BATTALION AID STATION

The battalion aid station was the first place a wounded man would encounter a physician. During the battle of Soissons, one of these was within 50 yards of enemy lines. While the physicians usually didn't get closer to the action than the battalion aid station, there were notable exceptions. For example, Lt. Junior Grade Weedon Osborne, a dentist with the 6th Regimental Aid Station in Montgivrault volunteered to help man the medical support for the 2nd Battalion of the 6th Marines and died in the effort. He was awarded the Medal of Honor for his actions. Lieutenant Joel Boone, the Marine 6th Regiment assistant surgeon, left the aid station and tended to wounded Marines in the fields near Vierzy (battle of Soissons). He was also awarded the Medal of Honor for his actions.

Photo of Navy Medical Unit Serving the Marine 3/6 from Navy BUMED Files.

For the most part, battalion aid stations were located along routes of evacuation dictated by the terrain. They had to be close enough for litter bearers to carry their casualties without undue exhaustion, with some protection from enemy fire. They were located in buildings, shell holes, culverts, quarries, dugouts, behind walls,

and occasionally in cellars. Cellars were dangerous, since most French cellars had one stairway and no alternative escape route should that stairway be destroyed by artillery. One station was located in a cave during the Blanc Mont battle.

Battalion aid stations were subjected to heavy artillery and gas attack. The battalion aid station in Lucy-le-Bocage was destroyed by artillery several times. Surgeon Richard Shea, at the battalion aid station in Champillon, was nearly hit by a German sniper outside his station. He had a hole in his tunic pocket to prove it.

Battalion aid stations were not strictly allocated to specific battalions. During the battle of Belleau Wood and Soissons, battalion aid station “affiliation” became very muddled. This was a matter of the pragmatic allocation of scarce resources and a reflection of the very dynamic nature of open warfare. This consolidation allowed staff to work in shifts and share equipment, personnel, and (sometimes) scarce “facilities”. This became increasingly evident in the case of the 6th Regimental aid station in Petit Montgivrault (that functioned more like a battalion aid station) and the battalion aid station in Lucy-le-Bocage.

The medical officer or chief pharmacist’s mate (CPM) examined patients and their dressings on arrival. The primary medical activities in the battalion aid station included hemorrhage control, Thomas splints application to long bone fractures, dressing inspection and revision, and initial shock treatment. Morphine and antitetanic serum were given, and wound tags updated. If a casualty received morphine, iodine was used to paint an “M” on his forehead. If antitetanic serum was given, a “T” was painted on the forehead. These were entered on the wound card, but the cards could fall off, thus the painted letters.
After arrival, those without abdominal, chest, head, or wounds were given hot cocoa or coffee to warm and prevent shock. The aid station usually had several shock tables for rewarming (see the Treating Shock article for details).

The battalion aid station was not equipped with anesthesia staff or equipment. They had limited supplies of Novocain. They had no operating rooms. In the case of a hemorrhage, tourniquets would be applied. In cases where a tourniquet could not be applied, the surgeons would do what they could with limited instruments and local or no anesthesia. Surgeons had no choice but to try to do what they could when casualties were stuck in the stations for hours at a time. There were no IV capabilities nor transfusions in these aid stations.

Wound care in the battalion aid station was rudimentary. Dressings applied at the front had to be removed and wounds inspected and cleaned to the degree possible.

Surgeons wore thick rubber gloves, a far cry from the thin flexible gloves we use in surgery now. The surgeons would don aprons and gloves. When a casualty arrived, corpsmen initially examined the man and his wound card. If antitetanic serum had not been given, they injected a dose. The dressing would be inspected, and clothing around a wound was cut away. The corpsmen did the “dirty” side of wound care, removing old dressings and adjacent clothing. The surgeons dredged their rubber gloves in alcohol or Lysol between cases and only touched the patient with disinfected instruments. They would typically cleanse the wound in a very simple way, trying not to cause undue hemorrhage. The cleansers used were either an iodine solution or Dakin’s Solution (a 0.5% bleach solution). The instruments used by the surgeon were disinfected in either alcohol or Lysol.

Wounds treated at the battalion aid station were not closed with suture. It was probably quite rare for the surgeons in the stations to use suture for much except to tie off bleeding vessels in urgent hemorrhage control cases.

The environment of the battalion aid station was arduous. The ones in shell holes were exposed to enemy direct and indirect fire, and subject to gas attack. Many in the medical staff became gas causalities. Those located in caves or culverts required the staff to work in a bent position for hours to days at a time. Those in enclosed buildings were hot, humid, and disorienting. In those stations, blankets were nailed to the windows and wetted down with antigas solution by enlisted personnel using orchard sprayers. Blankets covered the doors, but formal gas-proof air locks were not usually possible on the buildings used for these aid stations.

Patients were moved from the battalion aid station to the rear as soon as possible. In the heat of battle, such as at Belleau Wood, this could take many hours.

Supplies at the battalion aid station were limited, and they could quickly run out of Thomas Splints. Resupply was done by filling ambulance with supplies when they were able to get through. However, ambulance traffic to the battalion aid station ceased during German artillery barrages. During rapid advances the supply chain was unable to keep up with advancing battalion aid

stations. In many cases, the medical supplies of overrun German positions were used.

The mere act of communicating needs was a problem. Phone lines laid by the signal corps were destroyed in artillery barrages. The radios of the day were insecure, bulky, and generally useless. Runners carried many of the messages but had a high mortality rate. Communications from the battalion to regimental aid station staff and the dressing stations was very difficult as a result.

References:

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