

The Unexpected British Medical Emergency in the Gallipoli Campaign 1915-1916

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The Gallipoli Campaign, also known as the Dardanelles Campaign, of February 1915 to January 1916, remains to this day one of the most controversial British military campaigns of the First World War. From the start, British staff officers faced an unexpected medical emergency, in terms of the treatment and evacuation of their sick and wounded. In essence, the amphibious landing on the Gallipoli Peninsula in April 1915 sought to take control of the Dardanelles Straits, which were a vital supply route through to Britain's ally the Russian Empire, in the war against the Central Powers which included the Ottoman Turkish Empire. After the failure of a British naval bombardment of the Gallipoli forts begun in February, the amphibious landing in April was meant to clear the way for a much larger British campaign, which would lead to the capture of Constantinople (modern Istanbul), and in British hopes to the collapse of the Ottoman Empire. In reality, the first landings at Gallipoli barely managed to hold onto their own beaches, and the fighting became deadlocked almost at once. At Gallipoli, the troops from Britain and its Empire, and also from France, were fighting not only the Turks, but also the harsh climate, disease, and the mistaken decisions taken in the early days by British staff officers including medical staffs. The first reactions of senior staff officers, including those back in London, were simply to be unable to accept the scale of the medical emergency, and the logistics and transport problems that were involved.

The British Army's basic tenets and principles for the Royal Army Medical Corps (RAMC) for medical treatment and a 'chain of evacuation' had been created in South Africa during the Anglo-Boer War 1899-1902, and further refined to reflect conditions on the Western Front in France from August 1914 onwards. Its central principle was to provide rapid medical attention to trauma wounds, not only to stabilise the casualty but to reduce shock and the risk of further complications. This treatment of trauma patients has continued in modern British conflict and military medicine, being known as the 'golden-hour,' the critical first 60 minutes following the injury. At the start of the First World War, this vital time window had not been recognised, but it was clearly understood by medical officers that the faster a soldier-patient entered the chain of evacuation, the better were their individual chances of recovery, and return to active military service. In the often chaotic first amphibious landings on 25 April, the British chain of evacuation was already well understood, and operated successfully. Captain George Pirie of the RAMC, watching onboard the SS *Aragon* (which was acting as an officially-marked Hospital Ship), wrote:

We could see the troops being landed all day long and advancing on to the top of the cliff and lying in captured trenches and men cutting the barbed wire. We could also see the stretcher-bearers at work.¹

At Gallipoli the British positions were very shallow, with the front-line trenches up on the hill crests, while the beaches became the rear areas, and very crowded. Once the trench lines were established, the stretcher-bearers and walking wounded used communication trenches to reach the Regimental Aid Posts (RAPs) on the beaches. Once there, established practice was that only cases needing simple treatment or first aid would be treated and returned back up the communication trenches to their units. But many cases were recorded of more severely wounded men, who would on the Western Front have been passed along the casualty evacuation chain, being instead treated at the RAPs before being returned to their units. Since arriving reinforcements were given priority in using the communication trenches, at this early stage of the campaign the injured would often have to wait, sometimes for hours, before receiving medical assessment and treatment. Later in the campaign special 'medical evacuation' trenches were dug in parallel with some communication trenches. All British Army stretcher-bearers received some RAMC training. But, unlike stretcher-bearers on the Western Front, whose role was entirely that of carrying casualties, out of necessity because of the extreme conditions at Gallipoli, stretcher-bearers developed emergency trauma nursing skills, that were comparable to those of modern ambulance paramedics. Nevertheless, the system remained limited, and even these could be overwhelmed with wounded during a battle.

By far the greatest numbers of casualties at Gallipoli were caused by disease and sickness, rather than by the enemy. This is not surprising given the climate of the region, with its extremes of heat and cold, which caused sunstroke, hypothermia and frostbite casualties. Canvas tents or trench dugouts, in which sleep was always difficult, provided little protection against the extremes of the weather; and neither did British Army uniforms, especially those intended for more temperate climates. In winter, the trench system flooded, causing sometimes severe cases of tissue damage from 'trench foot,' more familiar on the Western Front. Soldiers were pushed into battle with little chance of acclimatising to the extreme conditions. The diet was monotonous with fresh fruit and vegetables usually completely absent, and consisted almost entirely of hard-tack biscuits and tinned 'bully' or corned beef, the salt content of both of which was vital, but which lacked the calorific values, vitamins and minerals needed to sustain hard manual labour and fight off infection. Water was scarce and often contaminated: all drinking water was rationed, and very little was available for any other purpose; troops were expected to use sea water for all washing and bathing. The bulk of drinking water was shipped in by sea, and stored in large tanks on the beaches, and it had to be filtered and distributed in re-usable tin cans. Local sea water was also treated in a desalination plant, and further purification processes also took place. Very strong measures, under military discipline were taken to protect water resources, and care was taken to prevent casualties through

¹ Michael Lucas, *Frontline Medic Gallipoli, Somme, Ypres – The Diary of Captain George Pirie, R.A.M.C. 1914-17* (Helion: Solihull, 2014), p. 43.

dehydration. But even at risk of severe thirst, many troops refused to drink water produced using the desalination process, since it used sea water in which they had seen the bloated corpses of their comrades floating. Flies and other insects were endemic, and another constant source of infection. Dysentery was an extremely severe problem, with over eighty percent of troops infected by the disease, including the British Army General Officer Commanding at Gallipoli, General Sir Ian Hamilton, who took ten years to fully recover from it. Enteric fever (or typhoid), was common and vaccinations were not always effective: one out of three patients infected died. Malaria from mosquitos was also a particular risk, and although treatable with quinine, it was severely debilitating and often repeating-relapsing. Many of the soldiers at Gallipoli already had impaired immune systems because of the prevailing conditions. Any cut or graze could become septic, and bites from insects soon developed into sores; 'trench fever,' a debilitating disease caused by body lice, was also rife.

Once a casualty had been assessed at the RAPs as too injured or ill to return to duty, he was passed on to an Advanced Dressing Station (ADS) as the start of the train of evacuation from the peninsula. An ADS was usually located on the beach in a canvas tent, in a 'sheltered' part of the front line, perhaps behind a sand-dune, but still within easy range of enemy shelling and small-arms fire. Here, further selection and treatment of the wounded took place, including minor operations. Most troops were returned to duty, and only the most serious cases were moved to the fixed Casualty Clearing Stations (CCS), also located on the beach in cramped canvas tents. These had limited equipment, often only one medical officer, one or two medical orderlies, and no nurses. Given the scale of the problem at Gallipoli, it was impossible to keep any casualty at a CCS for any length of time. Those who could be treated successfully were returned to immediate active service, but the conditions at Gallipoli were again so bad that a CCS could not carry out operations or keep patients for any length of time, as they were intended to do. Instead, serious cases of wounds and illness were evacuated to the Hospital Ships. This was a long and difficult process that exposed the soldier-patient to further danger and risk of injury. The British official correspondent Ellis Ashmead-Bartlett (1881-1931) later described in his book *The Uncensored Dardanelles*, writes of a common sight;

Endless processions of wounded, covered with dirt, congealed blood, half- dead with thirst, worn out with fatigue, and tormented with flies, were carried down to the beaches.²

Twelve stretcher cases at a time could be transported in 'lighters,' small and flat-bottomed boats which were very unstable in rough seas, and which acted as medical transports from the beaches to the Hospital Ships. This was so dangerous that it was only attempted at night, and by day the lighters brought in supplies of food and ammunition from ships anchored offshore. The Ottoman troops treated the lighters as legitimate targets, and they were subject to shelling and sniper fire, even when it was clear that they were carrying stretcher-cases. It could take several attempts before a lighter could launch, and sometimes they were held up for days because of bad weather or heavy fighting, further exposing the soldier-patient to the sun or

² E. Ashmead-Bartlett, *The Uncensored Dardanelles* (London: Hutchinson & Co, 1920), p. 154.

rain. It was not uncommon for soldier-patients to receive further internal injuries and wounds from bullets or shrapnel, while awaiting medical evacuation.

If a soldier-patient were fortunate, they would be taken by the lighters to an official Hospital Ship, painted all white with prominent Red Cross markings, and properly equipped and staffed; these were also designated 'HMHS' for 'His Majesty's Hospital Ship'. If the men were less fortunate, they would be taken to an ordinary troop ship, designated as a 'medical transport' but not equipped to carry or treat the sick and wounded. These were known as 'Black Ships' precisely because they were not painted white and carried no Red Cross emblems. The conditions on Black Ships were horrendous. They were always overcrowded, and all soldier-patients remained in 'trench condition' for the voyage, exactly as they had been when they left the trenches, in the same filthy uniforms. They had no facilities to wash, and they found whatever accommodation they could on the decks. No pillows or blankets were issued, and often food and drinking water were lacking. Of particular concern for the dysentery cases was that even basic sanitary arrangements were often non-existent. At the start of the campaign the Black Ships were each staffed with a small team of four or five of medical orderlies but again with no trained nurses. Major Fred Waite of the New Zealand forces recalled that:

On one ship, the only man with any knowledge of medicine was the veterinary officer who, assisted by clerks and grooms of the waiting Echelon B, saved dozens of lives by prompt and careful action.³

But understandably, the mortality rate on board the Black Ships was very high indeed. Most of the Black Ships sailed to the port of Alexandria in Egypt, a journey of 3-4 days, where the British Military Hospital Alexandria (BMHA) was long established. At the start of the campaign the casualty rate was so high that even the medical facilities at Alexandria were overwhelmed, so that Black Ships filled with the sick and wounded could not be unloaded, and instead sailed on to Great Britain and Ireland. Following this, the medical facilities at Alexandria were rapidly expanded, all suitable buildings were converted, and nearby hotels requisitioned, providing altogether 36,000 hospital beds by the end of the campaign.

The official Hospital Ships were fully equipped and staffed with medical doctors including surgeons, and with professional female nurses. Because soldier-patients were not receiving the intended treatment at CCSs, the Hospital Ships first of all took over this role. The professional nurses first of all 'triaged' the patients, deciding the order in which casualties would be treated, and stabilising those patients awaiting less urgent surgery. Then the sick and wounded were more thoroughly assessed, and those expected to recover within three weeks would be taken to the tented hospital complexes established on the nearby Greek island of Lemnos, a journey of four hours. Since the very start of the campaign in February 1915, the island with its deep harbour of Mudros had been used as a logistics base by the British, and by May 1915 it had a hospital bed capacity of 18,000, and a large hospital stores depot. The most serious cases were again sent on to the British Military Hospital Alexandria.

³ Yvonne McEwen, *In the Company of Nurses* (Edinburgh: Edinburgh University Press, 2014), p. 96.

The Mediterranean island of Malta, which was a British colonial possession, could be reached by ship in about six days. The first soldier-patients arrived on Malta in May 1915, where the British military hospitals specialised in medical cases requiring convalescence and long-term recuperation, treating on average 2,000 sick and wounded a week. By the end of the campaign the British medical effort on Malta consisted of 27 hospitals in fixed and tented locations, with 334 medical officers and 913 nurses, and 57,900 patients had been treated there. Either from Malta or from Alexandria, the medical evacuation chain then continued for some soldier-patients back to Great Britain, or to other parts of the British Empire, such as Australia, New Zealand, and India. Under British rule, the Indian Army was a separate organisation to the British Army, with Indian troops serving under British officers. The Indian Army Medical Corps was particularly highly regarded, especially its male medical orderlies, who acted as nurses, and it worked in close co-operation with the Royal Army Medical Corps to maintain the casualty evacuation chain. Indian troops who had served at Gallipoli were given transport from Malta and Alexandria back to India.

The problem of establishing proper medical services during the Gallipoli campaign taxed the abilities of the staff officers to the limit and beyond, while the fighting troops, who knew only about the appalling conditions in which they fought, had nothing but complaints about how the campaign was run. One very brave and competent staff officer, Captain Harold Mynors Farmar, who played an important part in the first landings, wrote to his wife Violet on 18 June 1917:

The uneducated, in a military sense – regimental officer, does not realise the immense amount of work, continuous work, which falls to a Staff Officer and the amount of knowledge he must have to cope with it.⁴

By the time the British came to evacuate Gallipoli in December 1915 and January 1916, the medical services had procedures and systems in place which were uniquely suitable for the conditions of evacuating the sick and wounded. A most insightful analysis of the decision to evacuate is given by Alexandra Churchill who stresses Ian Hamilton's, who had been replaced by the time of the evacuation;

...seemed incapable of balancing the reality of the situation with future prospects for the campaign....⁵

One of the British achievements at Gallipoli was that both evacuations were completely successful, almost without loss. The evacuation plans were devised by the staff of Lieutenant

⁴ Katherine Swinfen Eady, 'Gallipoli Staff Officer: Captain Harold Mynors Farmar CMG DSO' Chapter 10 pp. 277-313 in Rhys Crawley & Michael Locicero (eds.), *Gallipoli New Perspectives on the Mediterranean Expeditionary Force, 1915-16* (Warwick: Helion, 2018), p. 278.

⁵ Alexandra Churchill, 'The Decision to Evacuate the Gallipoli Peninsula' Chapter 6 pp. 157-189 in Rhys Crawley & Michael Locicero (eds.), *Gallipoli New Perspectives on the Mediterranean Expeditionary Force, 1915-16* (Warwick: Helion, 2018), p. 160.

General Sir William Birdwood, who served on the peninsula from the very first landings to the final evacuation. Birdwood's meticulous evacuation plans relied on deception and great attention to detail, and a method of troop movement based on the already tried and tested medical 'chain of evacuation'.

The Dardanelles Commission, was established in 1916, by the British government to assess what had gone wrong and produced a final report issued in 1919, which found major problems with the planning and execution of the campaign which focused on political strategy and the inadequate naval and military response. Captain Harold Farmar was not called to testify, nor were any other middle-ranking staff officers, but in October 1923 he was asked to give a lecture on the Gallipoli campaign at the Royal United Services Institute (RUSI) in London in which, he stressed the vital importance of training, devolved command, speedy re-organisation, the acceptance of responsibility, trusting in full subordinates with information and teamwork;

...very necessary in peace to practice exercises involving reorganisation, allowing for casualties, bold personal reconnaissance by leaders, and quick exploitation: to encourage audacity even to exaggeration.⁶

These are all qualities required and practised by military medical personnel in the care and treatment of the sick and wounded of the Gallipoli Campaign.

A version of this chapter was given at the Gallipoli Conference, Princess Royal Gallery, Portsmouth, 22 October 2016 and an expanded version was published as "Care-giving and Naval Nurses at Gallipoli" in Rhys Crawley & Michael Locicero (Eds) *Gallipoli New Perspectives on the Mediterranean Expeditionary Force, 1915-16* (Warwick: Helion, 2018).

⁶ Katherine Swinfen Eady, 'Gallipoli Staff Officer: Captain Harold Mynors Farmar CMG DSO' Chapter 10 pp. 277-313 in Rhys Crawley & Michael Locicero (eds.), *Gallipoli New Perspectives on the Mediterranean Expeditionary Force, 1915-16* (Warwick: Helion, 2018), p. 309.