

## FAMOUS FIGURES

### Major Jonathan Letterman, Director Of Medical Services, Union Army

The American Civil War was a major struggle for the new country. As so often happens, its outbreak after the revolution of the Confederate States, came as a surprise. But the fact that there was no concept of medical command or control – perhaps more obvious on the Union side – was not entirely a hazard of history; the emergent nation had had a war in 1812 when casualty evacuation and treatment was shown to be needed.



Fig 1. Letterman with nurses and patients.

When the war broke out, the majority of medical officers in the field were regimental surgeons commissioned by their State governors, and served under their regimental colonel, just as happened in our own Army of the day. The chief medical officer of the Union Army had no authority over the ‘volunteers’ (soldiers including doctors who had enlisted in support of their side) and had very few regulars under his command. Some regimental surgeons refused to treat casualties from other regiments, let alone enemy wounded (1). Evacuation of casualties was the responsibility of the regimental quartermaster. He controlled all the wagons, horses, tents and equipment, the rationale being that the wagon teams bringing supplies to the front could also return wounded to the rear. The system did not work. Patient movement was not co-ordinated. The drivers had no experience in handling the wounded, would ignore their complaints, and often stole alcohol from the medical panniers. The commanding general was reluctant to make enough equipment or men available for medical care because they saw it as a drain on their resources. As soldiers often carried their wounded comrades back, this often seriously depleted manpower.

Medical care consisted only of two levels of ‘echelons’ (2). The first was the field hospital,

placed within a mile of the front line. Wounded had to make their own way back, alone or accompanied by friends, to these hospitals, which could only carry out urgent amputations. They had no holding capacity. The second ‘echelon’ was army hospitals located within major cities. There patients could stay for long convalescence. There was no co-ordination between the two echelons, and doctors at the front had no idea of bed availability farther back.

Inevitably, major outbreaks of infectious disease broke out in epidemic form, with the poor conditions existing. Soon a group of concerned Northern citizens formed the United States Sanitary Commission. This Commission, described as ‘one of the great moral and physical forces of the war’, met with fierce initial resistance. The regular American military described the Commission, like their British military descendants described the BMA, as a group of ‘sensationalists and meddlers’ (2). With time the meddlers were proved correct, and began to dictate policy for care of the sick and wounded. They also raised thousands of dollars for medical supplies, and, as important, insisted upon their fair distribution. The Regulars had to listen.

The Director of Medical Services (DMS) of the ‘Army of the Potomac’, as the Union Army was called, was Major Charles Tripler, recorded as ‘having recognised the problems but felt bound by Army regulations and was incapable of effecting meaningful changes’ (2). What’s new? But his successor Major Jonathan Letterman made use of the climate created by the Sanitary Commission and at once produced a proper plan for military medical care. The ambulance plan was not original, being modelled on that of Baron Larrey. He had it approved by his GOC, Major-General George McClellan, and in 1862 an Ambulance Corps was set up. It had officers and men transferred from the Tenth Arms of the day to serve under medical command. The advantages of a systematic collection service was soon appreciated. After the Battle of Antietam in October 1862, Major Letterman, using his increased authority, went farther and re-organised the whole hospital system.

Aid stations supported field hospitals and provided front line care. They were placed in ‘protected or semi-protected locations on the edge of the battlefield’ (2). Regimental

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surgeons rotated from various affiliated units. The description of what they did shows that they were the equivalent of our RMOs. Patients were then sent on 4-wheeled ambulances to field hospitals (see Figure 2). Field hospitals were located one or two miles to the rear, where 'the most skilled medical officers were assigned to deliver care to the most severely wounded; other surgeons and assistants helped or performed necessary paperwork'.



Fig 2. Ambulances pulled by four horses – two were quickly found unsatisfactory.

Finally, treated patients were evacuated in the quartermaster's wagons, trains or boats,

for definitive care in the final echelon, the general hospitals. The word 'general' indicated in the US eyes that they would take men from any fighting unit. Such general hospitals had not existed at the beginning of the Civil War. As the war continued, the general hospitals grew larger and larger, until finally some took thousands of patients. These general hospitals were modelled upon the Florence Nightingale recommendations.

This account is interesting as showing how quickly the Americans, as soon as a competent man such as Letterman could take charge, picked the best method for the task needed – using Larrey's ambulance system and the Nightingale ward system without qualm. The American Civil War is less well known here than it should be; it has much to teach about the seeking of the best practice available without fear or favour.

### References:

1. The Winchester Accord. James Otis Breeden, *Military Medicine*, November 1993, **158**, pp689-692.
2. The Origins of Casualty Evacuation and Echelons of Care: Lessons learned from the American Civil War, Major JS Blansfield. *International Journal of Trauma Nursing*; 1999, **5** (1): 5-9.