Medical Care of American POWs during the War of 1812

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In 2005, a service in Halifax commemorated US soldiers and sailors who perished in Britain's Melville Island prisoner-of-war camp during the War of 1812 and whose remains now lie on Deadman's Island, a nearby peninsula. The service culminated nearly a decade of debate, in which local history enthusiasts, the Canadian and American media, and Canadian and US politicians rescued the property from developers. The media in particular had highlighted the prisoners' struggles with disease and death, often citing the sombre memoirs of survivors. Curiously, Canadian investigators relied largely upon American accounts and did little research on efforts at amelioration from the British perspective.

Coverage has emphasized British cruelty, citing accounts of internees such as that edited by Dr. Benjamin Waterhouse (an American medical officer) and American deaths at the hands of guards at Dartmoor Prison in England during a riot in April 1815, while ignoring more positive elements, such as medical care.

This article explores British medical care for American prisoners of war in terms of organization, delivery, treatments and results, and US observations on the matter. In fact, British medical authorities addressed problems in the custody system and provided humane and compassionate medical care.

In the absence of international codes for the treatment of prisoners and substantial provision for handling thousands of prisoners of war, upkeep was difficult, rendering medical care often chaotic. British medical officers none the less cared for captives adequately and comparably to the way they assisted their own forces.

Organization

Processing the Sick and Wounded

Few formal conventions dealt with the treatment of prisoners of war during the period. While it was common for combatant nations to agree upon temporary conventions once hostilities commenced, generally it was quasi-chivalric sentiments, notions of Christian conduct, and a sense of humanitarian obligation that moderated treatment of prisoners, allowing, for example, parole for officers and sometimes for enlisted personnel and care for sick and wounded soldiers. Therein, most nations had basic guidelines for medical treatment, but practice depended very much on available resources and the host country's attitudes. British military policy provided for such treatment, which in North America was nominally similar to that elsewhere, but pragmatism and local circumstances shaped the structure of care both in combat and in internment.

Most prisoners coming in touch with British medical authorities had sustained combat wounds that needed immediate attention. Generally, Army Medical Department or regimental doctors performed these duties on land, while Royal Navy and Provincial Marine medical officers did so afloat. Memoirs and letters from the conflict document British medics treating captured
Americans. Assistant Surgeon William “Tiger” Dunlop of the British 89th Regiment wrote about doing so at the siege of Fort Erie in 1814:

After the action was over, and it was drawing towards dusk, I rapidly traversed the ground, and finding only a few of the enemy, I ordered them to be carried to the hospital, but I preceded them to make preparations for their reception. When nearing the Camp, I found a party of the band of our Regiment carrying an American officer mortally wounded...I ordered them to lay him down, and set myself to dress his wound.3

Assistant Surgeon William Robertson of the 49th did likewise at Isle aux Noix, after the defeat of American gunboats on Lake Champlain in June 1813:

There were ten wounded & one killed of the Americans only two of our men wounded being the only medical officer on the Island I had my hands full for half an hour on their arrival.4

Measures such as long-term hospitalization, re-dressing of wounds, and surgery following complications took place later. If casualties overwhelmed medical services, the British could parole and repatriate enemy casualties for treatment, as they did after the Battle of Queenston Heights.5 In January 1814, Assistant Surgeon Alexander Ogilvie of the Royal Artillery advocated this for two officers captured at Fort Niagara: “Lt. Balch is in a very bad state of health from the wound he received which is [illegible] and that he will lose the use of his arm in consequence. I found Lieut. Baldridge confined to his bed with nervous fever and understood from the garrison surgeon that he has been confined for several months previous, he still continues in a very bad state of health.”6
If circumstances forbade such an exchange, authorities forwarded patients to detention facilities at Quebec and at Halifax to complete their convalescence and await their ultimate fate. When prisoners were interned, medical treatment officially became the responsibility of the Royal Navy; its Transport Board superintended delivery of troops and materiel to British forces around the globe and also interned and maintained prisoners, having in 1796 taken over the latter tasks from the Admiralty’s Sick and Hurt Board, which had sustained charges of neglecting prisoners.

The Transport Board employed a naval officer as agent for prisoners at each internment facility, and he supervised their welfare and administration. An American officer or diplomat was also appointed by either the Transport Board or the American government (depending on circumstances) as the U.S. agent to liaise with British authorities and arrange medical treatment when necessary. The Transport Board’s policy regarding sick prisoners was as follows: “Sick prisoners have the option of going to the Hospitals at the regular [i.e. British military] depots for Medical or Surgical Treatment.”

It also defined standards of medical care and emphasized that “Sick Prisoners in confinement are treated in every respect the same as Sick Seamen of the Royal Navy.”

Although the general process of medical care for prisoners of war seemed straightforward, in British North America conditions made it very complex.

A System in Crisis

Problems within the prisoner-of-war system and medical departments caused confusion and inefficiency and hampered the efforts of British medical officers. West of Halifax, increasingly makeshift arrangements emerged for internment and long-term care.

The key problem was control by the Transport Board, which concentrated on its supply duties. Most of British North America’s infrastructure for prisoners of war was in Halifax, the Royal Navy’s primary base on this continent. The navy had built a prisoner-of-war camp at Melville Island in 1803 to house French prisoners captured in North American waters, and the facility remained operational in 1812. Captain Kempt (Royal Navy agent for prisoners at Quebec) wrote to Sir George Prevost’s staff in June 1813: “Halifax is an old and well established depot where every necessary store has been sent from England, and a medical officer appointed by the board.”

In response to complaints about conditions at Melville Island, Lieutenant William Miller, the Royal Navy’s prisoner agent at Halifax admonished prisoners by reminding them of the availability of medical care: “There is a surgeon here for you if you are sick, and physic for you to take if you are sick, and a hospital to go to into the bargain ... and if you are not satisfied with this, you may die and be d---d.” Although supplies and infrastructure were apparently adequate,
rivalry between physicians occasionally caused difficulties. In 1814 Surgeon Rowlands (chief of the naval hospital at the Halifax dockyard, whom some called a drunken bully) arranged for the dismissal of the competent and well-respected Surgeon Hume, who had served at Melville Island for more than a decade.12

Still, the Transport Board had failed to provide facilities for prisoners anywhere else in British North America. Even at Quebec, capital of the North American colonies and a crucial military fortress, the British cobbled together prisoner arrangements (including medical care) from scratch only in 1813. Despite the presence of Captain Kempt, the city boasted no naval medical officers and few medical supplies for prisoners. When Prevost’s staff complained to Kempt about the situation in the summer of 1813, Kempt cited lack of directives and support from London, assuring Prevost’s military secretary that “when the like arrangement has taken place here, things shall be done with the same facility [as at Halifax].”13 Kempt proposed temporary transfer of prisoners’ medical treatment in Upper and Lower Canada to the army: “I therefore humbly suggest…the charge and expense of victualling, clothing &c. the sick in hospital to be done by the military department, until a proper Naval Hospital Establishment can be formed by an order from home.”14

Yet the army’s medical establishment could do little to assist. In Lower Canada, it was short of medical staff. Writing from Isle aux Noix in 1813, Assistant Surgeon Robertson complained: “All winter I had charge of a General Hospital at St Johns [St. Jean] and for the last two months have been the only medical man at this post where there ought to be three. However, we have a hard duty lately for the scarcity of Army Surgeons in this country, more are daily expected from England.”15 None the less, the under-staffed Army Medical Department took charge. Hospital Mate William Clark at Quebec attended to captives held offshore in old, dismasted prison hulks: “The vessels…and the number of men ill with dysentery, and other troublesome diseases rendered the duty extremely hard and fatiguing so much so that it brought on a fever of which I was several days confined to bed, and which has once very materially injured my constitution.”16 Occasionally, officials appointed civilian doctors to alleviate the shortages. Clark remembered that a Mr. Horseman, “a practitioner of medicine in this local [sic] was appointed assistant surgeon and dispenser [pharmacist] to the hospital for prisoners of war” and received more pay than
Horseman’s appointment suggests that Kempt may have taken on additional personnel to the naval establishment on his own initiative.

In Upper Canada, such problems continued well into 1814, and medical authorities had to improvise. Long-term treatment was nearly impossible. The Royal Navy in Upper Canada was chronically short of doctors, and occasionally had to borrow army doctors to serve on ships in action. Recalling fighting in the Niagara region in 1814, Assistant Surgeon Dunlop of the 89th Regiment noted ruefully that “the [medical] Staff of the army was never where it was wanted... when there was hardly a regiment in the field that had its full compliment of medical officers.”

Nor were post-triage procedures or acquisition of supplies clear cut. British medical authorities in the field hardly knew how to obtain resources for enemy patients, and even senior medical officers had to seek instructions in mid-campaign.

British forces in Upper Canada sometimes relied on the assistance of American doctors and resources. On 31 January 1813, Surgeon’s Mate McKeehan of the 2nd Regiment of Ohio Militia crossed near Detroit to tend wounded from the Battle of the River Raisin. Five months later, the British permitted a Dr. Young of the 14th Infantry to treat US wounded after the American capture of Fort George. Brigadier General Dearborn soon dispatched supplies and clothing to Young. Young was ordered to remain with the British to tend to 40 wounded Americans, after he tried several times to return to US lines.

Overall British strategy during the War of 1812 prioritized the defence of Quebec and Halifax at all costs, in which case the medical chaos in Upper Canada is perhaps not surprising. However, the disorder at Quebec, the largest and most important garrison in British North America, was striking.

**Conditions**

**Hospitals**

Provision of hospitals remained a problem throughout the war. Most military facilities suited a peacetime garrison, and the war sparked demand for military buildings of every sort. With hospitals crowded, British medical authorities found it difficult to house the wounded of either side.

Aboard ship, sick and injured men normally received treatment in the sick berth, whose size and location depended on the vessel. On rated ships, the British usually placed it under the forecastle on the upper deck, where space, light, and ventilation were good; arrangements on smaller Great Lakes vessels are unclear. However, the upper deck was exposed, and in battle the cockpit, below the waterline, served for surgery and triage. If heavy casualties flooded the sick berth or the cockpit, naval surgeons could also use the hold, cable tier, and other interior areas.

On land, the British hospitalized enemy wounded alongside their own in whatever structures were available. Dunlop recalled that after the Battle of Lundy’s Lane, the wounded stayed in the ruins of Butler’s Barracks, near Fort George: “Upon enquiring where my wounded were to be put, I was shown a ruinous fabric, built of logs...Nothing could be worse constructed for an hospital for wounded men...”

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**Detail of the map of Melville Island prison drawn by J.G. Toler in 1812, showing the prison’s medical complex including the hospital, fuel shed, cook house, privy, and sentry boxes.**

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great want of room, so that many had to be laid on straw on the floor, and these had the best of it, for their comrades were put into berths one above the other as in a transport packet, where it was impossible to dress their wounds, and their removal gave them excruciating pain.”

Nearby civilian houses sometimes sheltered wounded. Dunlop worried that this practice exposed American patients to local vengeance. Conversely, Mary Warren Breakenridge, a civilian living in York, Upper Canada, remembered that after the US attack in April 1813 local women received wounded American officers in their homes and that “they were entertained hospitably.”

Hospital facilities at major prisoner-of-war centres varied greatly. Melville Island certainly had a purpose-built hospital. John George Toler’s map of the island in 1812 shows this small building on the south side of the island near the warden’s quarters and the docks (see accompanying illustration). Presumably, sick prisoners at Melville Island at least received some medical care in this building.

At Quebec, vessels converted into hospital ships initially housed sick prisoners. Unlike prison hulks, these vessels had open gunports; removal of bulkheads permitted division into wards for different ailments and increased space, while air scuttles cut into the ship’s sides improved ventilation.

Financial statements from the Transport Board indicate that the British modified both the captured USS Nautilus and Jane (a merchantman) in this manner for use as floating hospitals. Still, these small vessels could not accommodate large numbers of sick men in the conditions that Transport Board regulations required. Brigadier General Winchester, an American agent for prisoners at Quebec, also recognized the potential for a major outbreak of disease to overwhelm these ships. He wrote to Sir George Prevost: “Between two and three hundred men crowded together in our vessels in the heat of summer I fear will produce diseases that will carry many of them off… I take the liberty to ask for them to be landed and confined in some [illegible] building during the summer months or encamped in this parish.”

Long-term treatment of sick prisoners required larger facilities on land, and the absence of infrastructure for handling prisoners exacerbated the need for adequate buildings. In June 1813 Garrison Surgeon Fisher (principal medical officer at Quebec) proposed that, “should contagion make its appearance, I would recommend sending the sick with every speed, to the Point Levi [sic] side of the river where houses might be easily procured, for that purpose.”

Hospital Mate Clark recorded that, instead, “On the 1st of August the sick were removed to an hospital on shore at Sans Bruit [near modern Quebec] and there received such care as circumstance permitted.”

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Vanier, Quebec] above two miles distance from Quebec.” 33 Although it took six weeks to establish the hospital on shore, the house that the authorities appropriated proved to be in poor repair. Clark complained to Fisher that the structure “will in the course of a few weeks not be habitable. I therefore earnestly beg that you will be pleased to represent to His Honour Major General Glasgow [commandant of Quebec] the absolute necessity there will be of soon providing another hospital.” 34

Glasgow did not know what to do with the patients. On 10 September 1813, he wrote plaintively to Prevost’s staff for directives: “I hope to hear from you in a few days what is to become of the Sick Prisoners I have sir two proposed. The one from Hunter is quite out of the question and the one from Sauvageau is also very high the house would do very well but the price is more than I should suppose [Prevost] is inclined to [illegible] and am quite at a loss how to determine. I shall have no room in the garrison hospitals unless the Hospital Barrack should be employed in that way.” 35 By late October 1813, the military selected a permanent location – Sauvageau’s house – at Lower Bijou (just west of the Hôpital Général along the Rivière St. Charles). Deputy Barrackmaster-General Van Cortlandt wrote to Glasgow: “I have likewise taken [the house]...at the yearly rate of £200,0,0 [sic] Currency Government being bound to keep it for one year and to give three months notice to be given up at the expiration of that period, to be kept for another year.” 36 Returns show that the structure served as a prisoner hospital into mid-February 1815. 38

Artillery projectiles could be even worse: round shot could easily plough through men and tear off limbs. At sea, shot could punch through ships’ sides and terrible splinter wounds could be caused by the flying pieces of wood thus created. Explosive or shrapnel shells wrought havoc: Thomas Verchères de Boucherville, a Canadian militiaman serving under Brigadier General Brock, made a grisly discovery after the capture of Detroit: “We found four officers dead in the mess-room, their brains scattered over the walls. They had been killed by the bursting of a bomb during the bombardment.” 37 The skeletal remains of American soldiers exhumed at a US field cemetery at Fort Erie in 1987 revealed effects of British shrapnel shells. One skeleton contained a brick fragment and an iron shrapnel ball from a British shell near the spine. 42

Diseases and other communicable ailments were the most common cause of deaths and illness. 43 Both Garrison Surgeon Fisher and Hospital Mate Clark diligently noted patients’ afflictions: a week in 1813 saw a typical range of ailments:

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<th>Ailments Suffered by Prisoners at Quebec, 28 August 1813</th>
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<td><strong>Fever:</strong></td>
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Fevers, indicative of diseases such as typhus and dysentery, were prevalent. Doctors viewed fevers as distinct illnesses, not as symptoms of disease and infection. They acknowledged the association between swammy areas and outbreaks of fever but did not grasp the transmission of diseases by insects. Assistant Surgeon Griffiths of the 1st Regiment saw fevers as endemic to Canada, a result of the unhealthy climate and decaying flora and fauna. Cramped internment facilities would have encouraged the spread of disease. Brigadier General Chandler (American prisoner agent at Quebec in July 1813) noted how rapidly this could occur aboard the hulks at Quebec, writing to Glasgow: “so alarming is the sickness getting onboard that I cannot avoid saying to you how desirable it is that the prisoners should be got on shore if possible.”

Kempt wrote several weeks later: “I have mustered, and otherwise enquired into the state of the Malabar prison ship [one of the hulks at Quebec], and find the number of sick 59, only 4 of them had patients confined to bed, the others principally itch, and many more labouring under the like complaint, who did not chuse [sic] to put themselves on the sick list.”

As for the health of American prisoners, Dr. James Mann, a senior US medical officer on the northern frontier, frequently refers to the fragility of soldiers on campaign. His memoirs mention many outbreaks of diarrhoea and fevers, two of the most common complaints at Quebec. He noted that new recruits – the majority of the US forces were the most susceptible. Many hailed from isolated communities and had never been exposed to communicable diseases, or were Southerners adapting to conditions in northern New York. Inexperience with campaign conditions led to inadequate preparation of food; strong drink became a “remedy” for the resultant bowel complaints and further debilitated the men. Mann also bemoaned poor hygiene. Many American patients may have been suffering from latent symptoms of diseases they contracted prior to capture, and internment may not have been the sole source of their medical complaints.

British medical officers faced a myriad of diseases and gruesome wounds among American prisoners of war. Although conditions were less than ideal, evidence suggests that some ailments were not unique to or the result solely of internment. None the less, treatments required all the doctors’ skill and knowledge.

**Treatments and Results**

**Treatments: Surgery, Pharmacy, and Diet**

British policy was to treat American patients as they would their own. British doctors used the treatments common to the period, which we can divide into three categories: surgical, pharmacological, and dietary. Treatments in combat were predominantly surgical; in internment, largely pharmacological or dietary.

Combat wounds demanded swift, sometimes brutal, surgical treatment. A surgeon’s frantic work often limited the types of procedures that could be performed, indicated by US naval surgeon Usher Parsons’ recollections of the Battle of Lake Erie: “The wounded poured down the deck so fast that nothing further was attempted for them during the battle than securing bleeding arteries and applying splints to shattered limbs, and severing form [sic] the body such limbs as hung by a small portion of flesh.” Amputation was “the prototypical act of early nineteenth century surgery” for severe trauma to limbs. Private Shadrach Byfield of the British 41st Regiment survived such a procedure in August 1814: “After a few days, our doctor informed me that my arm must be taken off, as mortification had taken place. I consented...They prepared to blind me, and had men to hold me; but I told them there was no need of that. The operation was tedious and painful, but I was enabled to bear it pretty well.” In an age without antiseptic, amputation allowed surgeons to convert a complex wound into a simple one (although most acknowledged that they could have saved many limbs if time and resources allowed). Unfortunately many amputees – one period source estimated as many as half – died during or after the operation.
Most wounds to vital organs were difficult to treat, and internal surgery was rare, with doctors allowing nature to take its course. Projectile or blunt-force trauma wounds to the cranium would necessitate trepanning – opening of the skull to reduce pressure on the brain, using a circular drill. Less traumatic injuries to soft tissue simply required removal of foreign objects and debris, securing of blood vessels, and routine suturing and dressing. Venesection (bleeding) was also a common treatment for prevailing diseases such as fevers, with physicians usually drawing blood from the temples to ease the illness’s effects on the head. Griffiths of the 1st Regiment recalled that he “bled freely in Canada.”

The treatment of most illnesses involved chemical and naturopathic regimens. British army regulations list nearly 70 pharmacological substances. Despite surgeons’ complex chests, treatments for common diseases could be rudimentary. Assistant Surgeon Douglas of the 8th Regiment recalled several basic regimens: “In the remittent [fever] of Canada, the ablation of the body with cold water often brought on a remission, after which the bark [cinchona] was given with advantage. Calomel, however, was the principal remedy.” Cinchona, or “Jesuit’s” bark, was a popular fever remedy – the patient took it as powder and drank it as an infusion with wine. Calomel, a mercuric compound, was as much poison as medicine. Its over-prescription could harm soldiers’ health. Military doctors did not understand mercury poisoning, even though they observed its symptoms. Other dubious substances were common: Douglas remembered using arsenical solutions for particularly stubborn fevers in York during the morbid summer of 1814. Other treatments were less deadly, but equally unpleasant. American prisoners’ reluctance to report the “itch” resulted from its rough and malodorous cure. British
army regulations stipulated: “Men with the itch should be cured in a separate tent in summer, or in a separate room of the Hospital; such men should each bring a clean shirt for a change after they are cured; – four frictions, or smearing of the body all over four times, at six hours distance, with the sulphur ointment (keeping in bed the whole time)...They must be well washed with warm water, and put on clean linen and clothes.”

Doctors also recognized the preventive and curative value of food. Prisoners with diarrhoea at Quebec may have received milk-based concoctions. A British medical pamphlet observed in 1812: “To Stay a Looseness [of the bowels]: Take a very good nutmeg, prick it full of holes, and toast it on the point of a knife; then boil it in milk till half be consumed; then eat the milk with the nutmeg powdered in it: in a few times it will stop.” Diets reflected contemporary theories of the human constitution, counteracting physical conditions to re-establish equilibrium within the body. Food was bland or meagre if the body was “excited,” as with fevers, and hearty for weakness. The typical dietary table (Table 1) appeared in the army regulations of 1808:

Local foodstuffs supplemented the hospital diet. In July 1813, Surgeon Rowlands advertised in the Halifax Weekly Chronicle for a good cow to supply fresh milk for the Melville Island hospital. Similarly, Royal Navy regulations ordered shipboard officers to employ fit men to catch fish for patients.

These treatments were standard procedures and regimens used by British doctors of the period, even though surgery was comparatively primitive and pharmacy often poisonous. Regarding their efficacy, Dunlop famously remarked: “some [patients] recovered by the remedies employed, or in spite of them.” Still, British physicians applied such treatments indiscriminately to American and British patients.

Results: Morbidity, Mortality, and Recovery

Sickness and death were ubiquitous realities for prisoners of war, and British medical officers strove to prevent and alleviate them. None the less conditions in most internment facilities rendered mortality and illness far too common. A dearth of records makes it difficult to determine mortality and sickness rates, but prisoner of war returns and records from Quebec and Halifax offer insight and also suggest the degree of British doctors’ success, despite hardships.

The prevalence of disease is clear in a sample of typical sick returns from Quebec between December 1813 and February 1814 (Table 2). An average sick rate of 20 per cent during winter appears to have been common at Quebec. The experience at Montreal was comparable; for example, during the week of 27 January 1814, 15 per cent of the 165 prisoners were sick in hospital. Despite prevalent sickness, mortality rates were moderate. Figures for the hospital at Quebec during summer 1813 (Table 3) are illustrative.

Registers from Halifax provide a longer-term perspective. Of the nearly 8,200 Americans interned there during the war, 195 died – the majority from diseases we saw above, such as pneumonia or fever. Private Jeremiah Woodman, captured near Fort Erie in August 1814, who died of fever at Halifax on 20 February 1815, is typical. A few men, such as Peter Adams, a sailor on the captured USS Chesapeake, who died on 7 June 1813, expired from wounds shortly after internment at Melville Island. Overall, the camp at Halifax experienced a mortality rate of two per cent over the two-and-a-half years of the war.

In spite of difficulties, British doctors did well treating sick prisoners. Consider discharge rates at Quebec during summer 1813 (Table 4). The sharp rise during the last week of August 1813 is difficult to explain, as returns for the preceding week have not survived. Still, earlier high rates show many more prisoners recovering than dying.

American prisoners suffered under internment in Canada, and conditions for prisoners were hardly conducive to captives’ welfare. While conditions at Quebec and Halifax were not ideal, and sickness and mortality were common, British medical officers appear to have striven, often successfully, to combat prisoners’ ailments and limit contagion. The high discharge rate at Quebec certainly suggests a degree of medical success under challenging circumstances.
Observations and Conclusions

Accounts of internment such as that of Dr. Waterhouse depict the custody of American prisoners as cruel and inhumane, with particular emphasis towards mortality and sickness. Similarly, British guards’ killing of rioting American prisoners at Dartmoor Prison in England in April 1815 has become evidence of alleged British maltreatment and brutality. However, when we compare these with similar experiences of British prisoners in American hands, the sickness and mortality rates appear neither extraordinary nor extreme.

British troops frequently endured comparable or harsher conditions while held captive in Kentucky, Pennsylvania and New York than American prisoners did in Canada. British forces on active service often experienced higher sickness rates than occurred under the worst conditions at Quebec and Halifax.79 Regarding mortality, British prisoners in the United States often fared much worse than their American counterparts. One detachment of sick British soldiers repatriated to Upper Canada from Kentucky in October 1814 had become so weak from their treatment under incarceration that 30 per cent of them died during the journey.79 Furthermore, the British did not intentionally treat prisoners badly, as sometimes occurred to British prisoners in the United States. Several British soldiers who escaped from the prison camp at Greenbush, New York, in 1813 told of...
American guards bayoneting starving comrades on the march to captivity and shooting at them through the prison barracks windows for amusement.\(^8\)

Although conditions for American prisoners in Canada were far from perfect, they were not wilfully careless. As we saw above, good intentions framed British policy, with most suffering caused by administrative and logistical complications. Indeed, evidence exists to contradict popular stereotypes of British cruelty and to suggest that British medical efforts \(\text{vis-à-vis} \) prisoners were compassionate and diligent, despite the prevailing difficulties. The most poignant sources are prisoners' correspondence and memoirs. As indicated, conditions at internment facilities are a major source of accusations of neglect. American prisoner agents gained first-hand experience of these conditions through their inspections, yet officials such as General Chandler at Quebec left reports that imply or confirm good care for American hospital patients. A poignant testimonial was written by Chandler during the summer of 1813: "I ...visited the prison ships at Quebec, and I am happy to say to you sir, that I found the Hospital Ships and the Malabar [prison hulk] in quite as good order as I expected. They appear to be kept clean & well regulated...They [the sick] will be made as comfortable as they can expect to be."\(^9\)

Amidst desperate shortages of supplies and hospital space, American prisoners maintained their confidence in British ability to rectify the problems. During the hospital crisis at Quebec in 1813, General Chandler wrote to Glasgow: "I am sure you will do all you can consistently with the public good to alleviate their [the sick prisoners'] distress."\(^9\) Even at Melville Island, which many Americans (particularly Waterhouse) depict as a death trap, not all prisoners were disparaging. According to the anonymous surgeon of Waterhouse's narrative, they "were generally robust and hearty at Melville Island," presumably with the help of British medical officers.\(^0\) Similarly, Captain Mills of the US 14th Infantry, while a patient at York during summer 1813, wrote "to the Head Quarters of the American Army and from thence to his Family, assuring them that his wound is doing well, that he is very comfortably situated, and experiences all the soothing attention which he would expect in the bosom of his Friends."\(^4\)

Clearly some American prisoners found British medical efforts effective. Indeed, Waterhouse's surgeon and Mills indicate that British medical attention could, even under adverse circumstances, be compassionate and effective. Such statements counterbalance the depiction of inhumane treatment in Canada.
The medical concerns of American prisoners under British custody were indeed great, but we must view them in context. Yes, illness was common among prisoners, but British troops on active service had notably higher sick rates. True, prisoners suffered from unpleasant and debilitating maladies, yet the observations of American doctors, such as Mann, of their poor health and general predisposition to disease suggest that internment was not the sole cause. Treatments were rudimentary by modern standards, but were the best available and the same as British personnel received. Many Americans did die in British custody, although a larger proportion of British prisoners succumbed under worse conditions. It was a brutal time, and medicine could accomplish only so much. Injuries, sickness, and death were common and unavoidable for prisoners of war on both sides.

The British sought to combat these realities. With minimal infrastructure, medical staff, and resources, medical care of prisoners of war often became a chaotic scramble. However, these issues affected care not only of prisoners but also of British personnel, who depended on the same doctors and resources.

Most British doctors were humane and did their utmost to overcome these obstacles. Captain Kempt could “not help thinking it is a rather curious circumstance that evils should have grown to such a magnitude,” and prisoners’ medical problems endured despite the best work of British medical authorities. American prisoners in fact received the best care possible under the circumstances, comparable to that for British forces, and they certainly fared no worse than British prisoners in US hands. The testimonials of the American prisoners to compassionate and effective care honour the efforts of British medical authorities on their behalf.

Notes

1. For example, see C. Nickerson, “Old War’s Victims Forgotten No Longer,” Boston Globe, 12 May 2000.
2. I. Shea and H. Watts, Deadman’s: Melville Island and Its Burial Ground (Halifax, 2005), pp.104-5. Waterhouse was an American army doctor who served as medical superintendent of US posts in New England during the war and thus never underwent internment at Halifax. He may have adapted his anonymous account from the journal of Surgeon Amos Babcock of the Enterprise (a privateer from Salem, Massachusetts) and stories he heard from repatriated prisoners from Melville Island.
4. W. Robertson to J. Robertson, Isle aux Noix, 5 June 1813, private collection of Mrs. J. Shaw, Toronto.
5. See The Letterbook of Sir Roger Hale Sheaffe (Buffalo, 1915), pp.282-93.
8. Ibid.
13. Kempt to Freer, Quebec, 25 June 1813. Ibid.
14. Ibid.
15. W. Robertson to J. Robertson, Isle aux Noix, 5 June 1813. Ibid.
17. Ibid.
19. Dunlop, “Recollections,” p.34.
20. See Macaulay to Freer, Quebec, 11 February 1813, LAC RG 8.1, vol. 689, p.203.
22. Dearborn to de Rottenburg, Fort George, 6 July 1813, LAC, RG 8.1, vol. 689, pp.175-9. Ibid.
23. Ibid.
24. Boerstler to Prevost, no location, no date (autumn 1813?), Ibid., p.144. This letter, though undated, probably postdates Boerstler’s capture at the Battle of Beaver Dams on 24 June 1813, and he wrote it while acting as US prisoner agent at Quebec. It presumably dates to the autumn of 1813, as Generals Chandler and Winchester had been his predecessors prior to their parole.
27. Ibid., p.16.
29. Regulations and Instructions relating to His Majesty’s Service at Sea (London, 1790), p.139.
32. Fisher to Freer, Quebec, 16 June 1813. Ibid., p.102-3.
33. Clark to Freer, Quebec, 6 September 1813. Ibid.
34. Clark to Fisher, Quebec, 29 August 1813. Ibid., vol. 690, p.113.
35. Glasgow to Freer, Quebec, 10 September 1813. Ibid., vol. 680, p.47-9.
36. Glasgow to Freer, Quebec, 17 September 1813. Ibid., p.82.
37. Van Cortlandt to Glasgow, Quebec, 25 October 1813. Ibid., vol. 691, p.64.
40. Baldrige and Balch to Prevost, Port Niagara, 14 January 1814. Ibid.
43. For example, see "Weekly Return of Sick American Prisoners of War," Army Medical Dept., Quebec, 26 July 1813.
44. "Weekly Sick Return of American Prisoners of War in Hospital at Sans Bruit from the 22nd until the 28th of August 1813," Army Medical Dept., Quebec, 28 August 1813. Ibid., vol. 690, p.114.
45. Chandler to Glasgow, Quebec, 27 July 1813. Ibid., pp.50-1.
46. Fisher to Freer, Quebec, 16 June 1813. Ibid.
50. Ibid., p.79.
52. See C.G. Roland, "War Amputations in Upper Canada," Archivaria 10 (summer 1980), pp.73-84.
54. Roland, "War Amputations," p.76.
55. See M.R. Crumplin and P. Starling, A Surgical Artist at War: The Paintings and Sketches of Sir Charles Bell 1809-1815 (Edinburgh, 2005). 2005. Though relating to treatment of casualties from the Battle of Waterloo, this work describes the complex wounds that British surgeons would have encountered and the corresponding procedures.
57. Instructions to Regimental Surgeons, For Regulating the Concerns of the Sick, and of the Hospital (London, 1808), pp.57-8.
58. Ibid.
59. Mann, Medical Sketches. p.80.
60. Douglass, Medical Topography, p.30.
62. Dr. Chicoynneau, Dictionary of Pharmacopia or Apothecary Notes on Medicines and Salves with Reference to the Principle Use of Surgeons and Physicians (London, 1812).
63. Instructions to Regimental Surgeons. p.56.
64. Shea and Waits, Deadman's, p.26.
71. "Weekly Return of Sick Prisoners of War," Army Medical Dept., Quebec, 26 July 1813. Ibid.
72. "Weekly Return of the Sick of American Prisoners of War on Board the Jane and Nautilus Hospital Ships from the 26th to 31st of July inclusive." Army Medical Dept., Quebec, 31 July 1813. LAC RG 8 I, vol. 690, p.52.
73. "Weekly Sick Return of American Prisoners of War from the 8th to the 15th of August inclusive." Army Medical Dept., Quebec, 16 August 1813. Ibid., p.84.
74. "Weekly Sick Return of American Prisoners of War in Hospital at Sans Bruit from the 22nd until the 28th of August 1813." Army Medical Dept., Quebec, 28 August 1813. Ibid.
76. Ibid. p.448.
77. Ibid., p.3.
78. Douglas recalled that during the 1814 Niagara campaign, 50 per cent of his regiment had been hospitalized with malarial fevers during the month leading up to the Battle of Chippawa. See Douglas, Medical Topography, p.21.
80. This information comes from statements by British prisoners who escaped from the prison camp at Greenbush, NY, during summer 1813. Adjutant General's Dept., Ibid., vol. 691, pp.91-7.
81. Chandler to Glasgow, Beauport, 27 July 1813. Ibid.
82. Ibid.
83. Shea and Waits, Deadman's, p.27. Ibid.
85. Kemp to Freer, Quebec, 25 June 1813.

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