

Chapter 1 : WW1 trooper who rewrote history books - Telegraph

Diseases of the War, Volume I Diseases of the War, Volume II Hygiene of the War, Volume I Hygiene of the War, Volume II Pathology Surgery of the War, Volume I Surgery of the War, Volume II Veterinary Services Medical and Veterinary History of the Great War based on official documents by direction of the Historical Section of the Committee of.

From the start they joined the war effort as nurses and ambulance drivers, and did other work in the Voluntary Aid Detachments. But, as British women learned in , military leaders balked at having women physicians working on an equal basis with male doctors at the front lines or in the military hospitals. Several years later, American women physicians faced similar obstacles. Anita Newcomb McGee reported that they could not, at least not as commissioned medical officers in the Medical Department. Like their male colleagues, they were moved not just by patriotism, but by the opportunity for the unparalleled surgical and clinical experience afforded by wartime service. Moreover, it was a chance for women doctors, still a small and often marginalized segment of the profession, to claim equal status and to be assimilated more quickly into the wider medical community. Baker to accept women into the military medical corps on equal terms with men. The medical board sent registration forms to all licensed physicians that summer, asking them to sign up for war service. Nearly a third of women responded that they would be willing to serve. In response, Judge Advocate General, Blanton Winship, ruling on August 13th, interpreted the requirements for contract surgeons as not gender-specific, and allowed that women physicians could be included in their ranks. Ansell also noted that women were unlikely to meet the physical requirements for medical officer service. Women physicians knew that the contractor positions carried no military rank thus no authority , paid less, and included no pension or other benefits available to medical officers. Many felt that only inclusion in the Medical Reserve Corps from which civilian physicians were drawn for service for the duration of the war would give them the professional respect they deserved. They continued to make their case for allowing women to serve as medical officers, and in February one group of eight exceptionally qualified women physicians asked the Surgeon General and the Secretary of War to give them commissions as a test case. Thus, women physicians who wished to serve had two options: It handled their applications for war service and their visas, and helped outfit them with uniforms and equipment designed and procured by the MWN. It also raised funds for its own field hospitals in Europe, the first of which opened in the summer of Loy McAfee, MD, ca. National Library of Medicine The medical department of the United States Army in the world war, Volume 1, National Library of Medicine RX1 Though many women physicians opposed becoming contract surgeons on principle, fifty-five women signed on for the service in They served as anesthetists, bacteriologists, and radiologists, or cared for military dependents at army dispensaries in the U. Only eleven of themâ€”all anesthetistsâ€”were posted overseas. One contract surgeon, Dr. After the war, as a civilian employee, she served as an assistant editor of the volume publication.

Chapter 2 : Trench Foot | Military Surgery, Medical History of the Great War | Medical Front WWI

History of the Great War, Based on Official Documents. Medical Services Surgery of the War. Full text is available as a scanned copy of the original print.

Somme casualties being evacuated from Charing Cross Station by J. In this book, he declared the heart to be off-limits to surgeons. He wrote, "Surgery of the heart has probably reached the limits set by nature, no new methods and no new discovery can overcome the natural difficulties that attend a wound of the heart. This was the beginning of cardiac surgery -- exactly one century ago. That same period would see the two costliest wars in history fought. As human tragedies, they were unsurpassable; but as for medicine, especially the new field of heart surgery, they were a boon. With ill-informed commanders repeatedly relearning that bravery was no match for machine guns fired over open sites, there were unprecedented scenes of horror in the casualty-clearing stations. It is difficult to imagine the carnage. Men were driven insane by the sight and sound of it. Most soldiers with heart wounds die on the battlefield. They perish from the immediate trauma, from shock -- the failure of the cardiovascular system to deliver sufficient blood flow --, or from the accumulation of blood in the pericardium. According to the British Official Medical History one typical Great War casualty clearing station saw only one patient among with chest wounds who had survived with a missile in his heart. These wounded survivors demanded some attention because their prospects were still dismal: Dedicated and resolute surgeons working under desperate circumstances bucked conventional medical wisdom and found new ways to work successfully on or near the heart. The British Official History tersely describes the post-war shift in attitudes: The feature of the surgery of the war as regards wounds of the heart is therefore a familiarity with conditions which were previously rare, and the evidence which is afforded that the treatment of injuries to heart has now become a definite and promising field for the surgeon. Once again the British Official History is instructive. It gives some excellent examples of the development of new procedures to drain the Pericardium, three new methods for repairing wounds to the heart and techniques for removing foreign bodies in it. The Victoria Cross is the highest British award for bravery in the face of the enemy. In our opinion, some type of medal should also have gone to the English surgeon, Mr. George Grey Turner [British surgeons are addressed as "Mr. On x-rays, the surgeons could see the tip of the bullet moving around in the left ventricle. With no blood bank, no antibiotics, with just primitive ether anesthesia and poor lighting, Mr. Turner exposed the heart through the left chest. The spot where the bullet had entered the heart was marked by a depression surrounded by a roughened, whitish area. At first, he could not find the bullet, even after probing with a needle. Finally, in desperation, he rotated the heart and palpated it; he could feel the bullet right in the middle of the heart, lodged in the septum. At that point, the surgical team got a fright because the heart totally stopped beating pacemakers had not been invented yet. The flap of chest was replaced and held in position with catgut sutures The soldier he had operated on in subsequently lived through when Mr. Turner reported the case. The soldier was quite well; just a little tired at times - more from his home front work for the Second World War than his wounds from the First! During the inter-war years minor advances were made in France and the U. Peacetime had reduced the numbers of the most challenging kind of cardiac patient -- those with missiles like shrapnel, bullets and splinters lodged in the heart. The individuals with such difficulties suffered a high mortality rate from operations, so foreign bodies were not regularly removed simply because of their presence. Unfortunately however, even without discomfort or other symptoms, patients with fragments left in their hearts had up to a 25 percent chance of dying of infection or other complications. Another war, however, was coming and, by greatly expanding the number of casualties with wounds to the heart, would challenge the practitioners of cardiac surgery to greater innovations. Traumatic shock was still a tremendous problem on both World War II battlefields and in surgical suites. They found that a 40 to 50 percent loss of blood volume caused a profound reduction in cardiac output, venous return, and a peripheral blood flow. To replace this blood loss, whole blood was more effective than plasma, a finding demonstrated again and again on the battlefields. Johnson goes on to discuss other results from this study that benefited heart surgery: It demonstrated that cardiac catheterization was a safe procedure that yielded much useful physiologic and

clinical information July marks the date of a series of important publications by the U. At the start of the Second World War surgeons had continued the conservative approach of not removing missiles from the hearts of patients who had survived the original trauma and were in a non-emergency state. Later, though, special thoracic surgery hospitals were established to treat casualties from D-Day. Harken was director of the Fifteenth Thoracic Center based at Cirencester in England and he knew that, if bullets or shell fragments were left in or near the heart, many patients would still die of sepsis or embolism. Harken and his team set out to remove as many missiles as possible using a variety of the latest surgical techniques: Prior to operation, the position of the missile was pinpointed by fluoroscopy. At operation, the patient was induced by intravenous pentothal sodium anesthesia; intubated with a large-bore endotracheal tube; and maintained with nitrous oxide, ether, oxygen, and assisted respiration. To remove the missile, the heart was often split wide open, with tremendous blood loss. Rapid, massive, blood transfusions were needed to keep the patient alive. Whole blood was often administered, under pressure, at rates up to one and one-half liters per minute. Penicillin, which was just beginning to make an impact on thoracic surgery, was often given in 10, unit injections Harken reported that there were no deaths among these patients. His wartime results inspired other surgeons to rethink surgical approaches to the heart. Following this pioneering boost to heart surgery, surgeons in peace time practice were encouraged to try to open up diseased mitral and pulmonary valves in the heart. In this way, with support from military medicine, heart surgery was truly established by the late s. It took fifty years for surgeons to prove that Dr. Paget was wrong about operating on the heart and that the former soldier, Ludwig Rehn, had been on the right side of medical history. A large part of this was due to the pioneering efforts of war surgeons working under desperate circumstances. They brought about revolutionary changes in the approach to the heart. This was possibly one of the very few good things to come out of the suicidal conflicts that engulfed the world. We still have a tremendous debt to Mr. Harken and their colleagues.

Chapter 3 : Full text of "Medical services; general history"

Trench Foot Extracts from the 'History of the Great War, Medical Services, Surgery of the War' Volume 1, Edited by Major General Sir W. G. MacPherson, Also a short extract from a book on Military Surgery by Dr Penhallow.

The Allies were later joined by Italy, Japan, and the U. To defeat the enemy, the Allies and the Central Powers used trench warfare to create strong defensive positions that were hard to breach. Frequently, these trenches were constructed in three interconnected rows, which enabled the combatants to retreat and continue fighting to maintain their positions. Tens of thousands of miles of trenches were quickly built from the Belgian coast to the border of Switzerland. Reliable, rapid-fire machine guns became widely used and forced troops to seek protection in the trenches. Barbed wire was used extensively to inhibit movement on the ground between trenches, and tanks were used for the first time in . Later in the war, poison gases and flamethrowers were introduced to kill and debilitate enemy troops. When World War I began in , the combatants wore only cloth hats as part of their uniforms. Soldiers had worn body armor in the past, but it became less effective after the long rifle was invented, so this early form of body armor was eventually abandoned. Because trench warfare exposed the head and neck area to gunfire and artillery assaults, many soldiers died as the result of penetrating intracranial injuries. In the British, and then the German and French, adopted widespread use of steel helmets. Although the number of fatal cranial injuries was reduced after the introduction of helmets, soldiers now survived with more devastating facial injuries. He then trained as an otolaryngologist and developed an interest in facial reconstruction, so he traveled to France to study with Charles Valadier, a French-American dentist, and Hippolyte Morestin, MD, a plastic surgeon skilled in facial reconstruction techniques. While serving in the British military, Dr. More than 5, patients received reconstructive procedures there primarily to rehabilitate facial injuries. Davis was the first U. In , the U. Army General Hospital No. More than 20, wounded soldiers were treated in this 3,bed receiving hospital from to , when it was closed. In , just one year before Dr. Gillies published *Plastic Surgery of the Face*, Dr. Davis published *Plastic Surgery: Its Principles and Practice*. Conclusion The texts by Drs. Gillies and Davis on plastic and reconstructive surgery formed the foundation for the surgical specialty both in the U. He served as the president of the AAPS in Davis was elected to serve as a Regent of the American College of Surgeons. Both the College and the ABMS focus on improving the quality of health care for patients, families, and communities through continuous professional development. Acknowledgments The authors gratefully acknowledge the assistance of Meghan P. The life of John Staige Davis, M. *Plastic Surgery of the Face*. Hodder and Stoughton, London, Pioneer American plastic surgeon.

Chapter 4 : History of the Great War, Based on Official Documents. Medical Services Surgery of the War -

It is impossible to talk about "the" medical care or "the" medical service of World War I. Medical care varied greatly, depending on geography, strategy, and national, social, or economic differences, and so did the people providing it.

In terms of the proportion of the public who received free treatment, the location of modern hospitals and the effectiveness of new treatments, Britain was well ahead of most other countries. Before , healthcare was mainly provided by charities, poor law local welfare committees that operated the workhouses and an unregulated private sector. However, building on 19th-century developments of mental health and fever hospitals, between to it moved to a highly effective mixed economy of mutual payment schemes, local authority services and not-for-profit providers, with little place for commercial medicine. In few working-class people paid for their own medical treatments, with charity and the poor law the main routes to treatment for the poorest. Others, including many in the emerging lower middle class, struggled to afford treatment, relying on hospital casualty departments, kind doctors or folk remedies. But the National Insurance Act of changed that. It provided access to general practitioners GPs for manual labourers and lower paid non-manual workers earning under a certain income, together with tuberculosis care. But this system had significant weaknesses. Fees for GPs were increasing for the middle class and wealthy who were outside the system, leading Thomas Horder, an eminent physician, to complain that his private patients were coming to him armed with the results of diagnostic tests carried out elsewhere to save them money. Yet some GPs created new types of practices, such as the Pioneer Health Centre , which opened its doors in Peckham, south-east London, in . Funded by weekly subscriptions, it was established with the belief that health and medicine should not be divided between medical services and the promotion of a more general healthy lifestyle. In addition to doctors surgeries, it housed a swimming pool, dance floor, nursery and cafeteria. Swimming pool at the Pioneer Health Centre in Peckham. In , acute and general treatment was provided by voluntary hospitals paid for by upper and middle-class philanthropists and staffed by doctors who treated patients for free. Infectious diseases, such as typhoid and diphtheria, were the responsibility of local councils, while the chronic and infirm had to rely on the workhouse. There was a small group of nursing homes where doctors treated their private patients for a fee. The donors and the ratepayers largely decided who could receive treatment and where, often on social rather than medical grounds. Although hospital treatment was not covered by National Insurance, access was made possible by working-class contributory schemes that collected around three pence a week from workers to secure members free hospital treatment. By about 20m people were covered by these schemes, the biggest being found in London, Liverpool and Sheffield. They ensured that most people would gain admittance to a bed on medical need alone. They were also an important focus for community activity, with members holding social events and engaging in an annual Easter collection of eggs. Poster asking the public to donate eggs to Nottingham General Hospital. In the poor law was abolished and a growing number of workhouse infirmaries became general hospitals. The main beneficiaries of hospital expansion between the wars were women and children. Most infectious disease patients were children, and as the threat of typhus and smallpox declined these hospitals switched to general child medicine. Maternity wards were the fastest growing specialist service, with the public hospitals converting old poor-law blocks for the needs of expectant mothers. Voluntary hospitals like the Jessop in Sheffield expanded their services, introducing scientific laboratories to help tackle rising maternal deaths. Building on the work of the British Red Cross and Order of St John Voluntary Aid Detachments of the Great War, the interwar period saw the growth of a voluntary first aid network, providing a range of first response services. At big events like the British Empire Exhibition at Wembley in the summer of , the two organisations collaborated, caring for over 16, people suffering from accidents or illness. In addition to this medical work, by they had trained over , people to deal with gas attacks expected in the event of a war. By well over half the population could access GP and hospital services free at the point of use. Certainly big gaps remained, some filled by voluntary bodies such as the British Red Cross. Women and children had limited access to GP surgeries but growing hospital services provided for them. The middle class were largely excluded and had to rely on increasingly expensive private doctors and their

sub-standard nursing homes. This exclusion, particularly from hospital treatment, probably explains why there was less opposition to the NHS than might have been expected, despite its radical restructuring of a broadly successful healthcare system. The middle class had little to lose and much to gain from a reform that reduced their direct costs and improved their access to the best facilities. More evidence-based articles about the NHS:

Chapter 5 : History of the Great War Based on Official Documents (British Official History)

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This research has resulted in a multitude of different, often national but sometimes comparative studies. Medical care during wartime varies as much as the war itself. It depends on the time period, weaponry used, geography, climate, military strategy, politics, the economy, the number of soldiers being treated, the amount of medical materials and of course the numbers, skills and knowledge of doctors and nurses. There were tens of millions wounded as well, and as a result of the violence and unhealthy circumstances of wartime, these wounded were surrounded by sick soldiers. In certain ways this medical effort was successful. Up until then, the death of most soldiers was caused by disease rather than wounds. Although disease remained the main cause of manpower depletion, World War I was the first war of some length in which this statistic was turned around, thanks to for instance hygienic measures, vaccination programmes or blood transfusion. However, for this to happen the army medical corps had to grow rapidly after the war began. Without medical care, battles would have been shorter and fought with fewer men. Medical opposition to the war was scarce. In , physicians found their way to frontline or military base hospitals en masse. Wounds never seen before, in numbers never seen before, promised there would be unlimited research possibilities, on an individual and societal scale. War, they said, was not an enemy of medicine; it was its teacher. Some even saw war as a colleague, for, despite the numerous individuals who would be killed or maimed, it would make the people, the nation, and the race physically and psychologically stronger. It is telling that, at least in Germany , the number of doctors in favor of abortion gradually fell as the war lasted. During the war the number of doctors and nurses kept increasing, and they took care of millions of sick and wounded in hospital beds, on stretchers, on blankets on the floor, or on the floor itself, either inside or outside field hospitals. No matter how vast healthcare provisions were, and no matter how hard physicians and nurses worked, medical care was no match for the number of wounded: Given the circumstances, not the failures, but the successes were surprising. Particularly on the Western Front , medical officers had to combat wounds and illnesses of an enormous variety and spanning all degrees of severity. Their successes would have been impossible without a high degree of organization. Despite some national differences, the organization of the medical line was generally the same throughout all armies, with first aid at the front, advanced dressing stations close to the front, followed by field hospitals or casualty clearing stations CCS near the front. Exceptions were determined by a combination of geography, climate and style of warfare - often determined by the former two. Examples are Gallipoli or the African jungle. The priority was triage and making a patient ready for the journey back. If times were quiet, triage practices followed medical standards, i. Heavily wounded patients were put aside, given a dosage of morphine if available , and left to die. The slightly wounded cost less time and were considered of greater importance because they could be made fit for battle again. This, to a great extent, also determined the popular policy of treating the wounded as quickly as possible and as close to the front as possible. This methodology of care profited and resulted from static trench warfare, providing health workers a more or less fixed place to work, fairly close to front lines. Recovery rates rose especially for simple wounds. Nevertheless, ambulances and hospital trains, carrying the wounded from one spot in the line to another, became a very frequent sight in warring countries. According to German writer Leonhard Frank â€” , the trains were the central metaphor of the war as they literally brought home its horrors. Field hospitals and casualty clearing stations were messy, at times filthy, and frequently overloaded. As said, the wounded were often lying on the ground or outside, not far from stacks of amputated arms and legs in a corner. In Britain alone base hospitals expanded from a 40,bed capacity at the end of to , at the end of the war. And in in the Berlin area alone, there were with a capacity twenty-fold greater than in the pre-war years. However, in spite of organization being more or less similar, medical care itself, as said, differed severely from time and place. Stretcher-bearers, although the first responders to injuries, are frequently forgotten. There were hardly ever enough of them, and their ranks suffered considerable losses. In theory, four stretcher-bearers were expected to bring a wounded man back to the first aid post within the hour, which could only be achieved if the violence had stopped and ground

conditions were reasonable. In reality it often took up to eight men, depending on the mud. The stretcher-bearers frequently felt worn out after delivering a single wounded man to a first aid post. Seeing stretcher-bearers taking a break or asleep, while the wounded remained in the field troubled the other soldiers, such as Louis Barthas , [9] a hostile attitude certainly not lessened by the order to preferably bring back the wounded they felt had the best chance of eventually being fit enough for active service. Although a task not prioritized by many physicians, nevertheless considerable effort was put into preventive care because sick soldiers posed a threat to healthy ones, and because, as Austrian soldier-novelist Andreas Latzko " wrote, soldiers had to be healthy enough to return to battle and face further injury and death. Nevertheless, in some armies, certain conditions were not treated as much as criminalized. Contracting them was considered an infraction. The care doctors and nurses delivered changed over the course of the war as a result of experience gained, a rise in the number of physicians and nurses, more refined medical supplies, and improved techniques. In August 1915, for instance in the Belgian army and the British Expeditionary Force , improvisation ruled the day. Material was qualitatively and quantitatively insufficient. Physicians and nurses short in numbers. Knowledge on specific war-injuries was lacking. Consequently, by the last year of the war, the survival chances of for instance those suffering abdominal wounds - if they were lucky enough to reach the hospital alive - had risen considerably, especially in the Allied armies. This was mainly due to the introduction of blood transfusion, to a high degree resulting from American war participation. The medical services of the Central armies were far more skeptical about blood transfusion. This left little time for to develop improvements in procedures or practices. There was hardly any time for further education and, consequently, newly arrived doctors were no more or less skilled than their predecessors. Standards of care actually dropped as the war continued. Furthermore, the ongoing search for soldiers led to a drop in physical and mental requirements for new recruits. Medical tribunals were turned into a variant of industrial conveyor belts, perfectly captured in a drawing by George Grosz in which doctors diagnose a skeleton fit for service. The result was that doctors and nurses got an even harder time than they already had. The fact that their numbers also constantly rose indicates that, especially in the last year of the war, the doctors, nurses, and orderlies too were not always as qualified as they should have been. So, as the war lasted, more and more hardly qualified caregivers had to cope with more and more soldiers who in fact were physically and mentally unfit to serve. These ailments often were caused by the living conditions: In 1918, Spanish influenza compounded these existing issues, leaving medicine virtually impotent and killing soldiers and civilians by the masses. Then there was the psychological condition now commonly referred to as shell shock , caused by stress that derives from constant violence, a feeling of uselessness, and, above all, fear. The fear was wide-ranging, both physical and psychological: There was hardly ever a sufficient number of people available to help, and medical materials often were in short supply. It also depended on the nature of the wounds themselves. For instance, in general a soldier who suffered facial disfigurement received better treatment than psychologically affected soldiers. German doctors, also military ones, voiced their concerns that the civilian health situation was worrying and should be prevented from deteriorating, if only because this would seriously harm home front support. Military medicine - or better: Medical care also differed from place to place. It mattered if the doctors and nurses were stationed near the swamps of the Belgian Yser, the mud of Ypres , the clay of the Somme , the shores of Gallipoli , the sand and heat of the Middle East , the jungle of Africa. At Salonika, the base of the British Balkan campaign, hospitals were in a dreadful state, every once in a while complicated even more so by extreme cold. Illnesses such as malaria, sand fever, typhoid, and dysentery raged among patients and doctors alike. In Egypt , British supplies fell short, and soldiers were exposed to the severe threats of dust, scorpions, and flies. Medical personnel often considered working in the Eastern Mediterranean a bigger challenge than working on the Western Front. Of course it mattered if they were stationed on land or at sea. And also healthcare varied depending on whether armies were homogenous or multiethnic and multilingual. If their conditions made transport impossible, patients were left behind with the hope that the enemy would be merciful and take over treatment. These problems also occurred in the west in the opening months of the war, and even more so in 1918. For example, it was only because they kept control of the railway system that the Allied medical line did not collapse during the German offensive of 1918. In general, across national boundaries, patient

rights were threatened by the war in the short term. Even ignoring the fact that soldiers had to obey physicians because they were officers, the pressures of total war, the wish to contribute to the war effort, and the sheer volume of soldiers requiring treatment were bound to cause a shift in doctor-patient relationships. Punitive action, however, was rare. To get their will done, in general the doctors relied more on moral persuasion. For instance, in the de-lousing process, the British set their faith in personal hygiene, while the Germans trusted disinfection. Differences in vaccination practices arose, in part, from the fact that Germany conscripted its soldiers, but the British did not until 1916. As a result, vaccination was always obligatory in Germany, but voluntary in Britain. However, British vaccination was really only voluntary in theory; most soldiers actually thought it was compulsory. It took considerable strength to resist medical and military pressure to get vaccinated, especially since the medical benefits were undeniable: The rate of infection amongst those refusing vaccination in 1916 was 15 times higher than the average for the army as a whole. Nevertheless, this affliction constituted between 3 and 8 percent of the total. Did they serve in a conscription army or an army of volunteers, in which facilitating organizations such as the Red Cross were less strictly incorporated? Were they part of a health service of a warring country or part of a neutral state ambulance corps? Young, inexperienced doctors were more likely to be stationed at or near the front, so the more severe cases went to base hospitals, where patients could be seen by university doctors. By virtue of education and status, these doctors tended to be more nationalistic and were often unaware of what their patients had gone through during the war. They distanced themselves from patients, in contrast to the more informal and closer doctor-patient relationships at or near the front. Military frontline doctors, in general, viewed treatment pragmatically; they were mainly concerned with crisis management, employing whatever methods would do the trick to heal or at least comfort their patients.

Chapter 6 : Medical Services (Home and Abroad)

> *The Great War and the evolution of plastic and reconstructive surgery* *The Great War and the evolution of plastic and reconstructive surgery* By Raymond F. Morgan, MD, DMD, FACS and Elizabeth A. Morgan, MA.

Additional Information In lieu of an abstract, here is a brief excerpt of the content: Published by authority of the minister of national defence, under direction of the General Staff. The writing of military medical history is an undertaking which requires a broad knowledge of military administration, organization, and tactics, of medicine and surgery, of hygiene and sanitation, and of statistical methods. Realizing this, in arranging for the preparation of the official history of the medical services in Great Britain, as early as a committee was appointed to study the subjects of which a medical history should consist. At the end of , Major-General Sir W. Macpherson was appointed editor-in-chief and given the task of organizing the writing of the history, assisted by a committee consisting of members representing Medicine, Surgery, Hygiene, Pathology, and Statistics. The inadequacy and fallacies of medical histories of wars in the past were responsible for this carefully planned organization to prepare a consecutive medical history of the great war. That the task he has attempted is beyond the powers of an individual writer is apparent on many of its pages. Without the assistance of recognized authorities as an editorial board, it was almost inevitable that inaccuracies and deficiencies should occur. The book begins with a description of the origin of the service and the preparations for war, followed by the story of the First Contingent and the Second Division. The activities of the service in the field are given at the Somme, Vimy Ridge, and Passchendaele. The controversy on administration is extensively discussed. The Nursing Service, the Dental Corps, and the other ancillary services are briefly commented upon. Descriptions of the Medical Services in Canada and the Red Cross are also given, after which appear the lists of honours and awards and the Roll of Honour. The book is brought to a close with a chapter on demobilization. Due credit must be given the author for the vast amount of work necessary in the preparation of this volume of four hundred pages. Many of these pages arouse interest and satisfaction, while others chronicling facts and dates make somewhat indifferent reading. The outstanding part of the book is devoted to the political controversy which occurred in on the administration of the Canadian army and the medical services. So much space has been allotted to the controversy, that the amount left for drawing a life-like picture of the particular features for which the different field ambulances, clearing and base hospitals were distinguished, is altogether too meagre. The book fails to bring out into clear relief the magnificent work which the C. The location of this unit or that, and the dates of their movements, are not satisfying when one is expecting to find the kind of work they did and the manner in which it was performed. The narrative lacks life and action. The descriptions of the active service in France in which the Canadian units played their part are very general in character, leaving one in some doubt as to whether he is reading a general treatise on war or the history of a particular branch of the Canadian service in the late war. The style has a tendency to be jerky and disconnected. Not only does lack of continuity of subject exist in consecutive paragraphs, but poor organization is shown in the arrangement of the chapters. In an official publication, the use of the English language, the spelling and such technical details as the index, should be irreproachable, for its employment as the final court of reference is sufficiently common to warrant the most scrupulous care in the preparation of every detail. That such care has not been taken is illustrated by the following examples: The exact meaning of the following is far from clear: Mistakes in spelling are found as follows:

Chapter 7 : The Great War Society: Relevance Archive

Medical services; casualties and medical statistics of the great war, by Major T. J. Mitchell and Miss G. M. Smith.

The volumes of the British Official History: Military Operations are as follows: France and Belgium, Volume I: Edmonds, Volume II: Edmonds, Military Operations: Battle of Neuve Chapelle: Edmonds and Captain G. Wynne, Volume II: Edmonds, Volume III: Edmonds, Volume IV: Edmonds, Volume V: Edmonds and Lieutenant-Colonel R. Maxwell-Hyslop, Military Operations: Aspinall-Oglander, Military Operations: Davies, Military Operations: Togoland and the Cameroons, , Brigadier-General F. Moberly, Military Operations: Moberly, Volume II: Moberly, Volume IV: Sir Julian died when he was completing Volume III and before he had agree to the corrections to this volume. The remaining works were completed by the writer and poet Sir Henry J Newbolt Naval Operations Volume I: The events leading up to war, organization of three fleets in Home Waters, coastal Destroyer Flotillas, opening movements on the outbreak of war in Home Waters and the Mediterranean, the passage of the British Expeditionary Force to France, Heligoland Bight action, operations off the Belgian coast October ,. By Sir Julian S. Naval Operations Volume IV: Maps Naval Operations Volume V: Early to the end of the war, German submarine campaign in Home Waters, the Mediterranean and off the American coast, the convoy system, blocking Zeebrugge and Ostend.

Chapter 8 : The New Zealand Medical Service in the Great War | NZETC

The medical history of the First World War was written by the Colonel-Commandant of the Royal Army Medical Corps (RAMC) Major General Sir William Grant Macpherson KCMG, CB (- October). Medical Services: Casualties and Medical Statistics.

Meanwhile, Mr Briffa was so touched by his discoveries about Trooper Martin that he has paid his respects to the heart patient he never knew by visiting his overseas grave. This is that story – Robert Hugh Martin, the son of an engineer, was born in Walkley, Sheffield, in , the second of six children. Gentle, fun-loving and a keen footballer, Martin left school for an office job before switching to become an apprentice printer. After the outbreak of the war, he continued working because he was too young to serve. However, when going to the printers one day, Martin was horrified when a woman showed him a white feather – implying he was a coward for not joining up. Shortly afterwards, he signed up, despite being just 17, with the Derbyshire Yeomanry. The regiment, including Martin, saw action at Gallipoli, before joining the Salonika Campaign, in what is now Thessalonika, Greece. It was here, in battle, on November 14, – his 21st birthday – that Martin was shot in the chest by a Bulgarian soldier while on horseback. Despite his injuries, he rode several miles to the nearest dressing station. However, the treatment available for wounded soldiers, especially those with major organ damage, was limited and – in the days before heart-lung machines to keep a patient alive – heart surgery was considered futile. Indeed, towards the end of the 19th century, Christian Billroth, the respected Austrian surgeon, had said: Modern-day heart surgeons, including Mr Briffa, have long believed advances did not come until the s, when doctors surgically treated patients with rheumatic disease of the mitral valve, but with limited success. It was widely believed heart injuries from battle were not dealt with by surgery until the Second World War, when Dwight Harken, the American surgeon carried out pioneering work in London. He found a way of treating patients by cutting into the wall of the beating heart, then inserting a finger to locate and remove the shrapnel. With this method, he became the first to enjoy repeated success in heart operations, removing shrapnel from wounded men without a fatality. Sadly, although the operation was successful, Trooper Martin later contracted an infection that claimed his life. He died on March 14, , still aged Mr Briffa believes that, amid the chaos of war, the extent of the innovative surgery was never recognised, even within the medical world. He returned last year, and visited the Pieta Military Cemetery, near Valletta. Now I feel sure similar efforts took place in other theatres of the Great War and that there were long-term survivors. Written by Sir Charles Ballance and Dr Marguerite White, a surgeon attached to the Hospital, the article described how they had removed the rifle bullet from the right ventricle of the heart with forceps, while internal stitches were used to stem bleeding. His great grandson, Peter Ballance, who lives near Paignton in Devon, retired as a consultant anaesthetist three years ago. She still possesses postcards sent home by Trooper Martin after arriving in Malta. In the hand-written cards, he played down his serious injuries and made no mention of any surgery. Mrs Hobson, who lives in Sheffield, said: The history of heart surgery is now going to have to be rewritten as a result of everything he has found out. To find out more about him and his work, visit www. Follow him on Twitter [LordAshcroft](https://twitter.com/LordAshcroft).

Chapter 9 : The Great War and the evolution of plastic and reconstructive surgery | The Bulletin

History of the Great War, Based on Official Documents. Medical Services Surgery of the War.