrist. Treatment and reconditioning was often possible within the regiment. If no visible improvement occurred at the end of a forty-eight hour period within the regiment, the patient was evacuated through medical channels to the division clearing station where the Division Psychiatrist took direct charge of the case.

If, after two days of therapy, there was satisfactory improvement the patient was transferred to the Division Training and Rehabilitation Center located in the vicinity of the division clearing station. If the therapy was unsatisfactory, the patient was transferred to the Army Neuropsychiatric Hospital. As a general rule most of the men were ready for duty following the second day at the division training and rehabilitation center, where a program of physical conditioning, supervised rest, and tactical training was carried out under the direction of experienced line officers.

The Division Psychiatrist, closely associated with the training staff, examined all cases before their return to duty, and when necessary recommended continued rehabilitation or evacuation for further treatment.

The Division Training and Rehabilitation Center was also used for troops returning to duty after hospitalization in rear areas. There these men were screened by a medical officer and by the psychiatrist in order to determine their fitness for combat.

Section 9. Use of Field Hospitals as Surgical Hospital

Augmented Hospitalization Units of Field Hospitals were used as Surgical Hospitals. Generally one Field Hospital of three units was attached to each army corps when engaged. This allowed the Corps Surgeon to employ the units as required by the tactical situation. They were placed near division clearing stations to provide surgical and post-operative care for non-transportable casualties who could not otherwise survive evacuation to hospitals further in the rear.

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Teams of the Auxiliary Surgical Group were attached to these units to expedite the provision of surgical care for the seriously wounded who required time-consuming operations. This procedure resulted in a reduction of mortality rates, and enabled Evacuation Hospitals to accept for treatment a larger number of less seriously wounded casualties, and to expedite their treatment.

Usually, four general surgical teams and one shock team were required for an active Hospitalization Unit. Hospitalization Units leap-frogged one another in maintaining close support to advancing troops.

Section 10. Army Dental Clinic

To meet a definite need, an Army Dental Clinic was established to produce the unexpectedly large number of dentures required. An average strength of 6 dental officers and 16 enlisted dental technicians proved adequate for this installation.

By pooling the dental officers and enlisted technicians of the Army Medical Battalions and by the use of dental officers and enlisted technicians from other units, a dental prosthetic laboratory and general dental clinic was formed. One hospital ward tent was used for dental prosthesis; one for general operative dentistry; one for admission, waiting and records; and one to house those soldiers on a quarters status who were stationed many miles away and for whom it was uneconomical and impractical to arrange daily visits to the clinic for the production of their dentures.

By this pooling of dental personnel, the quality and quantity of dental work benefitted considerably, the days the patients lost from duty were reduced, and transportation was conserved.

Section 11. Reserve of Medical Units

Available medical units must be utilized in such manner as to insure flexibility of operation. Needs for additional beds and increased evacuation requirements often arose which were far beyond the normal expected in combat.

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Unless a reserve was constantly maintained the medical service would have been seriously affected during these peak periods. Original planning must envision this fact.

Section 12. Selection, Demining Preparation, and Protection of Hospital Sites

Army medical units were placed as far forward as the tactical situation allowed.

Liaison was maintained with the G-3 [Operations] and G-4 [Supply] sections and information obtained regarding the location of supply dumps, gun emplacements or other installations which might prove a target for enemy fire. After a site was selected, clearance was obtained from the Army G-4, or from the Corps G-4 if the medical unit was to be established forward of the Corps rear boundary.

In selecting a new site, a ground reconnaissance was made of the area by a representative of the Army Surgeons's Office, the commanding officer of the medical unit concerned or his representative and an officer from the Army Engineer's section. The Engineer was consulted on drainage and road requirements. During the winter and spring months service roads were constructed prior to the movement of the unit to the site. Buildings used for Army medical units were often later occupied by Base section medical units.

As the needs arose, particularly in periods of rapid advance, two teams of mine detecting personnel were placed at the disposal of the Army Surgeon. They demined areas and neutralized booby traps on sites or in buildings to be occupied by medical units. During the Anzio operation, hospitals were protected from enemy shell or bomb fragments by digging in ward tents and lining the walls with sandbag revetments held in place with chicken wire and iron stakes. Within the ward tents sandbag compartments were erected for groups of patients, thus reducing still further possible damage from shell or bomb fragments.

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Operating rooms were given additional overhead protection by means of roofs constructed from heavy planking covered by sandbags.

Section 13. Employment of Corps Medical Service in Evacuating Division Clearing Stations

An Army Medical Battalion was attached to each Corps as a standard procedure. The Corps Medical Service, organically without the facilities of a medical battalion, was charged with the evacuation of division clearing stations to Army Evacuation Hospitals. Requests from the Corps Surgeon for additional ambulances to meet operational requirements were filled quickly, and upon the termination of their need these ambulances returned to the Army Surgeon's control. The evacuation of the clearing stations of the divisions in this manner was established as routine and proved entirely satisfactory.

Section 14. *Evacuation of Field Army Hospitals to Base Sections*

In Italy the Fifth Army always assumed the responsibility for the evacuation of its hospitals to the pertinent base facility whether it was a fixed hospital, hospital train, hospital ship, or holding hospital at air or sea base. Facilities were available in Army to accomplish these operations satisfactorily. This means of evacuation of Army hospital installations was used throughout the Italian campaigns.

Section 15. *Evacuation by Hospital Ship*

When port facilities were available, loading of casualties on a hospital ship was not a problem. When port facilities were not available, LCTs [Landing Craft, Tank] proved to be the most practicable intermediary evacuation craft.

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Inclement weather and sea swells presented a serious hazard in transferring patients from LCTs to a hospital ship. At times loading was impossible. Masters of ships determined the distance off-shore that they would anchor. There was wide variation in practice which made the logistics of loading patients a separate problem for each ship.

Evacuation of casualties by LST [Landing Ship, Tank] was used only when air, land and hospital ship evacuation could not be accomplished. This occurred during the Anzio beachhead operation and was never entirely suitable from the patient's or the Medical Department's standpoint. Organic facilities for feeding and for adequate medical care on the standard LST were unsatisfactory. It was always necessary to carry additional medical personnel and equipment on LSTs carrying patients.

During the amphibious operations of the Fifth Army, evacuation by hospital ship was an extremely difficult problem from the Army viewpoint. In spite of every effort by the Army Surgeon's staff there were many instances of confusion. Ships would arrive when not requested and vice versa. Closely coordinated staff work, especially between the controlling agency at AFHQ [Allied Force Headquarters] and the Navy, was essential to prevent such occurrences.

Section 16. *Evacuation of Casualties from Mountainous Terrain*

It was proven again and again that only young, robust, well-trained, strong-backed individuals could perform the gruelling task of moving litter casualties over the terrain which characterized fighting in Italy for the greater part of the campaigns. The manpower of the medical units of the divisions, with what help could be obtained from corps and army medical units, was often insufficient. It became imperative that most infantry regiments fighting in the mountains establish a central pool of extra litter bearers to provide litter teams wherever they were needed.

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Men organically assigned or attached to the regiment who were not otherwise tactically employed at the time were used. In mountainous terrain, where vehicles could not be used, the hand carried litter was shown to be the only practical means of evacuating the litter casualty.

Section 17. *Problems of Sanitation in a Limited Area*

Operations in the Anzio beachhead demonstrated very clearly the value of Engineer and Medical cooperation as to sanitary measures in situations which present crowded conditions over extended periods of time. Adequate numbers of incinerators, rubbish dumps, and wet garbage disposal points are necessary to prevent the dangerous accumulation of soakage, garbage, and refuse pits in unit areas. It was advisable to locate the sanitary installations away from congested bivouac areas. It was mandatory that individual units be continually reminded of sanitary measures by frequent inspections and constructive criticism of their areas by inspection teams.

Section 18. *Louse Control*

At the end of the malaria season, a Malaria Survey Unit was used to take over the control of lice in the forward areas. Many troops occupied rooms in homes still occupied, or recently vacated by civilians. Bathing facilities were often non-existent for civilians, and it was not uncommon to find thirty living in one large room. As high as 30 per cent of the civilians in billets had body lice and as high as 90 per cent had head lice. Due to the severe winter conditions and to operational needs, it was necessary to billet some troops in civilian shelters. The Malaria Survey Unit visited every building in close proximity to military installations, and dusted, with 10% DDT powder, every civilian found. At the same time every civilian with a fever of unknown origin had blood and fecal samples taken for laboratory examination to determine whether typhoid or typhus fever was the cause.

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Repeated checking and dusting were required, since undusted civilians continued to filter through the lines or to return from shelters in the hills. Louse control advice was given to the Commanding Officers of all units in the vicinity of the communities dusted.

Section 19. *A Method of Venereal Disease Control*

All prostitutes apprehended by the Military Police were incarcerated in civilian jails and examined for venereal disease by a medical officer. Vaginal smears and blood examinations were sent to the army medical laboratory. If a prostitute proved to have gonorrhea, she was treated for five days on sulfonamides, and then, if the smear was negative, the test was repeated three times before the prostitute was released from jail. In the case of an ulcer, darkfield examinations were made. If the blood serology was positive, she was given two treatments with mapharsen and then sent to the local civilian clinic for further treatment. Although this method of control was not entirely satisfactory, it was the best that could be done under existing circumstances.

Because of the unsatisfactory nature of available means of controlling the extensive prostitution, individual prophylactic measures were stressed with increased intensity.

Section 20. *Trench Foot - Causes and Preventives*

The incidence of trench foot in the Fifth Army during the 1944-45 season was approximately one-third of the 1943-44 incidence.

Trench foot was caused by exposure of the feet or hands to prolonged wetness and cold. The usual exposure required was three to six days, but with colder weather the exposure was often shorter. The most important contributing factors were those which tended to impair circulation in the feet, such as immobility, tight leggings, tight shoes (due to poor fit, shrinkage from being wet, or wearing too many socks), resting in a cramped position, and diseases of the peripheral circulation.

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The responsibility of the unit commander for the prevention of trench foot was made definite. The Army Commander held the division commanders strictly responsible for the curtailment of this preventable disease, suggesting that each company commander be required to report up to his battalion commander, or other appropriate commander, each case of trench foot hospitalized from his company, stating the circumstances under which the case developed and whether or not it was possible to carry out all protective measures.

The following physical protective measures were put in effect:

- a. All combat troops were issued shoe pacs to be worn with two pair of heavy wool ski-socks and a pair of felt innersoles;
- b. All divisions made provision to supply front-line troops with frequent changes of socks;
- c. Drying and warming stations were established at appropriate places near the front-lines;
- d. Front-line troops were given frequent relief from positions which kept them immobile.

Through the Army Surgeon, an intensive educational program was begun in advance of the trench foot season. All units were indoctrinated in trench foot prophylactic measures. Preventive medicine bulletins devoted to trench foot were prepared by the Army Surgeon at frequent intervals for distribution down to companies. Army Quartermaster officers conducted demonstrations in all rest centers on the proper use of shoe-pacs. Unit medical officers and company commanders conducted frequent inspections of feet and footgear.

A statistical control was established by having every patient admitted to an Army Hospital with trench foot fill in a questionnaire on the circumstances which preceded or accompanied the attack of trench foot. The questionnaire provided an index to the level of unit indoctrination in prophylactic measures, and the degree to which unit commanders and medical officers had advanced the trench foot control program.

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The Army Surgeon's office maintained a current compilation of this information by unit down to the company or battery. All division commanders required investigation of every case of trench foot by unit commanders to determine whether foot discipline was being properly carried out. Appropriate disciplinary action was taken when investigation revealed the failure to comply with control measures was the cause of trench foot.

Section 21. *Supply of Blood in Forward Areas*

A whole blood procurement and distributing unit (Blood Bank) was demonstrated to be an essential part of the base medical service.

In anticipation of the need for a greater quantity of blood in the forward areas than ordinarily supplied from the base blood bank, and because of the possibility of a failure of the daily arrival of the blood bank plane from the base area, an emergency blood bank was established in the army rear area. One officer and ten enlisted technicians operated the section of the Army Medical Laboratory used for this purpose when necessary. It was capable of drawing and processing 150 pints of blood daily.

Section 22. *Medical Maintenance Units*

Standard Medical Maintenance Units were found short or lacking in many essential items, and over in many others. To maintain balanced stocks, it was found necessary in submitting requisitions for medical supplies to request Medical Maintenance Units less the items for which there was no need, and to add to the requisition those desired items which were not included or which were present in inadequate quantities in the Medical Maintenance Units. Several proposed changes to the Standard Maintenance Unit were submitted to higher level headquarters.

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Section 23. *Protection of Medical Supplies in an Amphibious Operation*

Discarded waterproof fiber containers for shells were found very convenient and practical to protect medical supplies in the initial landings in an amphibious operation. Small holes were punched in the metal rims at the top and bottom of the container. The hooks of the strap contained in the Medical Enlisted Man's aid kit were placed in these, thus allowing the container to be carried over the shoulder. They were waterproof, comfortable to carry, were durable, would float, and could be obtained in various sizes. Each container carried a balanced assortment of supplies most needed in the initial stages of the attack.

Section 24. *Requirements for Nurses*

During heavy fighting additional nurses were required in all army hospitals to administer adequate care to the patients who were predominantly surgical. It was necessary to plan for the shifting of available nurses from rear (base or evacuation) hospitals to meet peak loads of battle casualty admissions. Base sections were always able to fill the requests for additional nurses; however transportation difficulties often delayed their arrival beyond the period of urgent need. The shortage of nurse anesthetists was partially overcome by selecting nurses from Army medical installations to attend a three month course in anesthesia at a school operated by the Base Medical Section.

Section 25. *Connecting Ward Tents*

Heating, blackout, and professional care were facilitated by connecting two or more standard hospital ward tents end to end or by placing a pyramidal tent in the center with the end of a ward tent connected to each side. Connected tents were especially useful in the surgical section of evacuation hospitals in inclement weather.

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The shock tent, x-ray tent, operating tent and post-operative tent were often arranged to provide all-round cover. In the Hospitalization Unit of Field Hospitals, when used as surgical hospitals, the use of four ward tents connected to a pyramidal tent in the center became a standard procedure.

Section 26. *Increasing the Mobility of the Dental Service*

To facilitate the dental care for combat troops, mobile dental dispensaries were constructed using the bed of a 1-ton trailer as a carrier. Five such trailers were authorized for each infantry division, and seven trailers for each armored division. The detailed plans for construction were made and distributed to the units. In addition, each division constructed and maintained a mobile dental laboratory mounted on a truck. These were all fabricated from salvaged material.

Section 27. *Medical and Dental Care at Rest Centers*

The operation of medical and dental clinics at rest centers proved to be effective and efficient. Provision of such care at these centers aided the physical and mental recuperation of the restees. In addition, the treatment there given often took care of minor ailments which if left unattended would have developed into time-consuming cases. Medical personnel to operate this service were not provided in any overhead organization. Since Rest Centers are a demonstrated necessity, provision should be made for adequate personnel in an authorized organization.

[end of chapter]

[The document as presented here is - within the limits of my vision, alertness, and stamina - an accurate rendering of the original; but it is not a "true copy". Occasional misspellings and typographic errors in the original have been corrected. Further annotations - primarily abbreviation and acronym expansions - and insertions of clearly dropped words appear in 'square brackets'

- Patrick Skelly, for milhist.net]

[Transcribed 2001-12-03]