Fighting a War Without Rifles: Deconstructing the Image of the Unflappable Medic

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"Medic!" is a word that every soldier learns shortly after being introduced to combat, a word to many that means help is on the way, but for some it is one of the last words they hear. On the battlefields of the Second World War, seconds determined if an infantryman was going to live or die; this reality made the medic one of the most valued members of the unit. The US Army Medical Department oversaw taking care of these wounded men, and the medics were their front-line treatment solution.[1] The job of the medic has long been respected amongst the infantry, and the myth of the medic has long been a part of Second World War studies.

At the end of the First World War, the US Army Medical Department realized that due to the nature of modern warfare and weaponry, treatment would need to be carried out as soon as possible. When examining how to improve treatment protocols, it was decided that members of the Medical Department would be attached to combat units during the interwar years.[2] After this decision, personnel from the Medical Department began to serve alongside infantry and armored personnel as they entered a combat zone, rather than waiting in the rear for casualties. The newly-embedded soldiers from the Medical Department were quickly held to a high standard. In 1945, the General Board, a review board of US Army officers, drafted the report *The Evacuation of Human Casualties in the European Theater of Operation*, in which they discussed the roles of the company aid man.[3] When creating the report, the General Board relied heavily on the frontline infantry divisions' reports in evaluating the effectiveness of the medic.[4] From these reports, an image of the medic emerges. The General Board learned that "a qualified aid man is held in the highest esteem by the combat soldier and is usually the most popular man in the platoon or company."[5] The infantry held the new addition to their units as more than just another soldier; the medic was seen as a vital part of the system. This image of the aid man has long been part of Second World War studies, even when the medics' experience is different from the image that portrays them.

As medics began to take a more active role on the battlefield, they experienced the same horrors as the infantry to which they were attached. The General Board established that medics "must be thoroughly trained not only in first aid but also in the tactics of the infantry soldier."[6] The frontline experience of the medics exposed them to the brutality of war. This depiction is kept up through works by the US Army, such as the Green Books, which are after-action reports for the civilian population, published after the war had ended. The Green Books hold the medics

[1] The Medical Department was responsible for all medical matters for the US Army. All medical personnel and facilities including frontline assets fell under their jurisdiction.
[2] John T. Greenwood & F. Clifton Berry Jr., *Medics at War: Military Medicine From Colonial Times to the 21st Century* (Annapolis: Naval Institute Press, 2005), 68.
[3] "Medic" and "aid man" can be used interchangeably; they refer to the same role within the Medical Department.
[4] The General Board, *Evacuation of Human Casualties in the European Theatre of Operation* (self-publish, 1945), 4.
[5] The General Board, *Evacuation of Human Casualties in the European Theatre of Operation*, 1.
[6] The General Board, *Evacuation of Human Casualties in the European Theatre of Operation*, 1.

of the Medical Department in a mythic light; within these reports, the Medical Department discussed in the ways the riflemen saw them, as men unafraid to risk their lives to save the wounded. When examining the letters and memoirs of soldiers from the Medical Department, it soon becomes apparent that the image created by the infantry is different from reality. The medics of the Second World War did not receive the thorough training that was expected of them, they were prone to psychological breakdowns, and under extreme conditions, they were even insubordinate. Their war was no different from the men they were attached to. This image of the unflappable medic does not hold up when the realities of combat set in.

Training and its Consequences

In both the Army and civilian medical practices, the training establishes the foundations of procedure and patient care. For the Army, this stage was a crucial part of a medic's life, as it prepared them to care for patients treated under small arms and artillery fire. The medic or aid man was expected to be a highly-competent individual who was trained to save lives. In the *Evacuation of Human Casualties in the European Theater,* the General Board highlighted the importance of these traits: "the infantry will not accept a mediocre or inferior soldier as a company aid man."[7] Both high-ranking personnel and infantry in the field understood how important it was to have men trained in saving lives alongside those serving at the front. The infantry appreciated how important the aid man was to their survival. For those at the front, "a qualified aid man is held in the highest esteem by the combat soldier."[8] To the infantry, the medic was more than just another member of the platoon; he was who they relied upon when they were the most vulnerable.

The medics sent to North Africa were men who had been in the service prior to the war's outbreak. One such man was Allen Towne, who enlisted in the United States Army on October 10, 1940 and was attached to the 1st Infantry Division.[9] When Towne was assigned to the "Big Red 1," he had a luxury that few medics would receive later in the war as casualties mounted: training in a medical environment before deploying overseas. Towne was sent to the Fitzsimons General Hospital in Denver, Colorado for ten weeks of training.[10] During his time at the general hospital, Towne learned many new skills that would prove necessary in the field, including how to properly draw blood, administer plasma, and perform a blood transfusion.[11] This experience allowed Towne to learn how to treat patients without being under the stress of combat or a boot camp environment, which gave him more time to absorb and digest the necessary skills that were demanded of a medic. The hospital was also where Towne first faced death, relating how "two of the men under my care died."[12] Towne was able to learn in a structured environment, yet still become acquainted with the split-second decision making that accompanied medicine. This time in the hospital taught Towne lessons he would use throughout the war.

[7] The General Board, *Evacuation of Human Casualties in the European Theatre of Operation*, 1.
[8] The General Board, *Evacuation of Human Casualties in the European Theatre of Operation,* 1.
[9] Allen N. Towne, *Doctor Danger Forward: A World War II Memoir of a Combat Medical Aidman, First Infantry Division* (North Carolina: McFarland & Company, Inc Publishers, 2000), 3.
[10] Towne, *Doctor Danger Forward,* 5.
[11] Towne, *Doctor Danger Forward,* 5.
[12] Towne, *Doctor Danger Forward,* 5.

Partnering with hospitals also allowed the Medical Department to have access to men who already had experience treating patients. Dr. Zachary Friedenberg had worked as a surgical intern in King's County Hospital, New York, prior to enlistment in 1939.[13] Friedenberg and other practicing doctors and surgeons were a vital part of field hospitals. Their experience outside of the Army gave them the opportunity to be trained in new techniques, compared to outdated training films.[14]

The 95th Evacuation Hospital where Friedenberg was assigned consisted of primarily general practice doctors from outside the military, along with twelve practicing surgeons.[15] These doctors would soon learn, however, that their civilian training would prove more valuable than what the Medical Department circulated. While preparing for their deployment, the members of the 95th were eagerly awaiting news on how to treat combat wounds: "the experiences of those in medical units currently treating casualties would have been of great value." However, these lessons were never circulated amongst the civilian doctors. To make matters worse, the information they did receive was from "medical consultants, usually physicians and surgeons with academic backgrounds," who "travelled to medical units, observed the results of treatment," and made their own recommendations on patient care.[16] This gap between what was occurring in the field and communicating it to those who entered the battlefield after the first wave was a constant dilemma throughout the war.

As the war raged, casualties amongst both the infantry and medical personnel mounted. During the war, the General Board created an internal study to see how the Medical Department was conducting evacuations in Europe. They dissected every aspect of care, even looking at the casualty rate for the aid men, and concluded that "most divisions with as much as six months of severe combat suffered one-hundred percent casualties amongst the company aid man."[17] This high casualty rate was not only unsustainable for the Medical Department, but it also jeopardized caring for the wounded. The problem of replacements was felt throughout the armed forces during the war. The fighting caused a manpower crisis in 1943 which affected all services.[18] This shortage caused problems between the infantry and medical personnel as many senior members thought that the policy of placing men who had scored high on the Army General Classification Test, necessary for medical specialists, were being diverted from combat roles such as infantry officer and noncommissioned officers vital for commanding rifleman.[19] This added stress led to medics having to be rushed through training or learning in the field rather than a hospital environment.

Robert Franklin was one such medic, rushed to the front to bring units to combat strength. Drafted into the Army in 1942, Franklin had no prior medical training.[20] He had never been on a hospital floor, treated patients, or even taken a class on basic first aid. His only

[13] Zachary Friedenberg, *Hospital at War: The 95th Evacuation Hospital in World War 2* (College Station, TX: Texas A&M University Press, 2004), 6.
[14] Friedenberg, *Hospital at War*, 4.
[15] Friedenberg, *Hospital at War*, 4
[16] Friedenberg, *Hospital at War*, 8.
[17] The General Board, *Evacuation of Human Casualties in the European Theatre of Operation*, 1.
[18] Leonard L. Lerwill, *The Personnel Replacement System in the United States Army* (Self Publish; 1954), 270.
[19] Lerwill, *The Personnel Replacement System*, 273.
[20] Robert, J. Franklin, *Medic!: How I Fought World War II with Morphine, Sulfa, and Iodine Swabs* (Lincoln: University of Nebraska Press, 2006), 1.

experience in first aid was what "I learned from sitting in an orphanage infirmary as a child and watching the nurse for hours."[21] During his training as a combat medic, Franklin received little guidance for his duties, admitting that "no doctor ever talked to us about treating wounds."[22] Franklin was not as fortunate as Towne or Friedenberg to be placed in a medical training program or have prior civilian work. Instead, he was one of many replacements who relied on doctors and others to prepare him for his role in combat. What little knowledge he did have was basic first aid: "we once got instruction about pressure points and the use of tourniquets to control bleeding." However, he did not receive training in "using the medicine and bandages that would eventually be in our medicine pouches."[23] This lack of training in a controlled environment created a medic that was not as prepared as the General Board said a medic should be. It also created a medic who, when faced with the horrors on the line, could not properly perform his job.

The need for replacements at the front also affected men who were already in training. Robert Smith, drafted in March of 1943, was one of the replacements who scored high on the Army General Classification Tests (AGCT) in the late stages of his training, prompting him to be transferred to the Medical Services.[24] This score allowed Smith to go and train at the hospital at Fitzsimons. Smith was enrolled in a more intensive training regimen than Towne had experienced at the same hospital. Smith received a comprehensive education of anatomy, pharmacology, and surgical care.[25] Thanks to his high score on the AGCT, Smith received training that provided him with comprehensive lessons in medical care. However, this training was short-lived. As the divide between the infantry and the other services grew with the replacement crisis, sacrifices were made. Orders by General George Marshall at the end of 1943 asserted that the Army Specialized Training Program, the program that the AGCT was designed to assess readiness for, was to be cut dramatically, freeing men for combat roles.[26] By cutting the program, those who were in the middle of their specialized programs were rushed through, or, like Smith, forced to cease altogether.[27] This caused Smith and many others who were still considered specialists to finish their training on the battlefield rather than in a controlled environment.[28] The manpower shortages the US Army experienced thus caused major shifts in the training of a major technical service.

Those going into the Medical Department after the limiting of AGCT candidates felt the effect of these changes during their time in training. Klaus Huebner had joined the medical Reserves Officers' Training Corps while attending medical school.[29] During his time in medical school, Huebner had received various forms of training within the civilian setting.[30] This experience in the civilian health system would prepare him for treating the wounded. During his time at Fort Sam Houston, Huebner went through a series of field exercises designed to acquaint

[21] Franklin, *Medic!*, 3.
[22] Franklin, *Medic!*, 3.
[23] Franklin, *Medic!*, 3.
[24] Robert L. Smith, *"Medic" A WWII Medic Remembers* (Berkeley: Creative Arts Books, 2001), 15 & 20.
[25] Smith *"Medic,"* 20.
[26] Lerwill, *The Personnel Replacement System*, 273.
[27] Smith, *"Medic,"* 26.
[28] Smith, *"Medic,"* 26.
[29] Klaus H. Huebner, *Long Walk Through War: A Combat Doctor's Diary* (College Station, TX: Texas A&M University Press, 1987), 3.
[30] Huebner, *Long Walk Through War*, 3.

him with the men he would be fighting alongside.[31] Huebner began to question why he was assigned to the infantry rather than to a hospital: "my orders came to report to duty, they read 88th Infantry Division. This was somewhat of a blow."[32] The manpower shortages at the front had forced the Medical Department to send men who would have been better suited for hospital work to serve alongside the infantry. During his time with the infantry, Huebner realized his assignment was not determined by "background or IQ," but what demands the Department had.[33] The high casualty count of the war forced the Department to address the issue of saving lives on the front lines first and in the hospital second.

The time that Huebner spent with the infantry also highlighted the dilemma of how medics were seen within the Army and their roles as noncombatants. Troops of the Medical Department fell under the category of noncombatants because of their role on the battlefield, and thus they had various rules of war associated with them. One such rule was their protection and safeguard: "Medical troops, installations, and equipment are to be protected *so long as they are not used to commit acts injurious to the enemy."*[34] Yet Huebner was receiving weapons training at Fort Sam Houston: "I learned many other things… such as good knowledge of the M-1 rifle, Carbine," as well as heavy weapons such as "Browning automatic rifle, bazooka, and 60-mm mortar."[35] Though an officer of the Medical Department, Huebner was still receiving training that was designed to end lives rather than save them. Other medics had similar experiences, including Robert Franklin, who was also an enlisted soldier with the Medical Department. While Franklin was assigned to a medical unit, "all our training was for infantry fighting close-order drill;" during weapons training he "qualified as 'marksman' with a Springfield #03 rifle."[36] By giving these men weapons training, the Army created a paradox within them: fighter and healer. Both Franklin and Huebner had received combat training rather than working on technical medical skills, as the leaders of frontline units and the technical services were fighting each other for the desperately-needed replacements.[37] These two men's training regimen highlights the Army's thought process during the manpower shortage: to get men who could fight to the front even if other vital units were understrength, units that the infantry depended on.

The Medical Department had a crucial role throughout the Second World War. It was tasked with saving as many men as possible from succumbing to wounds sustained in combat. This was no easy task, and the men who were assigned to perform it needed to be well-trained to handle the changing situation on the battlefield. Training was fundamental to the role the Medical Department would play in the war, yet it varied greatly from soldier to soldier. It was not a standardized process like the infantry's boot camp. Some recruits, such as Towne and Friedenberg, were able to learn how to treat wounded soldiers, as well as other patient needs, well before the conflict started. Replacements like Franklin, on the other hand, were expected to learn on the field. Even those lucky enough to get specialized training well into US involvement in the war were casualties of the constant need to rush men up to stem the bleeding at the front. This rushed training caused many men to learn under the chaotic conditions of combat how to

[31] Huebner, *Long Walk Through War,* 4.
[32] Huebner, *Long Walk Through War,* 3.
[33] Huebner, *Long Walk Through War,* 3.
[34] US War Department, *The Battle Field Medical Manual 1944* (United Kingdom: Amberley, 2014), 16.
[35] Huebner, *Long Walk Through War,* 4.
[36] Franklin, *Medic!,* 3.
[37] The technical services are services that fall outside of typical combat roles such as the engineer corps, medical services, signal corps, and other vital parts of the army.

properly treat the wounded. This gap in standardized training in patient care caused a lack of consistency in treating the various combat wounds of the war, as well as how different medics would react in combat situations.

Each soldier reacted differently to combat; the same can be said for medics. Towne's first combat experience was landing on the beach near Oran, Algeria during Operation Torch.[38] His first time in combat not only involved the horrors of war but the effects of a poorly-planned operation. When Towne landed alongside the infantry, the only medical supplies he had to work with were "what we could carry in our large haversack vests."[39] The planners of Operation Torch did not have any background in the logistics of medical supplies, and thus they did not know how to best allocate the various equipment that would be needed to treat the casualties that mounted on the beaches.[40] Because of this supply shortage, Towne had to adapt and treat patients with what little he had. Relying on his training, Towne was able to help the wounded on the first day of Operation Torch with a few "dressings, sulfa powder, morphine syrettes, bandages and other supplies," a fraction of what he would normally have accompanying him from the aid station to which he was assigned[41] The supply problems of the landing forced Towne to economize both care and medical supplies.

The medics, while dealing with the supply problems of the landing, also had to contend with the confusion of combat. Towne and the men alongside him were forced to remember all the skills they learned under the stress of combat. This was a difficult task, with some men succumbing to the confusion of battle. One such soldier was Billy Edwards, a member of the same collection station as Towne. According to Towne, as they were treating a soldier with a large wound to his shoulder, Edwards went to "pour pure alcohol in the gaping wound when I stopped him."[42] Although the men had been trained to be ready for combat, the stress had temporarily impeded their actions. The initial shock of combat had caused Billy Edwards, the aid man, to forget his training. According to the Battlefield Medical Manual, "there is no substance which should be used by the first-aid man to wash a wound."[43] The manual listed various reasons why, from further contaminating a wound to substances not being strong enough to kill bacteria.[44] While these men had received training on how to deal with combat, they could still have lapses in judgment when treating the wounded.

Other men, like Franklin, went into combat knowing that their lack of understanding of medicine would affect patient care. Franklin was aware of the how his lack of training affected the men under his care. During the landing in Sicily, Operation Husky, Franklin had to make decisions that affected the wellbeing of multiple men. Shortly after landing in Sicily, Franklin had to treat a group of freezing men who had been soaked in water from the landing.[45] In order to remedy their state, Franklin poured some ammonia into canteen cups for them. "I thought it

[38] Towne, *Doctor Danger Forward*, 19.
[39] Towne, *Doctor Danger Forward*, 19.
[40] Charles M. Wiltse, *The Medical Department: Medical Services in the Mediterranean and Minor Theaters* (Washington D.C.: Center Of Military History United States Army, 1987) 207.
[41] Towne, *Doctor Danger Forward*, 19.
[42] Towne, *Doctor Danger Forward*, 19.
[43] US War Department, *The Battle Field Medical Manual 1944*, 122.
[44] US War Department, *The Battle Field Medical Manual 1944*, 122.
[45] Franklin, *Medic!*, 10.

might warm them. Hell, for all I knew about medicine, I might have been poisoning them."[46] Franklin's lack of training with medicine could have put these men in danger. The medic was forced to make calls in the field that had long-term ramifications for the troops being treated. Another such incident involved a GI with an unknown pain. When a jeep with two officers drove by, Franklin managed to get a five-gallon water can from the reluctant officers to treat the GI. After the soldier drank and vomited the water, Franklin discovered that he had ingested unripened grapes, causing his stomachache.[47] Yet even in this moment of triumph, Franklin mentions how he got lucky with his treatment: "yet he might of just well had appendicitis. We were far from our company aid station, so I took desperate chances."[48] While the Medical Department needed to get men on the front, doing so could have cost many men their lives due to insufficient training.

One thing that the battlefield taught many medical personnel was the ramifications of their speed or delay in a way teaching could not: with the lives of patients. Doc Friedenberg learned this lesson during his first engagement in the landings on mainland Italy. It was not until two days after landing on the Italian coast that the men of the 95th Evacuation Hospital were finally able to set up their equipment, even though they had accompanied the infantry during the initial landing.[49] This delay was catastrophic for the wounded from the previous forty-eight hours. While the battle raged, the wounded were left to lie out in the sun, baking under its heat.[50] This heat, mixed with the various wounds, created a deadly combination of gas gangrene. This disease is caused when a bacteria of the Clostridium family is able to grow in a wound due to dead tissue; as it mixes with this tissue, it creates a toxic gas that proves lethal as it spreads through the body.[51] Many of those treated by the 95th on the first night the hospital was operational were wounded forty-eight hours prior, allowing the gas to spread within them.[52] With the delay in establishing the hospital, wounds that could have been easily treated proved fatal due to gas gangrene.[53] Friedenberg, fresh off a two year internship, was ill-prepared for the mass casualties of the battle.[54] Through this event, the members of the 95th learned just how valuable time was on the battlefield.

As combat raged and casualties mounted, medics had to quickly diagnose the wounded and move to the next patient. The diagnosis of wounds relied heavily on the training one received before being sent to war. During combat, a multitude of various wounds can be inflicted, the most common wounds being incised, laceration, and puncture wounds, which all have separate treatment procedures.[55] Lacerated and puncture wounds, caused by shell fragments and bullets, respectively, can carry with them debris or powder, leading to wound contamination.[56] Incisions, on the other hand, are wounds caused by sharp objects such as a knife

[46] Franklin, *Medic!*, 10.
[47] Franklin, *Medic!*, 17-18.
[48] Franklin, *Medic!*, 18.
[49] Friedenberg, *Hospital at War*, 37 & 44.
[50] Friedenberg, *Hospital at War*, 45.
[51] Friedenberg, *Hospital at War*, 46.
[52] Friedenberg, *Hospital at War*, 45.
[53] Friedenberg, *Hospital at War*, 44 & 46.
[54] Friedenberg, *Hospital at War*, 45.
[55] US War Department, *The Battle Field Medical Manual 1944*, 138-139.
[56] US War Department, *The Battle Field Medical Manual 1944*, 138-140.

or bayonet.[57] As a battle raged, casualties of each type mounted, and the medical personnel had to adapt to a growing casualty rate. To cope with this, medics were trained to fill out an Emergency Treatment Tag, a detailed description of all treatments a wounded man had received as well as a rudimentary diagnosis.[58] These cards were used to make a complete list of all wounds inflicted on a casualty. But due to the nature of combat, this procedure in practice was too time-consuming, and medics began implementing their own forms of communicating treatments in battle. One such signal was morphine syrettes pinned to a soldier's clothing to indicate how much of the substance was given to avoid an overdose.[59] Though the Triage card was an important part of frontline medicine, filling one out could have been lethal for medics and their patients. Training could not prepare medics for everything in the field; the reality often proved overwhelming.

Another thing that training could never prepare troops out in the field for was how a medic's job went beyond saving lives to comforting the dying. The medics were for many the last interaction they had with the world. Each person confronts death in a different manner on the battlefield. The first time Franklin was faced with this moment was when he treated a downed enemy pilot. When his unit came across a downed German fighter, a doctor from the company aid station told Franklin to "make him comfortable," which Franklin did not know how to do.[60] Franklin had to confront death in the most intimate way possible, by being part of the process. He failed to realize that the pain killer, morphine, that he carried could comfort the dying pilot. Instead of administering a syrette, he sat with the young German pilot as he passed in the cockpit of his downed fighter.[61] Other aid men tried all they could to comfort the wounded in their final moments. While Friedenberg was combating his gangrene epidemic, he did all he could with what he had to alleviate the pain. As the casualties came in, soldiers and civilians alike, Friedenberg distributed morphine liberally to his growing number of patients.[62] He understood that in order to make the dying comfortable he had to numb the pain that foreshadowed death. He tried to do all he could with the little that was available after the landing. It was not until morning that Friedenberg came to terms with the dead and the horrors of the war: "I realized how impotent a doctor was without the drugs and tools of his profession."[63] Simply having the tools of the profession were not enough, however; in Franklin's case with the pilot, he had the tool but did not have the knowledge to use it effectively. The two men are different sides of the coin. Franklin had all the tools at his disposal to comfort a dying man but did not know how to use them. Friedenberg had the knowledge to save the dying under his care but only had the tools to make death comfortable. The difficulty the troops of the Medical Department faced was that no matter how hard they tried, they could not save every patient. Sometimes saving the patient meant helping them move on rather than continuing to feel pain.

The consequences of the training gap affected how many medical personnel treated the wounded of the war. Men who had more training had the advantage of entering the combat zone with some idea of what was happening around them, while others struggled to find their ground

[57] US War Department, *The Battle Field Medical Manual 1944*, 138.
[58] Graham A. Cosmas & Albert E. Cowdrey, *The Medical Department Medical Services in the European Theater of Operations* (Washington D.C.: Center Of Military History United States Army, 1992), 361.
[59]Cosmas & Cowdrey, *The Medical Department Medical Services in the European Theater of Operations*, 363.
[60] Franklin, *Medic!*, 15-16.
[61] Franklin, *Medic!*, 16.
[62] Friedenberg, *Hospital at War*, 45.
[63] Friedenberg, *Hospital at War*, 45.

in the maelstrom. As the men of the Medical Department became more experienced alongside their rifleman counterparts, they were able to adapt to the changing situations that combat brought to the aid stations and hospitals, just like it did to the men at the front. Events like the manpower shortage in 1943 created paradoxes in which men were taught how to take lives when they were charged with saving them. Even though they demanded highly-trained and competent troops, the burdens of war made this ideal hard to achieve.[64] The increased casualties the Medical Department and the infantry faced quickened training to stem the bleeding at the front. The men who made it to the front came face to face with the wounded and dead that the war had brought, casualties that the inexperienced aid men had to put back together in hopes of saving what little they could.

Unflappable

The medics of the Second World War were highly respected amongst the infantry for rushing into harm's way in order to save the wounded on the battlefield. For the Army, only a handful of men were allowed to hold the title and perform the task. As discussed earlier, the General Board emphasized that "It has been proven without question that only the highest type of individual is suitable for assignment as company aid man."[65] It is through statements like this, made by the General Board, and the close relationship of the medic and aid man with the troops on the line that members of the Medical Department were deemed unflappable. This myth portrayed the medics as something more than they actually were: men who were thrown into the horrors of modern combat with the sole task of saving as many men as they could with what little time they had, and who reacted to the horrors just as any other human would.

The relationship between the infantry and the medics was formed after the First World War when steps were taken to improve the time between being wounded and getting treatment. The medic position was created in the interwar years when the Medical Department discovered that the best way to save lives was reducing the time to treatment.[66] Medics were embedded with infantry units to ensure that a soldier received the quickest time to treatment, on the battlefield itself rather than at an aid station out of harm's way. Medics were no longer their own separate entity but members of the unit. Doctor Klaus Huebner reflected on his relationship with the men he served alongside: "living with the men daily, treating them, and moving among them… give me a profound knowledge of their character, ability, and mental stability."[67] This close relationship drove how the infantry saw the medics, the only thing keeping them from bleeding out on the battlefield.

However, the men of the Medical Department were not immune to the horrors of combat. They struggled to cope with the events of war alongside the infantry and could easily buckle from the stresses of the battlefield. Because the medic was part of the first echelon of care, they worked under direct enemy fire with death all around. Allen Towne remembered, "I found you either get used to this life or one of two things happen. You could go into an anxiety state or…

[64] The General Board, *Evacuation of Human Casualties in the European Theatre of Operation,* 1.
[65] The General Board, *Evacuation of Human Casualties in the European Theatre of Operation,* 1.
[66] Greenwood & Berry Jr., *Medics at War,* 68.
[67] Huebner, *Long Walk Through War,* 4.

you could take an extreme measure and shoot yourself."[68] The men of the Medical Department saw the infantry at their worst possible moments and were expected to keep calm and perform their task no matter what. In the preface to his memoir, Huebner commented extensively on how important remaining collected was to his job: "A battalion surgeon learned to remain calm in any situation and show no emotion no matter the casualty."[69] If the medic lost his cool on the battlefield, it would place the lives of all those in his care in jeopardy.

When medics could not withstand the pressures of war, the people most affected were the patients they were sworn to protect. Towne experienced this first-hand as he was treating a GI who was "on the operating litter with a deep shell-fragment wound in his chest," so deep it "penetrated his lung."[70] This casualty's life rested in the hands of Towne and the men around him. When bombers flew over the aid station, "everyone left the tent and dived for their holes, and I was left alone with the wounded man."[71] As the men dove for their foxholes, the men of the Medical Department betrayed the trust of the men they were sworn to protect. The sudden departure from the surgery by those inside, including the aid station commander, Captain Tegmeyer, violated the core procedures of the medical practice. Tegmeyer was the acting operating surgeon during the incident, meaning that he was the sole person in charge of all conduct in the operating room. He was "responsible for the patients' life and for the successful outcome of the operation."[72] In this instance, the men of Towne's aid station not only betrayed the trust of their patient, an infantryman who relied on them to live, but also violated the chain of command within the operating room.

Once Towne deployed to Europe, occurrences of battlefield breakdowns became more frequent. One such occasion occurred when an anti-aircraft (AA) battery near the aid station came under tank fire. After a German tank had been shelling the AA for twenty minutes, Towne realized that some of the men at the battery were still alive and wounded.[73] However, in order to treat the wounded, he had to rally the litter bearers, also known as stretcher bearers, of his aid station to accompany him to the gun emplacement.[74] According to the myth of the medic, these men would have rushed into harm's way to save the AA gunners, but not on this night. The men were terrified to move forward, and Towne had to convince them to help the wounded, illustrating the stress medical personnel were under during the war.

Medics were also tasked with patching men who were torn apart back together. During his time in Italy, Franklin had been pushing into the mountains with the advance, and during one encounter with German artillery, he reached a point of near breakdown. During an artillery bombardment, his company's command post was struck. The shelling left several men wounded, and as he approached, "the first thing I saw froze me."[75] Franklin had come across seven casualties; three had been killed by the shell fire as the shrapnel tore them apart.[76] Franklin was

[68] Towne, *Doctor Danger Forward* 35.
[69] Huebner, *Long Walk Through War,* XIII.
[70] Towne, *Doctor Danger Forward,* 54.
[71] Towne, *Doctor Danger Forward,* 55.
[72] US War Department, *The Battle Field Medical Manual 1944*, 93.
[73] Towne, *Doctor Danger Forward,* 112.
[74] Towne, *Doctor Danger Forward,* 112.
[75] Franklin, *Medic!,* 70.
[76] Franklin, *Medic!,* 70.

terrified as he treated a replacement who had come up to the line a few days before the barrage.[77] The replacement's jaw was blown off by a piece of shrapnel; "his eyes looked terrified while I bandaged him."[78] Franklin was no stranger to the death and destruction of artillery fire, but this one incident changed how his platoon operated. One of the sergeants came up to help Franklin but quickly walked away when he saw his friend torn apart by the shell fragments.[79] Being at the front, aid men were susceptible to the same horrors as the infantry and were just as vulnerable to the fire of the enemy. The only difference was that no one was there to comfort the medics when they reached their limit.

Robert Smith experienced the same horrors during the Ardennes offensive in December of 1944. As the rifle battalion he was attached to engaged German armor and artillery, the losses were devastating. "Dave and I were busy bandaging wounds from rifle fire" as well as "trying to hold together extremities blown apart by cannon and mortar fire."[80] The Ardennes was the breaking point for many US soldiers during the war, as casualties mounted during the fierce German attack. Smith and his fellow aid men were forced to act on instinct as "the shock of the severity of the injuries we saw, we probably would not have been able to function," if they took the time to think. [81] Smith and the other medics with him were forced into an environment that they could not comprehend, the violence of which was the only thing keeping them running. As the men around him fell, Smith struggled with men who had their jaws blown off and limbs hanging to the body by strands of tissue, hoping that the decisions he made had a chance of saving the men under his care.[82] The nature of the fighting had caused Smith to override the impulse to contemplate what was going on, to react and treat without dwelling on the scenes in front of him, scenes that would come back to him at night when he tried to escape from the war around him.[83] The war had brought men to their breaking points in every branch of the military, and the men of the Medical Department were no exception. They could only take so much death and destruction before they themselves succumbed to the events around them, becoming numb at times.

Huebner on the other hand reached his breaking point as his unit attacked Santa Maria Infante, Italy. The road to Santa Maria Infante became clogged with US tanks and transports, providing a tempting target for German artillery: "the Germans' artillery which [had] been silent all day, now opened up with everything at its command."[84] As the artillery fired upon the clumped-together US forces, Huebner and the rest of his medical team sought shelter in a gully across from the chaos.[85] While the shell fire raged, Huebner's concern lay not with the men under his care but a guide who was to take him to a different aid station: "Where the hell is my guide?" ran through his brain, along with, "I can't sweat this murderous fire out much longer."[86] Huebner's own self-preservation kicked in. Like the men who had abandoned Towne in North Africa and refused to move in Europe, Huebner was concerned with his own safety rather than

[77] Franklin, *Medic!*, 70.
[78] Franklin, *Medic!*, 71.
[79] Franklin, *Medic!*, 70.
[80] Smith *"Medic",* 85.
[81] Smith *"Medic",* 85.
[82] Smith *"Medic",* 85 & 86.
[83] Smith *"Medic",* 85.
[84] Huebner, *Long Walk Through War*, 65.
[85] Huebner, *Long Walk Through War*, 65.
[86] Huebner, *Long Walk Through War*, 66.

that of the men under his charge. As soon as he was able to, he abandoned the battlefield: "At a moment when I think the shelling [had] somewhat slackened, I departed."[87] Huebner had reached a point where he could no longer take the bombardment from enemy artillery and left. His actions were not that of the unflappable medic, but of a man who had had enough of combat and its aftermath.

The troops of the Medical Department did not just crack from the sights of the battlefield. Over-burdened from patient flow, men were fatigued, their environments pushing them to their limits both mentally and physically. During the gangrene epidemic that Friedenberg treated as mentioned earlier, not only was Friedenberg dealing with the gore and horror of war, but with the cries of despair as well. As he tended his various patients, their wails filled the hospital: "*Mia bambino…mama mia…*the Lord is my shepherd…Mother of Mercy…*Mein Gott…*Doc, do something I can't breathe."[88] Friedenberg was fresh out of both internships and school, yet he was expected to have the mental fortitude to take charge of more than 40 patients.[89] He could only do so much for the various patients under his care with what little he had. The limited supplies and equipment that were available were not the tools needed to treat the volume or types of cases that he had.[90] Friedenberg was facing a situation that every person in the Medical Department feared: not being able to treat those under their protection. In his first combat experience, Friedenberg was faced with this reality, an event that affected the way he saw his role in the war. With this one event, he realized "how impotent a doctor was without the drugs and tools of his profession;"[91] he came to grasp how devastating war could be. By realizing both how ineffective he could be and how quickly death could set in, Friedenberg had reached a point of despair that followed him through the war as he treated patients. Events like these terrified the men who were expected to compartmentalize the events around them and left them with their own trauma as they continued to treat wound after wound.

The men of the Medical Department had to perform their tasks under harrowing fire. Medics at the front and aid men in aid stations were both susceptible to enemy fire and bombardment, and as such, they had their own breaking points, just like the men they treated. The nature of the medical field had put these men in an environment where they had to dwell on the devastation of war. Unlike the infantry who had to keep moving and could not absorb the carnage around them, the medical troops lived in it. They saw the devastation that modern war had wrought on the human body. Bandaging torn flesh in ways they had barely trained for, the medics were expected to stay calm under fire. Their presence was a moral boost for the infantry, but these men were not always the anchor the troops needed them to be. They were human; they could only absorb so much death and destruction before they themselves were no longer combat effective and could not perform their duty on the battlefield.

Psychological Wounds and Treatments

[87] Huebner, *Long Walk Through War,* 66.
[88] Friedenberg, *Hospital at War,* 45.
[89] Friedenberg, *Hospital at War,* 45.
[90] Friedenberg, *Hospital at War,* 45 & 46.
[91] Friedenberg, *Hospital at War,* 46.

Throughout the war, the US Army struggled with various forms of psychological wounds. As the war progressed, the ways that these wounds were diagnosed differed between the Medical Department and the medics at the front. As more and more men were suffering from psychological ailments, the medics and the Department struggled with how to treat the afflicted men.

Before the war, the US Army and its counterparts around the world were still thinking in terms of the First World War when it came to psychological wounds. In a 1939 article in the *British Medical Journal*, Maurice B. Wright discussed, "How can we differentiate the real coward?"[92] In 1939, the world was seeing those who suffered from psychological wounds in war as cowards. The article goes on to mention a form of anxiety called an "Anxiety Stupor."[93] This form of anxiety was very similar to what the Army would call "Hysterical Unconsciousness" late into the Second World War.[94] Wright described these wounds as "lying apparently in deep sleep or unconscious."[95] The anxiety stupor caused unconsciousness, forcing a person to shut down all mental functions. The casualty would no longer be in control of their ability to function. This wound had the same causes and effects as its physical counterparts, yet those in military medicine considered it an act of cowardice rather than an actual combat wound.

Wright's article was focused on the idea of hysteria and its impact on those in combat. Anxiety stupor was one of these hysterical states. The crux of the article was how terror affects those in combat situations. Wright understood that all the forms of hysteria he discussed were manifested in the ideas of a person becoming overwhelmed by the events surrounding him or her. Anxiety hysteria was an example of this, being manifested by "the dangerous situation, whether past, present, or anticipated."[96] What Wright described was similar to what was termed "shellshock" in the First World War. The "accompaniments of fear are so intense that no amount of reassurance or removal to a place of safety" will calm the casualty effectively: "the effect of fear on the whole automatic system has for the time being put out of action."[97] These casualties were in a catatonic state and could not function in their previous manner. The casualties were so incapacitated that they "will not come themselves to the casualty clearing station," but were "brought there, often as stretcher cases."[98] Wright's understanding of psychological wounds in 1939 was the product of the First World War. This perception influenced the Second World War's understanding of how to treat mental afflictions.

The *British Medical Journal* published several articles that had similar viewpoints to Wright, including "Medical Problems in War Neuroses in War," written by E. Wittkower and J. P. Spillane. While Wright explored the origins of hysteria, Wittkower and Spillane looked at how neuroses manifested themselves. Wittkower and Spillane saw psychological wounds not as casualties but as men seeking attention: "under such stresses these individuals increasingly

[92] Maurice B. Wright, "War Wounds and Air Raid Casualties. Psychological Emergencies In War Time," *British Medical Journal* 2, no. 4105 (1939): 576.
[93] Wright, "War Wounds and Air Raid Casualties," 577.
[94] US War Department, *The Battle Field Medical Manual 1944*, 150.
[95] Wright, "War Wounds and Air Raid Casualties," 577.
[96] Wright, "War Wounds and Air Raid Casualties," 576.
[97] Wright, "War Wounds and Air Raid Casualties," 577.
[98] Wright, "War Wounds and Air Raid Casualties," 577.

regressed to a narcissistic level of development."[99] These diagnoses called into question whether men suffering from wounds caused by mental trauma were even suffering at all or simply acting out. These actions were described as "a state of infantile helplessness, with complete surrender to their suffering and a need to be pampered, cared for, and petted like children."[100] The divide between wounded and pretender grew wider with this idea as it devalued men who were suffering from psychological wounds. With this language, the sick were no longer patients but children to be taken care of.

Wittkower and Spillane also made reference to what medics who fought earlier in the war called the "anxiety state." The anxiety state as described by Wittkower and Spillane had many moving parts; its development and manifestation took on several stages. The first major description of the anxiety state was that it is a form of fatigue from prolonged exposure to combat.[101] An anxiety state manifested itself in various ways, including hallucinogenic sleep, "in which the main events from the day appeared in troublesome visions."[102] The constant repetition of the horrors of war wore on the soldier at a time when he expected reprieve from the sights around him. This tore at the soldier's psyche, creating a state that "developed fear and horror of the sights around him and was unable to keep his mind away from the possibility of injury."[103] This stage of the anxiety saw soldiers' bodies hijacked by fear. They were no longer in complete control of their actions and were no longer combat effective.

Ideas such as these shaped how the Army saw the psychologically wounded in the Second World War. In time, medics on the front line realized that more had to be done to help those with wounds that could not be easily seen. Medics learned that men were suffering from the pressures and stresses of combat. After seeing their friends die or be brutally maimed in front of them, simply soldiering on was no longer an option. As the US entered the Second World War, the ideas of the last war bolstered its understanding of the impact of these psychological wounds for those suffering through them.

Influenced by the developments in the prewar years, the Medical Department was finding new ways of diagnosing psychological casualties. The *Battle Field Medical Manual 1944* referred to these episodes as "hysterical unconsciousness," instructing medics to treat the men as if they were acting up for attention and leave them be.[104] This older method of taking care of broken men was similar to ideas from the First World War. Men who could not take the pressure of combat were treated as if they were attempting to get out of fighting. By claiming that the soldier was falsifying his wounded mind, he was placed on the same level as men who physically wounded themselves to avoid combat. During his time in Africa, Towne saw many of these men who had "shot themselves in the hands or feet;" they even acted differently than most wounded in that "the men seemed to be in more pain than the more severely wounded men."[105] To the Medical Department, these men were the same as the psychologically wounded early in the war;

[99] E. Wittkower and J. P. Spillane, "Medical Problems in War Neuroses in War," *The British Medical Journal* 1, no. 4128 (1940): 265.
[100] Wittkower and J. P. Spillane, "Medical Problems in War Neuroses in War," 265.
[101] Wittkower and J. P. Spillane, "Medical Problems in War Neuroses in War," 266.
[102] Wittkower and J. P. Spillane, "Medical Problems in War Neuroses in War," 266.
[103] Wittkower and J. P. Spillane, "Medical Problems in War Neuroses in War," 266.
[104] US War Department, *The Battle Field Medical Manual 1944*, 150-151.
[105] Towne, *Doctor Danger Forward*, 35.

both groups were acting up to get out of combat. However, the medics at the front like Towne saw the psychologically wounded in a different light.

Medics had a vital role on the battlefield that required them to be close to the line and even behind it, close to the wounded and the dying, and even the dead. Early on in the invasion of North Africa, Allen Towne encountered his first psychological casualty. Towne was sent with a squad of medics to collect a group of US GIs that had been killed in an ambush.[106] The scene that Towne encountered startled the medics "they were lying in various positions… One had his water canteen in his hands" and "another soldier was lying on his back with his hand frozen in rigor mortis, holding rosary beads over his eyes."[107] Towne and his squad were not prepared for the scene they encountered. While their job surrounded them with men who were mortally wounded and dying, Towne and other members of the Medical Department were not trained to deal with collecting the dead off of the battlefield. This task was reserved for the Mortuary Corps, but in North Africa these units had not yet arrived.[108] This event shook many of the men who had accompanied Towne; one man started to have a nervous breakdown, and needed to be restrained and sedated.[109] Despite their medical position, some men could not take it, and they broke.

At the front, the medics and aid men saw the same horrors of war that the infantry saw, understanding how the chaos of combat shook men to their cores in a way that officials and analysts could not. Towne's aid station changed how they labeled the psychologically wounded; they abandoned the term "shell shocked" for "anxiety state," limiting the stigma that came with the condition. [110] The men at the front did not let the anxious men sit and wallow in their tortured minds but gave them sedatives such as morphine to keep them calm while being evacuated. [111] The men who suffered from these anxiety states were not men who wanted an out or attention but men who had to come to grips with war. Those working in aid stations had to come to terms with this as well; medics sometimes slipped into anxiety states during high casualty battles because they could not cope with the trauma around them.[112] Sedatives alone could not keep men calm, and partway through the war the various frontline aid stations and personnel learned what others had done to treat the psychologically wounded.

One such unit was the 95th Evacuation Hospital. The aid men and nurses of the 95th evac hospital treated the men they called "battle fatigued," men who needed rest above all else. [113] These men had suffered more than just anxiety attacks or hysterical outbursts; they were mentally and physically exhausted from the stresses of combat. It was this idea that led them to treat these men as they would treat any fatigue, with rest. The 95th created a treatment system that revolved around uninterrupted rest for an extended period of time. [114] The 95th gave the fatigued both sleeping medication and sedatives to place soldiers in a deep sleep, resting both

[106] Towne, *Doctor Danger Forward*, 21.
[107] Towne, *Doctor Danger Forward*, 22.
[108] Towne, *Doctor Danger Forward*, 21.
[109] Towne, *Doctor Danger Forward*, 22.
[110] Towne, *Doctor Danger Forward*, 22.
[111] Towne, *Doctor Danger Forward*, 22.
[112] Towne, *Doctor Danger Forward*, 55.
[113] Friedenberg,, *Hospital at War*, 59.
[114] Friedenberg, *Hospital at War*, 59.

mind and body.[115] During this deep rest, the men were able to escape the horrors of the front line and the chaos of the aid station. What was most important about this treatment was its high success rate in treating the men who were evacuated to the hospital. Doctor Zachary Friedenberg, one of the physicians in charge of the hospital, remarked that a majority of the men "went back to their units within forty-eight hours."[116] Instead of the soldier being left alone and unable to fight or sedated in a hospital in the rear of the line, men were able to rejoin the fight. This rest treatment was eventually copied by the other units later in the war.

The resting treatment was taken to extremes during the Battle of the Bulge. What started as an effective treatment for those who had reached their breaking point turned from a break from horrors to reliving them. During the battle, the Medical Department issued an injection containing sodium pentanol which put GIs into a lucid dream state.[117] During this state, the soldier's dreams could easily be manipulated; doctors and aid men would take advantage of this by recreating the events that broke the soldier before arrival.[118] In the *War Department Film Bulletin 184*, a doctor and several aid men are shown recreating the sounds of an artillery strike as a soldier who was injected with sodium pentanol screams in agony and makes himself as small as possible to avoid the incoming "shrapnel," thinking he is reliving the events that brought him to the safety of the hospital.[119] The Medical Department believed that by augmenting the rest treatment that the 95th saw high success rates with, audio recreations would help the wounded get over their shock. They failed to realize that the new treatment created more pain and suffering then regular sleep could ever cause.

The Medical Department also implemented pure sleep treatment like the 95th, but with more powerful medications. Again, the Medical Department issued new drugs designed to enhance the rest treatment. Sodium-ammiol was given to troops to put them in a deep sleep for a period of forty-eight to seventy-two hours at a time.[120] The pill was so effective at knocking the exhausted GIs out that it received the nickname "blue 88" amongst troops, a reference to the German artillery piece obliterating them at the front.[121] The Medical Department thought this heavily-medicated sleep was enough to allow troops to rest and recover from the devastating offensive. However, the blue 88, combined with the injections of sodium pentanol, had the opposite effect. Men had reached a point during the Battle of the Bulge where no amount of rest could prepare them for returning to the front; the treatments that were designed to get men back into the fight quickly broke what little morale the devastated troops had.[122] They were completely unwilling to return to the frontlines. When asked to tell men they were returning to combat, a Medical Department Officer stated, "I couldn't tell these men they were going back. I broke down and said I never wanted to do that again."[123] The faces of the broken proved too

[115] Friedenberg, *Hospital at War,* 59.
[116] Friedenberg, *Hospital at War,* 59.
[117] *War Department Film Bulletin 184: Psychiatric Procedures In the Combat Area,* directed by United States War Department (1944, Washington D.C.) Digital Archive. https://archive.org/details/FB-184.
[118] *War Department Film Bulletin 184.*
[119] *War Department Film Bulletin 184.*
[120] *Battle of the Bulge the Deadliest Battle of World War II,* directed by Jeremy Stavenhagen and Gary Steele (1994; Boston, MA: PBS, 2004), DVD.
[121] *Battle of the Bulge the Deadliest Battle of World War II.*.
[122] *Battle of the Bulge the Deadliest Battle of World War II.*
[123] *Battle of the Bulge the Deadliest Battle of World War II.*

much for the officer. The horrors of war proved that the Medical Department personnel was unable to cope with a growing number of psychologically wounded.

The Medical Department throughout the war faced a rapid shift in how men with psychological wounds were treated. The shift from anxiety state to battle fatigue not only changed the diagnosis process but how men were treated as well. By changing how they thought, the Medical Department allowed for new and different ways of treating those who were suffering from wounds that were unseen and could not be bandaged by traditional means. The stigma of the anxiety state that was mentioned in the Wittkower and Spillane article created the idea that a soldier was regressing to a coward-like state. By 1943, units such as the 95th Evacuation Hospital in Italy had recognized the stigma associated with the anxiety state. By treating the men as fatigued, the 95th created a new diagnosis that did not paint the soldier in a negative light. They went from men with weak and fragile psyches to men suffering from the natural wear and tear of combat. This allowed for the expansion of treatment options for the medic on the front, as well as the ability to understand which methods did and did not work. The treatment of wounds beyond the physical was just as important as treating the maimed and dying.

The Reality and Reactions of Medics in the Field

The men of the Medical Department had the sole purpose of keeping wounded soldiers alive and getting them back into action as soon as possible. For this reason, they had to find the best way of treating patients that worked effectively in battlefield conditions. This created disagreements between the men on the front and those at the top over various procedures and needs. Throughout the war, this conflict became part of how frontline units treated patients as they fought to save as many men as possible, affecting procedures, equipment, and even chain of command. When it came to saving lives on the battlefield, where seconds mattered, medical personnel did not have time for procedures that hindered their ability to provide care.

A key component of the evacuation of wounded soldiers from the battlefield was the various evacuation echelons that stretched from the combat zone to deep behind friendly lines. At the crux of these echelons were the effectiveness of the various transportation vehicles the Medical Department had at its disposal. At the front, litter bearers had access to three tools for carrying the wounded: a collapsible field carrier, a 1/4 ton trunk also known as the "jeep," and an M3A2 half-track.[124] In their review of the evacuation process, the General Board members were surprised by how medics reacted to each of these three assets. The first, the collapsible field carrier, was completely phased out on the front line due to its lack of popularity amongst the medics.[125] The remaining two carrying methods, the jeep and the M3A2 half-track, were a point of contention between what the Medical Department intended and what the medics encountered on the front lines.

The M3A2 half-track and the jeep both were issued to the Medical Department to help in easing the wounded onto litters and rapid transportation to aid stations, but due to the nature of war, the two vehicles had dramatically different receptions from those at the front. The M3A2 was issued to both infantry and the Medical Department as an armored transport.[126] Designed to

[124] The General Board, *Evacuation of Human Casualties in the European Theatre of Operation,* 2.
[125] The General Board, *Evacuation of Human Casualties in the European Theatre of Operation,* 2.
[126] The General Board, *Evacuation of Human Casualties in the European Theatre of Operation,* 2.

protect the occupants from small arms fire and fragments from explosives, on paper, it fulfilled an important role in evacuation.[127] However, being deployed to both infantry and medical installations caused severe problems for those who set out to use these trucks to aid the wounded. One of the greatest drawbacks of the M3A2 was its shared nature between the infantry and the litter bearers; as the General Board learned, "It bears a close resemblance to armored combat vehicles and tends to draw anti-tank fire from the enemy."[128] For the men inside, this was a devastating event, as Robert Smith experienced firsthand.

Smith was part of a five-vehicle convoy that was trying to break out of a German encirclement near Wallendorf, Germany, and attempting to get severely wounded men out of the combat zone.[129] The M3A2 was a perfect vehicle due to its protection from small arms fire, but on that night, the Germans responded to the fleeing armored transports with cannon fire. "The explosions shook our carrier, and then we heard the massive explosion caused by one of the other half-tracks being hit and exploding;" the parade of M3A2's was too tempting of a target for German gunners.[130] The M3A2 was issued with the intention of protecting the wounded troops being transported to various echelons of care, but for some, its link to the US armored infantry led to their deaths.

The other alternative mode of transportation for the men at the front was the 1/4 ton truck or jeep. This vehicle was popular amongst the medical staff due to its stark difference to the M3A2 and the collapsible carrier. The first major advantage over the M3A2 was the smaller profile of the jeep, making it harder to spot than other vehicles by enemy gun crews.[131] This, combined with its speed, made the jeep, according to the General Board, "the most popular and widely used form of motor transportation available for frontline evacuation."[132] The jeep's speed, shortening the time to move patients, coupled with its low silhouette, cemented its role in aid stations. This popularity was seen in the General Board report. Any attempt to redesign the jeep was rejected: "it is believed that any attempt to design an enclosed type of ambulance for evacuation forward of the battalion aid station would result in the loss of the desirable characteristics which made this vehicle so universally popular and useful."[133] The medics' own input and experience at the front was used to ensure that patient care was being achieved as effectively as possible. Even when some thought the jeep lacked several characteristics crucial for an ambulance vehicle, the medics' experience deterred those who saw the jeep as an insufficient medical transport.

The jeep also became the central part of Robert Smith's revolutionary idea for evacuating wounded in the Battle of the Bulge. After receiving a field promotion to technical sergeant-4, Smith, alongside his fellow aid man Dave Johnson, set out to change the response time of ambulance crews in the heat of battle. Smith and Johnson noticed that it took the aid station up to several hours to receive a soldier after he was wounded.[134] In order to remedy this, they decided to take steps to speed up time to treatment. Establishing themselves in a house within mortar

[127] The General Board, *Evacuation of Human Casualties in the European Theatre of Operation,* 2.
[128] The General Board, *Evacuation of Human Casualties in the European Theatre of Operation,* 2.
[129] Smith, *"Medic,"* 10 & 11.
[130] Smith, *"Medic,"* 12.
[131] The General Board, *Evacuation of Human Casualties in the European Theatre of Operation,* 2.
[132] The General Board, *Evacuation of Human Casualties in the European Theatre of Operation,* 2.
[133] The General Board, *Evacuation of Human Casualties in the European Theatre of Operation,* 2.
[134] Smith, *"Medic,"* 91.

range of the fighting, with a jeep and a radio, they maintained direct contact with the various company command posts, waiting for the call to pick up wounded soldiers.[135] Instead of waiting for forward units to bring their wounded behind the line, as was standard operating procedure, Smith and Johnson went to the line to collect the wounded. They drove as close as possible to the fighting and wounded men so that litter bearers did not have to carry the injured the several miles back as well as carrying up to four wounded on litters and three who were able to sit within the jeep.[136] Smith's and Johnson's actions allowed the forward litter bearers to stay at the front to help the wounded there rather than run back and forth several miles for each casualty. Medics like Smith who thought on their feet changed frontline treatment in ways the top brass of the Medical Department never imagined.

The conflict between the M3A2 and the jeep is one of many examples of how the combat zone changed medical treatment in the Second World War. As the men at the front learned and adapted, they were able to see what did and did not work under fire. This created a divide between these frontline troops and those at the top. At various points in the war, the Medical Department took their own steps to attempt to change how troops in the field treated their patients. These changes were met with stiff resistance from the medics, as they were the ones who understood combat and its effects on even the simplest forms of treatment.

In an environment where transportation often determined if the wards under their care lived or died, many men were resistant to the changes of the Medical Department. Minoru Masuda was a medic attached to the 100th battalion of the 442nd Nisei Regiment. These men were second generation Japanese Americans who saw the fiercest fighting of the war. During the winter months of 1944, the Medical Department issued a memorandum that stated that to avoid trench foot, men should sleep with their shoes off in order to keep their feet dry.[137] While writing to his wife, Masuda observed, "The Medical Department comes up with some crappy memo about GIs must not sleep with wet shoes and socks… Some of these guys higher up should come around once in a while instead of sitting in some soft chair giving good advice."[138] Because Masuda was at the front, he understood that combat could occur at any moment, so GIs left their boots on when they slept, always at the ready.[139] The disconnect from the people at the front by those behind the line created many incidents of insubordination. To the medics, it seemed that the Medical Department had a hard time understanding what happened in the field.

The constant reviewing and implementation of new procedures wore on the men who had to carry out the new orders. Other times, meddling from the Medical Department ended up giving the teams out in the field more freedom to save lives. In Italy, Zachary Friedenberg was relieved when he received orders that authorized unorthodox treatments.[140] The Medical Department reviewed the various treatments from its field hospitals and realized that sometimes the best treatments were "not necessarily giving the best functional results; function could be sought outside the combat zone."[141] The Medical Department began to learn from the men at the

[135] Smith, *"Medic,"* 91.
[136] Smith, *"Medic,"* 91.
[137] Minoru Masuda and Hana Masuda, *Letters from the 442nd: The World War II Correspondence of a Japanese American Medic* (Seattle: University of Washington Press, 2008), 104.
[138] Masuda, *Letters from the 442nd*, 104.
[139] Masuda, *Letters from the 442nd*, 104.
[140] Friedenberg, *Hospital at War,* 63.
[141] Friedenberg, *Hospital at War,* 63 & 64.

front how treatment was different from what they expected. These new procedures were all focused on wound care. Where in the past the Department said that irrigation of a wound was never permissible, now "head wounds were to be irrigated and cleaned."[142] Procedures that had once been thought to not be effective now turned out to be the proper way to help the wounded. Some of the new procedures even allowed Friedenberg to speed up a treatment: "shell fragments or bullets were now removed as encountered."[143] Now Friedenberg and the surgeons in the 95th Evacuation Hospital could quickly suture and treat wounds rather than getting caught up looking for each fragment. These new procedures were implemented by the Medical Department because those at the front had discovered that the function was not always possible in the combat zone.

These procedures also saved lives in ways the Medical Department never anticipated. The changes to procedures involving the use of casts were small, but their effects determined if a soldier lived or died. When Friedenberg described the new procedures, he put an emphasis on why the changed cast procedures made a major impact. The sealing of wounds was changed so that "plates, screws, or wires were to hold the bone ends together were expressly prohibited," thus requiring a "cast or spica" to be applied.[144] This new reliance on casts brought to light how dangerous a partial limb or full body cast could be. Because of the restrictive nature of casts, they made soldiers vulnerable under many emergency situations: "A soldier in a body cast did not have much chance on a sinking ship."[145] The inability of a soldier to move coupled with the weight of the casts made it near impossible for soldiers to escape sinking transports. It also left them vulnerable when aid stations came under aerial bombardment or artillery fire due to the possibility of being "reinjured" since they could not avoid the flying shrapnel.[146] To combat the stationary nature of the cast, medics took precautions to ensure they could quickly move these immobile patients. The Medical Department adopted the procedure of having personnel "split all [casts] so that they could easily be removed,"[147] allowing medics to quickly move them out of harm's way. The men at the front had to learn how to move past what the Department deemed as the right thing to do and invent new methods of saving soldiers.

The Medical Department was in constant conflict with the men under its command. As they tried to improve patient care, the men at the front rapidly found flaws in the new systems and procedures. With every advancement made by the medics, there was an alternative procedure from the Department that was either rejected or resisted. It was only the procedures that had been tested at the front that truly affected what the medics would and would not do. If they felt that a treatment in any way jeopardized the fighting men, medics would either change it, so its impacts were minimal, or else abandon it outright, just as Masuda did. This conflict was not just between the men at the front and their commanders, but also with other aid men and the infantry. The medical troops were willing to take any steps and even issue their own orders, if necessary, to save their patients.

During combat, the troops of the Medical Department had to deal with multiple wounded and treat them effectively at one time. The need to address a hierarchy of care caused some medics and doctors to come into the same conflicts the two groups faced with the leaders of the

[142] US War Department, *The Battle Field Medical Manual 1944,* 122.; Friedenberg, *Hospital at War,* 64.
[143] Friedenberg, *Hospital at War,* 64.
[144] Friedenberg, *Hospital at War,* 64.
[145] Friedenberg, *Hospital at War,* 64.
[146] Friedenberg, *Hospital at War,* 64.
[147] Friedenberg, *Hospital at War,* 64.

Department. Robert Franklin came into such a conflict during a skirmish in Italy. Franklin had managed to pull two wounded men out of harm's way so men from the aid station could take over.[148] One man had suffered an eye wound and was unconscious and unresponsive; the other had a gunshot wound to the collarbone and was experiencing severe shock.[149] Shock is defined as "a profound depression of all mental and physical processes usually resulting from injury and severe blood loss," and can be fatal if left untreated.[150] When a doctor attached to the aid station came to assist, he and Franklin came into conflict about the two wounded men. Franklin had noticed that the doctor in front of him appeared to have little training: "from what I witnessed, this doctor must have been rushed through medical school to supply the army."[151] The two men fought over experience versus rank. The young doctor had written off the shock patient as dead, regardless of Franklin's claim of a pulse: "he didn't check it; he told me I was feeling the pulse in my own fingertips. I was no doctor, but I knew a pulse when I felt one."[152] Franklin's experience had taught him how to find even the faintest pulse, while the doctor's training guided his decisions. The conflict between the two decided the fate of one wounded soldier over the other. A judgement call was all that was needed to determine the fate of the wounded, and when the two people making that call clashed, the person who suffered the most was the patient.

Medics would sometimes come into conflict with the men they were sworn to protect and who looked to them for aid. When it came to the battlefield and a soldier's life was on the line, the medics had the authority do all things necessary to save the patient, even if that meant breaking the chain of command. Franklin learned this while he treated men during the advance through Sicily. As the men of his platoon were becoming more dehydrated from the heat, Franklin was forced into a conflict with a captain who was prohibiting him from using a well to refill the units' canteens.[153] When Franklin was fed up with the captain's ignorance of the situation, he snapped, "Sir, I've got to have water for the men passing out from the heat," and proceeded to fill the platoon's canteens.[154] The priority of treating the wounded men overrode the captain's strict orders. It was in this moment that Franklin "realized that a medic could talk back to the brass and get away with it."[155] Because of their role on the battlefield, aid men and medics needed to have a degree of freedom, and if an order came into conflict with this, they simply issued their own. Other medics found this particular ability very useful, especially when they were tasked with treating high volumes of wounded.

The flow of combat made finding places to treat the wounded a priority. On a battlefield, the placement of various assets was important, as command posts, aid stations, and other supply stations needed to be in a place where they were easily accessible by the fighting men. Due to the importance of these battlefield assets and the lay of the land, sometimes a location would be contested by those who were establishing them. Robert Smith experienced such a situation when he desperately needed to set up an emergency aid station near St. Die, France. When a truck transporting men to St. Die was struck by a landmine, Smith had to find a place nearby to

[148] Franklin, *Medic!*, 25.
[149] Franklin, *Medic!*, 25.
[150] US War Department, *The Battle Field Medical Manual 1944,* 146.
[151] Franklin, *Medic!*, 25.
[152] Franklin, *Medic!*, 25.
[153] Franklin, *Medic!*, 17.
[154] Franklin, *Medic!*, 17.
[155] Franklin, *Medic!*, 17.

transport the wounded.[156] Smith chose a house that was close enough to the wounded men to allow him and other men to quickly navigate the minefield; however, the house was being used as a command post.[157] Smith was faced with a two choices: take the long route of navigating the minefield the wounded were in, or confront the officer in charge of the command post in order to commandeer it, turning the structure into an emergency aid station. Smith followed the advice of a medic who had trained him: "someone had told me that if I needed something to save a man's life, I took it, no matter the consequences."[158] The medics out on the front put their own duty over the strict chain of command that was the backbone of the US Army. Due to the time-sensitive nature of saving the lives of the wounded, medics had to move quickly and take whatever they needed to get the job done.

The need to take care of the wounded at any cost prompted medics to face conflict with those whose authority was called into question. As seen by one of Robert Franklin's experiences recounted earlier, sometimes the break in the chain of command caused soldiers to hesitate when a medic issued orders. While Franklin was struggling to treat the soldier suffering from a stomach ailment, who he would later find out was suffering from a food ailment, he was forced to confront two officers.[159] These two men were hesitant to follow the orders of a soldier below them in rank. However, due to the nature of Franklin's role on the battlefield, they had little option but to hand over the five gallons of water Franklin ordered them to turn over: "they eyed me suspiciously but reluctantly off-loaded it."[160] Even though the medic was vital to ensuring men survived the wounds of war, by having a unique place in the rank structure some officers could have seen the medic as a challenge to their own position and authority. Other officers understood the necessity and gravity of a medic's orders and requests. When Robert Smith approached the captain in charge of the command post he needed for an aid station, he was surprised by the response he received: "I desperately spouted out my medical priority needs, and much to my surprise, the captain surrendered the house."[161] Some officers understood the urgency of the medic's duty, and in doing so were quick to respond to medics' orders. The nature of war and medicine had put the medics into an area where their duty held more authority than rank.

Conclusion

When the Second World War is taught and studied, there is a focus on the politics and battles of the conflict. When looking at the battles that were waged , the numbers of dead are presented as cut-and-dry statistics. Rarely are the men who fought on the battlefield to save these statistics ever mentioned. When the soldiers of the Medical Department are mentioned, they are presented in a highly romanticized light, the men who the infantry idolized, seen as the stoic saviors on the battlefield. The medics and aid men have been portrayed as the calm and collected soldiers on the front line. This myth of the calm stoic medic has long been part of the story of Second World War.

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[156] Smith, *"Medic,"* 100.
[157] Smith, *"Medic,"* 100.
[158] Smith, *"Medic,"* 100.
[159] Franklin, *Medic!*, 17-18.
[160] Franklin, *Medic!*, 18.
[161] Smith, *"Medic,"* 100.

As the men of the Medical Department entered the war, some were lucky enough to have received the necessary time to train for the struggles of the combat zone. However, they quickly learned how ineffective their training was when engaging the enemy. The first taste of combat overcame some men as they were forced to deal with the aftermath of war even as it unfolded around them. The initial shock of combat caused some men to forget what they had learned, while others became casualties themselves. As the casualties mounted, men were quickly rushed through training programs that had previously relied heavily on the opportunity to spend extensive time in hospital. Others were rushed through without the most basic understanding of first-aid. The Medical Department was forced to send men out into combat who did not fully understand how to save the men under their care.

As these soldiers became acquainted with the struggles and tribulations of war, they quickly realized that in order to save as many of the wounded as possible, they would have to adapt to the chaos around them. They had to be able to treat, transport, and communicate all aspects of treatment in ways that not only were effective but kept the lives of the medics out of jeopardy. These necessary changes caused the men at the front to come into conflict with those at the top of the Department. In order to properly achieve patient care, orders were disobeyed or ignored. Treatments were improvised and altered from what was prescribed by men who had not seen what was happening in combat. Similar forms of treatment for the same ailments created drastically different effects, and medics out in the front found success compared to what the Medical Department theorized to be a valid option. This confrontation with rank was not confined to the Department as medics came into conflict with infantry officers who got in their way as they struggled to treat the wounded.

The image of the steadfast medic was one that did much to bolster the morale of the men at the front, but at what cost? By perpetuating the myth, the Medical Department left the men under their command with few options to perform in any other way. Men who were in the same harm's way as the men they sought to protect began to suffer the same limitations. These limitations created an environment where myth and reality clashed. The aid men at the front were just as prone to losing their nerve as the infantry. They could freeze under fire. They could only watch the men they fought next to die for so long; they could only be subjected to so many rounds of artillery before abandoning the responsibilities expected of them. The medics of the US Army could only run into harm's way for so long before they had to be evacuated due to enemy fire or a psychological wound, forcing another man to take their place.

Deconstructing the image of the unflappable medic adds another dimension to the study of the Second World War. By understanding the struggles and tribulations of the men tasked with saving the wounded on the battlefield, a different way of interpreting the statistics of war surfaces. By shifting the focus from how the various combatants maimed and killed one another to how they saved their soldiers, the struggles of the men tasked with saving lives has more gravity. The advancements that were made to save lives in order to combat the paralleled strive to kill have made a lasting impact. Medicine is not confined to a frozen point in time but moves past the conflict that drove it. The medics of the Second World War were doing more than saving the men of their conflict; they were also affecting those of future wars. The medic is still the soldier on the battlefield who every person looks to for help in their darkest moment. By understanding the limitations of those who serve in this capacity, the efforts made by all those before them can be recognized. The men who served in the Medical Department in the Second World War had just as important a role on the battlefield as those they fought to protect. By

keeping men alive who otherwise would have succumbed to their injuries, the medics and aid men developed an image that went beyond reality, an image that captures the gravity of their role in the war, but also an image that overshadows their own struggles in conflict.

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