The AMEDD Historian

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CONTENTS

A Revolutionary War Hospital	5
WWII Medical Art	9
A Doctor's Great War	13
Capturing a Hospital	18

Welcome to issue #55 of the *AMEDD Historian Newsletter*! This edition departs from a narrow-focused theme for a specific conflict or subject but continues to concentrate on AMEDD History. Army Physical Therapist history, a Revolutionary War hospital, and art produced by a battlefield surgeon fill the first portion of the newsletter. The articles provide insight on the expansion of the physical therapy field and a quick glimpse into American Army hospitals of the 1770s. The art images capture various moments of service for medical personnel and associated Soldiers during World War II.

In the article "What Value Patronage?", the military career of Richard Derby is examined. His abilities and possible trajectory are compared with his connections to high command levels. He served during World War I and proved to be an able surgeon and organizer during the war. The newsletter concludes with an article on the 130th General Hospital, which was captured during World War II. The hospital's service and that of its commander continue during and after being held by the Germans.

You may have noticed *The AMEDD Historian* has a different appearance. For now, it has wider margins and is not MS Publisher based, as that program is being phased out. There may be more format changes in coming months.

Army Physical Therapists and Direct Access
LTC (Ret) Timothy Kauffman, PhD

When today's US physical therapists evaluate a patient without a referral, few realize that the roots of this autonomy stretch back to the battlefields of the 20th century. Long before "direct access" became a catchphrase for professional independence, U.S. Army physical therapists were quietly reshaping clinical practice in the most demanding environments imaginable — war zones, field hospitals, and rehabilitation wards filled with the wounded and the weary.

A new collection of personal recollections, *Evolution of Neuromusculoskeletal Evaluation and Direct Access* (see below for full access), edited by LTC (Ret.) Timothy L. Kauffman, PhD, FAPTA, brings these stories vividly to life. Spanning WWI to the conflicts of the Middle East, it chronicles the experiences of Army physical therapists whose courage and competence helped redefine what it means to be a clinician.

Reconstruction Aides: The Birth of a Profession

The profession of physical therapy was forged in the United States in the crucible of crisis. Polio epidemics in the early 1900s and the carnage of WWI created an urgent need for trained rehabilitation specialists. The U.S. Army responded by establishing programs to train "Reconstruction Aides" — the precursors to modern physical and occupational therapists.

In 1921, these pioneering women, led by Mary McMillan, founded the American Women's Physical Therapeutic Association, the forerunner of today's American Physical Therapy Association. Army orthopedist COL Joel Goldthwait wrote in the first issue of *P.T. Review* that the war had proven, "even severe injury need not lead to serious disability, provided suitable treatment…can be given." He recognized that the therapists' contribution had "so definitely established" the principles of physiotherapy that civilian hospitals would soon follow the Army's lead. That same spirit — disciplined, evidence-based, and quietly revolutionary — would characterize Army physical therapy for the next century.

Women at the Frontline

WWII and the conflicts that followed offered no shortage of challenges for Army therapists, many of them women serving in extraordinary circumstances. 1LT Myrl Jean Hughes recalled shipping out to New Guinea in 1943 at the tender age of 21, evading submarines along the way. Concerning physical therapy she remarked, "We weren't allowed to do anything on our own. Now they get advanced degrees and can do anything they like."

Her colleague, 1LT Bette Horstman, trained at the Mayo Clinic before being deployed to the Pacific. She treated burns, sprains, and fractures under combat conditions and bristled under the nursing chain of command until she fought successfully to report directly to physicians — a small but significant victory for professional autonomy.

LTC Priscilla Gilchrist's career spanned three wars, from the Battle of the Bulge to Korea and then arriving in Vietnam during the Tet offensive in 1968. Additionally, she was the consultant to The Surgeon General on physical therapy operations. She observed that the wounds she treated in Vietnam were worse than in the previous two wars because the weapons were more destructive.



Major Sue Osborn in Vietnam, 1968-1969. Courtesy of the author.

Necessity Breeds Innovation

The turning point came during the Vietnam War. The shortage of physicians — especially orthopedic surgeons — forced the AMEDD to rethink how healthcare could be delivered in the field. In the absence of doctors, physical therapists began evaluating and managing neuromusculoskeletal injuries independently. This necessity became the seed of "direct access." Kauffman, who served at Madigan General Hospital in 1973, recalls being informed by his superior that because of physician shortages, "we would be granted new privileges as PTs." Soldiers with uncomplicated low back pain could report directly to physical therapy without a physician referral. Therapists could order X-rays, issue limited-duty profiles, and prescribe simple medications such as APC pills (Aspirin, Phenacetin, Caffeine). Kauffman remembered, "None of the orthopedists enjoyed seeing so many back pain patients. They were ecstatic when PTs took on that responsibility." The model was so effective that it spread to other Army hospitals and later influenced the civilian sector, where it became a rallying point for professional independence.

Building the Knowledge Base

For autonomy to be sustainable, education had to evolve. The Army's physical therapy programs, grew into graduate and doctoral degrees through partnerships with Baylor University and later the U.S. Army-Baylor Doctoral Program in Physical Therapy.

COL Virginia Metcalf, who served from the 1950s through the 1980s, described this evolution as "an outstanding accomplishment of all the staffs and faculties throughout the years." She witnessed the transformation from technicians to diagnosticians — clinicians capable of evaluating neuromusculoskeletal disorders and contributing directly to patient management.
By the 1970s, structured training in manual therapy and differential diagnosis became standard. Courses taught by figures such as Florence Kendall, Stanley Paris and Army leaders like COL David Greathouse, COL Duane Saunders, and COL Doug Kersey formalized the process of neuromusculoskeletal evaluation (NMSE). Greathouse recalled, "We were being trained as physician extenders. Our programs in orthopedics, radiology, pharmacology, and lab studies prepared us for independent evaluation and treatment."

Direct Access Takes Shape

The Army didn't simply permit direct access, it built a framework for it. At Fort Riley, Kansas, Greathouse and his team developed one of four demonstration sites for NMSE, complete with physician oversight and continuous quality improvement. These pilot projects proved that PTs could safely and effectively serve as first-contact providers for musculoskeletal conditions.
When the Office of The Surgeon General later formalized the NMSE credentialing process, Army therapists were already functioning as autonomous practitioners. By the 1980s, the credential known as the "8G identifier" signified an Army physical therapist trained in advanced neuromusculoskeletal care — a military counterpart to today's board certification.
Many of the therapists interviewed by Kauffman noted how their Army training sharpened their clinical instincts. COL Bill O'Grady, for example, recalled detecting a malignant melanoma and a spinal tumor in patients referred for "back pain." He said, "The Army taught me to be confident, but also wary of red flags. Know your limits, but never doubt your clinical judgment."



Madigan Army Medical Center, circa 1973. Physical therapists L-R: 1LT Kauffman, LTC Putnam, 1LT Zarbano, CPT Going, MAJ Sakson, LTC Thompson, CPT Sorenson. Around this time, female AMSC officers were authorized gold trousers because their white uniforms caused patients to mistake them for nurses. Courtesy of the author.

Courage Under Fire

For many of these therapists, clinical innovation came hand-in-hand with danger. LTC Barbara Reid described treating wounded soldiers under fire during the Tet Offensive at Qui Nhon. Equipment was scarce, much of it homemade from metal scraps and lead shot, but clinical ingenuity was abundant.
LTC Aida Nancy Sanchez, a physical therapist, was dispatched on a secret mission to Cambodia to treat President Lon Nol after a stroke. She was the only American allowed in the palace and thus she was asked by the US State Department to identify persons around President Nol. It upset her that she was supposed to treat the Cambodian President and spy for the government. Such

stories reveal not only the therapists skill but also their moral and emotional fortitude. They served as clinicians, soldiers, and sometimes diplomats — all while expanding the frontiers of their profession.

From Army Clinics to Civilian Practice

As soldiers returned home and Army-trained PTs transitioned into civilian roles, the philosophy of autonomous practice followed them. The research, educational models, and clinical confidence developed in Army hospitals helped drive legislative changes that eventually allowed direct access to physical therapy across the United States.

COL Ron Franklin, who taught at the Army-Baylor Program, noted that "it was assumed that our graduates would experience evaluate, treat, and refer if necessary — that was the expectation."

The Army's approach anticipated modern evidence-based practice, long before it became a civilian standard. Even outside military walls, former Army therapists became champions for independence. COL Duane Saunders advocated for direct access legislation in Kansas, crediting his Army experience with showing that PTs can safely provide NMSE.



COL Gail Deyle teaching doctoral physical therapy students at the Army-Baylor DPT Program at FT Sam Houston, San Antonio, Texas.
Courtesy of the author.

A Legacy of Leadership

What emerges from the compilation is not just a military history but a professional lineage, one of courage, intellect, and relentless progress. From the Reconstruction Aides of 1917 to the doctoral graduates of the 21st century, the evolution of Army physical therapy mirrors the evolution of the entire profession.

As Kauffman reflects, "This was a gargantuan step for the physical therapy profession and our patients."

That step, taken in the dust and heat of war, paved the way for millions of civilians to receive faster, more effective care today. The next time a patient walks directly into a clinic and sees a physical therapist first, they are unknowingly benefiting from a century of military innovation — a legacy built not on conquest, but on compassion and training.

This is adapted with permission from a longer piece, *How US Army Physical Therapy Pioneered Direct Access*, https://history.physio/how-us-army-physical-therapy-pioneered-direct-access/ and http://history.physio/wp-content/uploads/2026/02/Army-HX-history.physio26-Revised.pdf

The Army Hospital at East Nottingham, Maryland

Josephe Lee Boyle, former historian, Valley Force National Park

The East Nottingham Friends Meeting House in Calvert MD was listed on the National Register of Historic Places in 1977. Near the structure is a stone marker with the inscription:

IN MEMORY OF
THE UNKNOWN SOLDIERS.
BURIED AT
BRICK MEETING HOUSE
WHILE IT WAS USED AS A
HOSPITAL
IN 1778.

Sources conflict on structural data. The Meeting House was built either in 1724 or 1735 with brick reportedly brought from England or locally made. After a fire in 1748, 1749 or 1751, a stone addition 30’ x 40’ was built and the brick part restored. It was considered to be “a very large meeting room for those days...capacity probably not equaled south of Philadelphia.”



The meetinghouse in 2010. The brick and stone portions were used in the Revolutionary War, the wooden part was added later. Courtesy Wikipedia.

The use of this building as a military hospital resulted from George Washington’s strategic decisions. On December 19, 1777, when the main Continental Army marched into Valley Forge, Washington ordered BG William Smallwood to Wilmington DE. Smallwood had

the command of two brigades composed of seven Maryland regiments, the Delaware Regiment, and the Second Canadian Regiment. Smallwood was to fortify the town and draw his supplies from between Wilmington and British-held Philadelphia, "as it will be depriving the Enemy of all chance of getting them…an object to us of importance." Smallwood was also to carefully observe traffic on the Delaware River and report anything of importance. Washington determined to do this as he had "great reason" to believe that "the Enemy mean to establish a post at Wilmington, for the purpose of Countenancing the disaffected in the Delaware State, drawing supplies from that Country, and the lower parts of Chester County, and securing a post upon the Delaware River during the Winter."

On February 15, 1778, Smallwood wrote from Wilmington that he had established a hospital for the sick at Newport, Delaware, and a house for men with smallpox at Newark so they would not infect others. He complained that "Necessaries" were not being provided for them by the hospital department, and that medicine was needed. Washington replied ten days later:

> I will order the Directors of the Hospital, to furnish medicines and supplies for the sick at Newport. In the mean time, the Quarter Master of the Division will accommodate them, as well as it may be in his power. I approve of your proposal for inoculating and wish the business to go on, as fast as possible.
> P.S. Upon consideration of the situation of Newport, I think, if a more interior place could be conveniently got, proper for a Hospital, it were to be wished. Tho' it is not immediately on the Delaware, yet it lies rather too much exposed.

Smallwood apparently did not promptly act on this recommendation, as on April 1, William Shippen Jr. (Director General of Hospitals in the Middle Department) reported there were 135 patients at Newport, 5 wounded, 60 sick, and 70 convalescent. With better weather, Washington grew concerned about a British attack from Philadelphia toward Wilmington. He wanted the main body pulled back and only an outpost left, but a Tory insurrection delayed the withdrawal. Smallwood's first response was about moving his sick and those being inoculated back to Nottingham. While Smallwood remained at Wilmington with his two brigades, he moved his hospital to the East Nottingham Meeting House. George Churchman recorded on April 19 that "they entered & took Possession of our Meeting-house as an Hospital" and further commented:

> Anoter disagreeable circumstance happen'd among us at East Nottingham; permitted perhaps for a Trial of our Faith and Patience….Great Exertions in the military Line were used to strengthen the American Forces....Militia men for that purpose were call'd from many Places; from the Southern Part of the Peninsula between the two Bays &c, a number were brought hither and Station'd in this Neighborhood; some to be inoculated for the small Pox; some sickly and disorder'd otherwise, under the Care of Doctors, for their Relief & preparation for Action when called upon....A Number of those more healthy, yet appearing as Objects in distress, got into an old building for Shelter, near our dwelling-house, where they remained several Weeks; Hence daily opportunities offered for the Exercise of tender Pity & Charity towards fellow-Creatures in a dark, bewilder'd or tossed State; some neerly at their Wit's End, under the Command of Men governed by a Martial Spirit, scarcely provided with sufficient food to satisfy Hunger; and strangers to that fortitude & Stability which are obtained by knowing and Possessing the Christian Religion in it's Purity.



Inside the meeting house, c.1936. Courtesy Library of Congress.

Dr. James Tilton wrote from Newport on April 22, to Jonathan Potts at Reading that:

> Since the first of march, I have had charge of the hospital, for the reception of sick. from General Smallwood's Division. I have just received a Letter from Doctr. Shippen, directing me to expect my future supplies of medicine & stores from you. We have Occasion of an immediate supply of Both. The stores we want are Wine, Coffee & Tea. The enclosed List will shew you the medicines we need. - The hospital is Just removed from this place to Nottingham brick meeting house; where I shall be glad to receive a supply as soon as possible. Besides the ordinary sick of the Garrison, We have about 50 Recruits under Inoculation & expect a great many more.
>
> Doctr. Latimer requested me, in your name, to purchase a number of Lancets, of Major Aiken some distance from this place. As soon as I could take the time I waited on the Major & purchased 50, all he had, for 29 Dollars. - By the first good opportunity I shall send them to you, all except 3 or 4, which will be necessary for the use of this hospital. I expect likewise, in a few days, to have the Turner's business set up, in a manner, that will, probably in a short time, furnish as much of that kind of ware, as you have occasion of. - I don't know what the expence of the work will be, & shall be glad of your Direction, whether it may go on to greater expence than the three hundred Dollars sent me by Dr. Latimer.

Some wooden items were made locally; there were several "turners" who had lathes to turn wood. Lancets were also procured locally, but medicines had to be shipped in, and the hospital even lacked a mortar and pestle to grind items. Also needed from supply depots were "pots, Scales & weights, Twine, Lint & Bandages, Writing & wrapping paper, - also Bed Cases, Shirts, Sheets, Blankets, & Spoons. - we have had no wine since the hospital was removed to this place. I have been obliged to substitute Strong Beer, in many Cases of great Weakness."

Dispossessed, the Friends had to hold their monthly meeting of April 25 and successive meetings in a barn, "the meeting house, then, being taken up by military men…." On June 6 a deputation of three Friends went to Dr. Tilton and other staff "to shew them our dissatisfaction with that being used as an hospital, who treated us with civility." The building was still not clear on July 25, as the monthly meeting minutes comment on "our meeting house at East Nottm. being taken up by military people more that three months past, & Converted to the use of a hospital as they Call it." However a meeting on August 20 was held in the building, and Churchman noted the military had left about three weeks earlier. Even with soldiers taking over their meetinghouse, "The Friends

treated the soldiers in the hospital with much kindness, and furnished them with blankets and other things that contributed to their comfort, and washed and mended their clothes."

Muster rolls of the Delaware Regiment and the Maryland regiments that were stationed under Smallwood at Wilmington show a number of men "At Nottingham Hospital" and "Sick at Nottingham." However, no lists are known of the men who were sick there, or those who died. The muster rolls of the Second Maryland record on January 21, 1779 that 15 men had deserted from Nottingham on or about July 1, 1778, so some troops took opportunity of being away from the main body of the regiment to leave.

In the Revolutionary War, any large building, public or private, was liable to be used as a hospital. The Quakers tried to avoid the war, but when the war came to them they were patient and charitable to the sick.

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— 27 July 1775 —



2LT Ellen Ainsworth was a nurse with the 56th Evacuation Hospital. Born in Wisconsin, she joined the Army in 1942, promptly after graduating nursing school. After service in the U.S. and North Africa, her unit was in Italy and sent to support the amphibious landing at Anzio, just south of Rome. The Germans contained the beachhead, and pounded the limited area with artillery, rockets, and air attacks. Over seventeen weeks, the U.S. suffered over 33,000 casualties, although around 14,000 returned to duty in the beachhead. Over 500 medical personnel were casualties; there was no safe rear area, hospitals were clustered together but right next to other support units. Ainsworth was on duty when shells began to fall nearby, and led the placement of the litter patients on the ground; shell fragments hit her. She died, tended by her comrades, four days later. She was posthumously awarded the Silver Star.

Waiting in War's Shadow: Richard Stark's World War II

Deethya Trivedi, AMEDD Museum Foundation volunteer

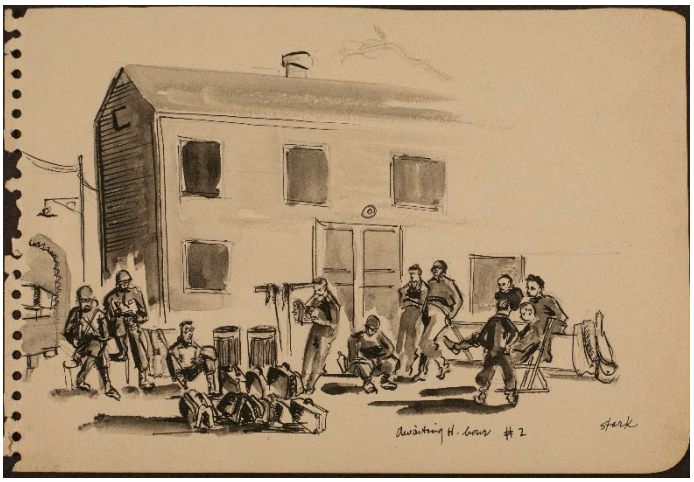
History often remembers World War II through its defining moments of action. Yet for the millions who experienced the war firsthand, life was shaped by more than moments of action, by the countless moments in between them. War was, in many ways, an experience of waiting. Soldiers waited for orders that could send them into battle or spare them another day. Medics and nurses waited outside operating rooms, uncertain about a patient's survival. Army surgeons stood ready for the arrival of ambulances carrying the wounded, knowing that each siren signaled lives hanging by a thread. Families at home waited anxiously for letters not knowing what sort of news they would bring. Patients waited to learn whether they would heal, whether they would recover or if they would ever return to the people and places they called home. These intervals of uncertainty, though often overlooked in traditional narratives of war, formed the emotional landscape of daily life.

Dr. Richard Boies Stark, a battlefield surgeon who we now know as a pioneer in the realm of plastic surgery, perfectly understood this reality with uncommon depth. Through his watercolor and pen and ink drawings, he specifically chose not to depict victories or scenes of combat alone. Instead, he documented the quieter, deeply human moments lying amidst them. His pieces invite visitors to experience World War II through anticipation, uncertainty, exhaustion, hope, and relief and a glimpse into the lives of the ones on the frontline. He reminds us that history is not just written through decisive battles and celebrated victories, but also through the ordinary moments that test the human spirit. Waiting was something neither passive nor insignificant, but an emotional and psychological battleground of its own. Within these quiet intervals, courage was sustained, compassion was practiced, and resilience quietly took root, offering a powerful testament to the humanity that endured amid one of history's most devastating conflicts.



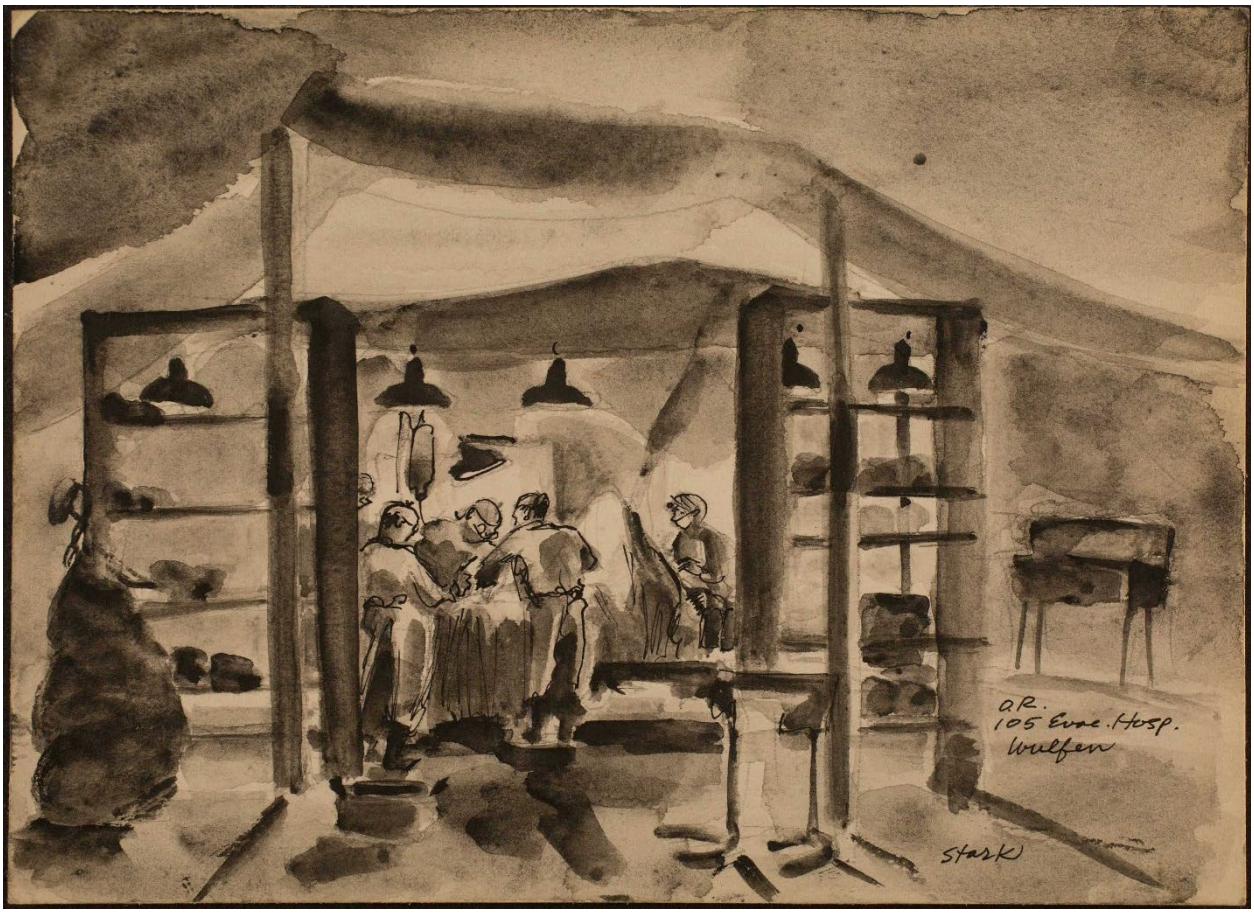
Awaiting "H" Hour #1.

A soldier sitting alone reading a copy of Time *magazine.* At first glance, this scene appears to be quiet. However the TIME magazine acts as a powerful symbol. Reading offers a brief escape from reality and uncertainty, allowing the soldier to reconnect with the outside world and maintain a sense of normalcy before entering combat. Stark captures an intimate moment in which an ordinary routine of reading a magazine becomes an act of emotional resilience. Museum CCN:620365



Awaiting "H" Hour #2

Groups of soldiers wait together, some writing, others reading or quietly sitting. In contrast to the solitude of *Awaiting "H" Hour #1*, this piece reveals waiting as a shared experience. Each soldier copes differently: writing letters, reading, reflecting, or simply sitting together. It depicts that anticipation during this time was both deeply personal and profoundly communal. Even in silence, these men found comfort in one another's presence. Museum CCN:620418



O.R. 105th Evacuation Hospital, Wulfen

A wartime operation inside the 105th Evacuation Hospital. This work marks the moment when waiting gave way to action. Yet even inside the operating room, doubt endured. Surgeons and nurses worked against time while waiting for a patient's condition to stabilize, for a procedure to succeed, and ultimately, for signs of survival. Stark reveals that even in medicine's most urgent moments, hope was often found in the quiet pauses amongst decisive actions. Museum CCN:620370



Tired Nurse

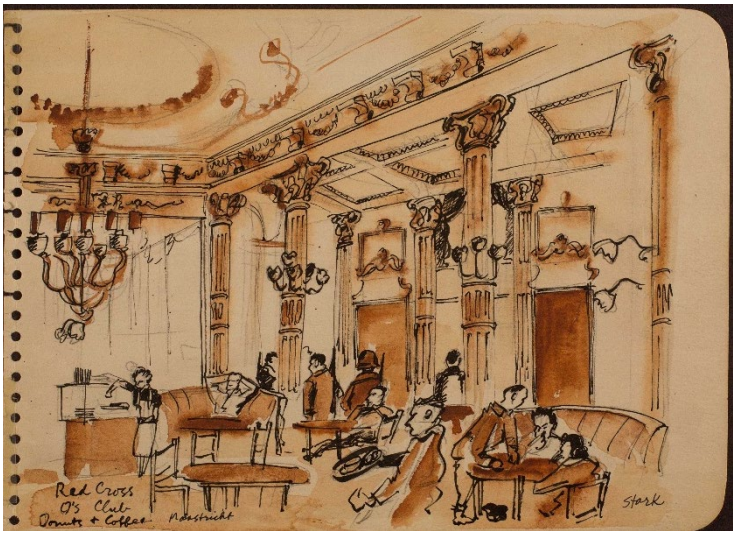
A nurse sits with her head buried in her knees. Seated with her head buried in her knees, the nurse embodies a rare moment of stillness within the chaos of war. Stark captures the pause between responsibilities and the brief stillness when a caregiver can process the emotional toll of witnessing suffering. This moment of waiting reveals the human side of medicine, where compassion, fatigue, and perseverance exist at the same time. Museum CCN:620368



The Card Players

Five soldiers gather around a table playing cards together. Five soldiers gather in a shared space, playing cards during a brief pause from their wartime responsibilities. Stark captures an ordinary moment of connection and camaraderie, showing how familiar activities provided comfort and routine, during a time that is unpredictable. Museum CCN:620505

Image has had contrast increased to enhance visibility.



Red Cross O's Club, Donuts & Coffee, Maastricht

Service members gather around inside a Red Cross Club for coffee and donuts. A simple cup of coffee and a warm meal offered more than physical nourishment. They provided a brief sense of comfort and familiarity. Stark depicts officers gathering at a Red Cross club, where everyday rituals created a welcome pause from military duties. These quiet moments of connection reminded soldiers of home and offered a chance to regain their strength before returning to the demands of war. Museum CCN:620363



V-J Day USS General Richardson

A soldier watches a distant explosion from the front lines. A lone soldier watches a fiery explosion lights the distant sky. Rather than depicting celebration, Stark captures a moment of quiet observation, where the outcome of war is uncertain. The soldier can only watch and wait, reminding viewers that even as victory approached, many service members continued to confront danger and the unknown before peace truly arrived. Museum CCN:620427



Crowds, including a sailor and a nurse in Times Square are in famous photos of V-J Day. This lesser known photo is of visitors around the White House, pausing and saluting amid the revelry, relief, and thinking about the future.
National Park Service photo via National Archives.

What Value Patronage?
Sanders Marble, PhD, ACHH

Richard Derby was born in 1881, his father a politically- and socially-connected ophthalmologist in Oyster Bay on Long Island. He attended the elite Groton School, then Harvard (joining the Porcellian Club, the oldest and most prestigious of Harvard's social clubs), and then the College of Physicians and Surgeons (now Columbia University's medical school), where he graduated in 1907. He paid his own way to Berlin for a few months further surgical experience. For the next few years he practiced medicine in New York City, including instructing at P&S.



Richard Derby in a contemporary photo.

In spring 1913 he married a girl from a few miles down the road, Ethel Roosevelt. Roosevelt as in Theodore Roosevelt's daughter. He fit in well with the Roosevelt family, living the 'strenuous life' that TR talked about.

In 1914 war broke out in Europe, and both Dick and Ethel went to France to work at the *Ambulance Americaine* outside Paris. From October to December he was a surgeon and she a nursing aide. On returning to the U.S., Derby gave talks and wrote articles on war wounds and how America needed to prepare itself for war. He joined the Medical Reserve Corps and attended the volunteer camps outside Plattsburgh, New York. These were 90-day camps that taught young men (all prosperous, they had to pay their own expenses, and self-limited to college graduates) a bit about military leadership. Derby attended in the summer of 1915 in an infantry company, and in 1916 with the medical section.

In April 1917 the U.S. joined WWI, and Derby was in Plattsburgh again (incidentally having attended with three of his brothers-in-law) as medical examiner of the volunteers. (The Derbys were tight with the Roosevelts; in 1917 both Richard Derby and his brother Roger were busy trying to recruit volunteers for a Rough Rider-like division that TR wanted to command.) In July he was ordered to Camp Oglethorpe GA, where he went through the quick training camp for medical officers; he did well enough that he was immediately put in command of one of the student officer battalions. In mid-September he was ordered to Camp Upton, on Long Island, assigned to the 77th Division which was forming from New York City draftees. He was clearly one of the best-prepared non-Regular Army doctors: he had clinical experience of the war, and had about as much administrative and leadership experience as possible.

However, his father-in-law had written an old friend asking to get Derby to France. The old friend was MG William Gorgas, Surgeon General of the Army, and TR also name-checked LTG John Pershing, commander of the American Expeditionary Forces, and subtly reminded Gorgas how TR had made Gorgas' career. All that TR asked was a chance for Derby, nothing more – but both of them knew what that would mean: Gorgas would get Derby to France soon.

About a month later, Derby was indeed in France. He was promptly assigned to the 2d Division as assistant division surgeon. The division was gradually assembling in training areas as elements arrived; the medical units had not even arrived. There was time for Derby to attend the Army Sanitary School, which was a train-the-trainer institution, meant to give a few medical officers an overview of the latest clinical developments and also advice on medical operations, what was then called 'sanitary tactics.' That involved visits to hospitals, lectures, and visiting French and British military schools over six weeks. One idea Derby got was a forward surgical hospital; there was no such unit in the U.S. Army, and he worked out how to reorganize the existing units (and acquire some equipment from the French and American Red Cross) to create one.

The 2d Division's first battle was from early June to mid-July 1918, with 9,000 casualties. The division had long lines of evacuation, and the division surgeon decided to stay at HQ, sending Derby out on battlefield circulation. Derby put the divisional triage hospital in the church at Bezu and moved around (in a motorcycle sidecar) to the ambulance companies and aid posts. The 2d Division had a USMC brigade which was heavily engaged at Belleau Wood, and Derby especially helped the Navy doctors to deal with the heavy casualties. Derby was constantly at work, often under fire from both high-explosive and gas shells. When the battle ebbed, he had to be sent to Paris for few days, likely gassed. (Being gassed was not necessarily considered wounded, so he was not eligible for a Purple Heart.) When he returned to duty, the division was in a lull, and the medical units received replacements, absorbed lessons, and trained.



During the war, the 2d Division used the church at Bezu as a dressing station. After the war, Derby raised money to have it rebuilt. Image courtesy American War Memorials Overseas, Inc.

The division's next battle was the AEF's first major battle, St Mihiel, 12-15 September 1918. Derby was put in charge of evacuation for the 3d Brigade. At H-Hour he went forward with a party of stretcher-bearers, leaving one here and another there to treat groups of wounded. He reached Thiaucourt, the brigade objective, reconnoitered it, and went back to lead ambulances forward once the roads were rebuilt. Ambulances were a temporary solution, and he next led the divisional medical companies forward – all under shellfire. As that battle wound down, he was appointed division surgeon. By then, one of TR's sons had been killed and two others wounded (Derby had attended both of the wounded), and Teddy wrote Derby a letter saying "I strongly feel you should avoid unnecessary risks and not jeopardize your live in any uncalled-for manner". There were limits to a strenuous life.

In early October GEN Pershing attached the 2d Division to the French, who sent it into action to take a locally-dominant hill, Blanc Mont. Derby made sure there were American Role 3 hospitals to take care of the casualties. He then built the divisional medical support plan, and again went forward, not at H-Hour but waiting until the reserve battalions moved up. However, he balanced going forward with being a staff officer. He made sure medical units stayed in supporting distance, moving ambulance units and the hospitals forward when there were safe locations for them.

The Indianhead Division was out of action for only a few days before going into the Meuse-Argonne battle on 1 November. Again, Derby kept his medical units as close to the combat troops as possible, and got out and about to see what was happening, as well as performing some surgery himself. German resistance cracked, and the Allies shifted to a pursuit, but a pursuit on foot, no faster than the Germans could retreat. Derby shifted gears, and organized support for the march into Germany (for instance, not having ambulances with each battalion because he thought it would encourage too many soldiers to have 'foot problems' to get a ride; instead ambulances followed each regiment so fewer soldiers would see them but they'd still be nearby) and the occupation of Germany. That involved plans for billeting, bathing, delousing, other sanitary measures, all amid the 1918-1919 influenza pandemic. 1918 had been a busy year, but he was able to see two brothers-in-law at Christmas.

A week into 1919 a telegram came: TR had died. Derby received the equivalent of emergency leave and was promptly on a ship home. His military days were over, although he briefly worked for the American Legion, helping some demobilizing Doughboys find work. He also dashed off a book about his experience in France that was published before the year ended. Derby did not stay in the reserves or National Guard, and practiced medicine around New York City. He died in 1963.

For his wartime service, he received a Citation Star (for his actions 12-15 September 1918, in the St Mihiel battle), and the Distinguished Service Medal for being an effective division surgeon. He also received the French *Croix de Guerre* with gilt star for actions at Blanc Mont, and was made a *Chevalier* of the *Legion d'Honneur* although it's not clear for what actions.



Derby (upper left) with two of TR's sons (Archibald, front row) and Kermit, with Eleanor Butler Roosevelt (Theodore Junior's wife), France, 1918. Courtesy Library of Congress.

President Roosevelt had clearly intervened to get Derby an opportunity. What impact did that patronage have? Was Derby successful because of TR's intervention? He clearly got to France earlier because of the letter, but he was still an assistant division surgeon. Counterfactuals are inherently uncertain, but we can consider some alternatives. Without TR's letter to Surgeon General Gorgas, Derby would likely have stayed with the 77th Division and gone to France later. Yet it would not have been much later, because the 77th was in France in April 1918, and in action from July in some of the same battles as the 2d Division. Derby would not have had opportunity to attend the Sanitary School, so his gallantry and energy might not have been as well channeled and he might have been less effective as a medical commander. He would not have been at Blanc Mont, but might have been involved with the 'Lost Battalion,' six companies from the 77th Division that were isolated for about a week. His opportunities would have been different in the

77th Division, and he likely would have been division surgeon there as well. He likely would not have received the Croix de Guerre. His Distinguished Service Medal was for "demonstrated high professional attainments, excellent judgment, and gallantry in the execution of his important duties. Due to his energy, the sanitary units under his control were amply provided with facilities for the proper care of the sick and wounded in the field." Few division surgeons received a DSM, and perhaps Derby received some favorable attention at headquarters for his family connections. From Gorgas' position, he took a well-prepared officer and gave him the same position but deployed him sooner, it was a favor to a friend, but there was no loss to the Army.

TR had asked Gorgas "for a favor which I would not ask were I not convinced that to grant it would be to render a service to the United States." Whether he was justified in pulling strings will be a matter of opinion. From the records we have, Derby did a good job, but would someone else have done a better job?

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Field Hospital No.1, 2d Division, in the church at Bezu, 16 June 1918.
Derby worked to push surgery close to the forward units; in June, this hospital was about 7km behind the front, and the closest hospital to the frontline troops.
From Medical Department, U.S. Army in the World War, vol.8.



PFC John A. Coolidge of the 1st Field Signals Battalion, 2d Division, in the Field Hospital No. 1 triage at Bezu, 16 June 1918. The hospital occupied both the church and the school, “carpeted, all through June, with the undiscouraged, grinning wounded, brought back by the ambulances from the fight just up the road”. U.S. Army photo via National Museum of Health and Medicine.

The 130th General Hospital: An Odd Interlude in WW2

The colonel surrendered the hospital to the Germans.
Many strands of story came together for that unusual sentence.

The 130th General Hospital started as an ordinary general hospital: a 1000-bed unit (about 660 personnel) intended to provide definitive care for troops in a theater of operations. Obviously they wouldn't cure everyone, but general hospitals had the most elaborate equipment (for treatment and rehabilitation) and most skilled doctors, and if you were going to recover from something serious, it was probably at a general hospital. Army planners realized they didn't need to ship many general hospitals overseas before there was much fighting, so many were activated in 1943 and deployed in early 1944. Moreover, the "professional staff" (of doctors, dentists, laboratory staff, and nurses) was pulled from brick-and-mortar hospitals in the U.S. and added to a cadre – the enlisted men, administrative officers, and a few senior clinicians – to minimize disruption of patient care in the U.S. There was no exact limit, but general hospitals were not intended to operate near the front: they were not mobile and their mission was for long-term care.

The 36th and 312th Station Hospitals would be intertwined with the 130th. Station hospitals were intended for low-acuity care, the ordinary sick and injured of military life. They provided healthcare to the men (and increasingly women) at a post, camp, or station, and the deployable (i.e. numbered) hospitals were to provide healthcare for an area, perhaps a port, or a city with numerous depots, or an area with several airbases. But they could be adapted, and the 36th and 312th were repurposed in late 1943 to be psychiatric hospitals for the U.S. forces in England. The 36th would take psychotic patients and the 312th would take up to 1000 neurotic patients (in the terms used then); both were broad categories that do not match with modern terms but neurotic conditions were generally milder. Some draftees had slipped through cracks in the psychiatric screening that all recruits went through (and the cracks were wide, sometimes no more than the question "do you like girls?"), some men had trouble adjusting to military life, some reacted to combat. Many of the available psychiatric-trained medical personnel in Britain were reassigned to these two hospitals, providing improved care. The 312th had excellent return-to-duty rates. That was not very surprising, since it was dealing with less serious patients, but still surprising since most of the patients had been treated at another hospital for some time and not improved.

By early 1944 Operation Overlord was on the horizon, and it was obvious (from studies of combat experience in Italy) there would be many psychiatric casualties from the ground combat. More psychiatric care was needed, so the psychiatric specialists from the 36th and 312th were transferred to the 130th, which was also scheduled to deploy to France earlier than most general hospitals: properly treated, many psychiatric patients could return to duty quickly, while the average wounded patient would be hospitalized almost 120 days. For 'return on investment' it made sense to prioritize a psych hospital, while the wounded would be treated at other hospitals on their way to recuperate in England. (The 96th General Hospital was also reorganized to be a psychiatric hospital, but it was going to stay in England.)

The colonel was Ernest H. Parsons. From McAlester Oklahoma, he was the son of a wholesale grocer. He attended Vanderbilt University for his bachelor's degree and medical degree. He'd been in the medical ROTC, and immediately came on active duty, attending the basic professional military education schools. First stationed outside Denver, he later specialized in neuropsychiatry (neurology, the study of the brain and nervous system, had not been professionally separated from psychiatry). He wrote several medical articles, showing clinical diligence, and attended his duties, getting promoted at the normal pace. When the Army expanded in the war, his promotion (like plenty of others) was accelerated: from major in 1941, he was a bird colonel in 1944. Extending his tour at his last peacetime duty station would have changed his life: he was in the Philippines 1939-41, but rotated back to the U.S. As a prisoner of the Japanese, his conditions would have been worse. He was first commander of the 36th, then commander of the 312th, helping run a quick training program on psychiatry for general medical officers, many of whom had no training in neuropsychiatry, and contributing to a training film. With this background, he was an obvious choice to command the 130th when it was reorganized.



COL Parsons in 1944. U.S. Army photo.

Surrendering was easier because the 1929 Geneva Conventions were in effect for WW2. These covered both treatment of the sick and wounded, and of prisoners. Medical personnel were not to be targeted if they wore a distinguishing mark (i.e. the standard Red Cross brassard) although they could certainly be hit by indirect fire. Medical facilities (including hospital ships and medical evacuation aircraft) were also not to be deliberately targeted if marked. But medical personnel had to treat all wounded equally: they had to be neutral in the fight between nations and try to save anyone. If medical personnel were captured, they were officially detained rather than captured, a legal distinction that made no difference. But as neutral personnel, lawyers felt they should not be captured, so applied a different label.

Deploying the 130th was harder than forming it. The personnel had been reassigned in the spring of 1944. Then they sat in Britian, probably because the Normandy beachhead was too small – there were plenty of "combat exhaustion" patients, but there were "exhaustion centers" over in France and acreage in Normandy was in demand. Airfields, supply depots, headquarters,



The 130th's main building in Ciney. It is not clear if the Germans or the Americans painted the Red Cross on the roof. Image courtesy National Library of Medicine.

everything needed space, and the Germans were not yielding. Then the Allies broke out at the end of July, and suddenly there was limited fighting and few combat exhaustion patients – but gasoline was in short supply so there were few trucks to move a hospital and the hospital would have to be moved further to be close to the front and benefit the patients. Finally, in September 1944 the 130th disembarked in Normandy, and a location was picked in Ciney, Belgium, in a building the Germans had used as a hospital. There was a suitable large building, it was close to the front, and close behind several armies. Moreover, it was near the hospital center (and logistics center) at Liege, and could easily evacuate to railroads. Ideally it would be operational on 1 October. But an unlucky German torpedo had sunk the ship with the unit's equipment. It took until 6 November for replacement equipment to arrive, and the hospital was only gradually able to become operational, but was ready on 17 November. Meanwhile, Col. Parsons kept personnel busy, including scouring the area for German pre-fab buildings that they hauled over to the hospital site. While optimized for neuropsychiatry patients, they still had medical and surgical capabilities, and the 130th reported the adaptation had gone smoothly. When it was ready, patients flowed in: there was intense fighting in the Huertgen Forest, and a replacement depot 40km away had a steady stream of sick and injured patients who needed care. However, these were mostly 'normal' wounded and sick, not psychiatric casualties, because the hospitals at Liege were overflowing.

Then the Germans attacked on 16 December, 1944. It would get the name Battle of Bulge, but at the time nobody knew it would only be a bulge and not a full breakthrough. Liege was an obvious German target, and Ciney was even closer. Forward hospitals were being cleared out, and the 107th Evacuation Hospital's patients were moved back to the 130th. Some, most, of the 130th's patients were moved back in turn, but the non-transportable patients (those too fragile to survive evacuation on the bumpy roads) could not be evacuated. On 21-22 December the 130th was also evacuated, but COL Parsons and a skeleton staff of volunteers stayed to treat them. (The evacuated staff moved with the patients and augmented other hospitals.) The Germans moved around the 130th, and there was fighting only a few hundred yards away. The Germans knew the hospital was there, but did not occupy it until on 24 December German officers arrived. They told Parsons they would send German patients, and expected him to treat them

appropriately. German casualties began arriving on Christmas Day, along with the pre-planned turkey dinner. Patients were patients, and while three operating rooms were full a Belgian woman arrived needing attention; her baby girl would be named 'Lucky.'

A few days after Christmas, Parsons tried the telephone, expecting that the lines had been cut – if not deliberately, by a random shellburst. Instead, the line to Liege was clear and he was told to stay put – while the front lines were fluid, and he might have been able to evade the Germans, Allied troops were counterattacking and the Germans would soon be gone. The risk was the Germans might take the medics with them. A day or two later, the Germans were indeed gone. The 130th stayed put, hardly a normal way to provide forward surgical support, and Combat Command B of the 2d Armored Division was surprised to find the 130th on site when they pushed into Ciney. The Germans had been 'correct' when they had occupied Ciney, and they were 'correct' and caused the 130th no problems as they left. Parsons had probably talked with the German commander, but it must have been an edgy conversation.

Afterwards, the 130th stayed put until late in the war. With the sustained fighting to push the Germans back in the Ardennes, only in March 1945 was it able to focus primarily on psychiatric casualties, suggesting that having a large specialist hospital far-forward was not as good as on paper. Late in 1945 the unit was inactivated at Camp Crowder, MO. After the stress, COL Parsons moved to being a neuropsychiatry adviser in the European Theater, and finished the war as head of psychiatry at Brooke General Hospital at Fort Sam Houston, TX.

It had been a small, strange episode in a big war. The Army had tried to provide better treatment for psychiatric patients, which would benefit them, and the Army, by returning many to duty. COL Parsons was dutiful and brave in staying put. And the Germans were decent. A lot could have gone wrong.

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27 September 1967, My Tho River, Vietnam. A UH-1D medevac aircraft comes to land on an Armored Troop Carrier ("Tango boat") of the Mobile Riverine Force to evacuate two casualties from an early-morning firefight. U.S. Army photo.

To engage Vietcong forces in the Mekong Delta, a maze of creeks, rivers, canals, and streams, with almost no roads, the Army and Navy organized the Mobile Riverine Force. Using a variety of landing craft, barges, and motorboats, the MRF could go more places than ground troops could, and could be quieter and stay longer than helicopters could. An infantry brigade was task-organized (e.g. far fewer trucks, but some troops trained to handle boats) and quartered on barges (the Navy called them Repair, Berthing, and Messing Barges), with artillery and other support units on barges and motorized craft. Some WWII-era landing craft were up-armored and could carry a platoon of infantry, and designated Armored Troop Carrier. Some ATCs, like this one, had a small flight deck installed.

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