



MEDICAL SERVICES IN THE POLISH CAMPAIGN OF 1939 – A SYNTHESIS. PART II: PREPARATIONS AND WAR PLANS

Służba zdrowia w kampanii polskiej 1939 roku – synteza. Część II. Przygotowania i plany wojenne



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Abstract

Introduction and objective: This research paper was created as part of the project “Polish Campaign of 1939 – Synthesis” conducted by the War Studies University. The aim of this three-part article is to provide a comprehensive account of the role of the Polish health service during the 1939 campaign. The subsequent sections examine the initial capabilities of the health service, wartime planning and preparations, and the actual participation of medical services during the campaign. The primary research question focuses on the factors that led to the collapse of Poland’s medical services in September 1939. **Material and methods:** The author drew on historical materials collected at the Central Military Archive (Warsaw-Rembertów) and the Archives of the Polish Institute and the General Władysław Sikorski Museum (London). This synthesis also incorporates previous research by historians, published sources, and a wide range of personal recollections and testimonies. **Results:** The Polish health service suffered a defeat in 1939. The system for evacuating and treating the wounded collapsed within the first days of the war. Evacuation difficulties, rapidly depleting stocks of prophylactic serums, and delays in surgical care led to widespread complications from infected wounds, including numerous cases of tetanus. **Conclusions:** The main factors that led to the medical crisis in 1939 included the very limited initial capacity of the medical service (staff shortages, underdeveloped hospitals), low financial investment and insufficient material reserves, the highly centralised medical supply system, reliance on railways for medical evacuation, the low degree of motorisation in both the Polish Army and society, poor road conditions, and the nature of the enemy’s operations – sudden, deep attacks on the rear, disruption of communication networks, and targeting of civilian areas.

Streszczenie

Wprowadzenie i cel: Praca powstała w ramach projektu „Kampania polska 1939 roku – synteza”, prowadzonego przez Akademię Sztuki Wojennej. Celem trzyczęściowego artykułu jest kompleksowe przedstawienie działań polskiej służby zdrowia w trakcie kampanii polskiej 1939 roku. W kolejnych częściach artykułu omówiono wyjściowy potencjał służby zdrowia, plany i przygotowania wojenne oraz udział służby zdrowia w kampanii wojennej. Podstawowe pytanie badawcze dotyczyło przyczyn załamania się systemu pomocy rannym we wrześniu 1939 roku. **Materiał i metody:** Podstawowy zasób źródeł, który posłużył do opracowania artykułu, znajduje się w Centralnym Archiwum Wojskowym (Warszawa-Rembertów) oraz w Archiwum Instytutu Polskiego i Muzeum im. gen. Władysława Sikorskiego (Londyn). W syntezie uwzględniono również wcześniejsze ustalenia historyków, źródła drukowane oraz szeroki wybór wspomnień i relacji. **Wyniki:** Polska służba zdrowia poniosła w 1939 roku klęskę. System ewakuacji i pomocy rannym w ciągu kilku pierwszych dni wojny uległ załamaniu. Problemy z ewakuacją, szybko wyczerpujące się zapasy surowic profilaktycznych oraz spóźniona pomoc chirurgiczna były powodem masowo stwierdzanych powikłań septycznych ran, w tym licznych przypadków tężca. **Wnioski:** Do najważniejszych przyczyn, które doprowadziły do katastrofy sanitarnej w 1939 roku, należą: bardzo skromny potencjał wyjściowy służby zdrowia (deficyt kadr, niski poziom szpitalnictwa), małe nakłady finansowe na służbę zdrowia oraz brak odpowiednich rezerw materiałowych, centralizacja systemu zaopatrzenia sanitarnego, wiodąca rola kolei w planach ewakuacji sanitarnej, niski stopień motoryzacji Wojska Polskiego oraz polskiego społeczeństwa, zły stan dróg, a także sposób prowadzenia walki przez wroga (gwałtowne i głębokie uderzenia na tyły polskiego państwa, porażenie sieci komunikacyjnych, atakowanie celów cywilnych).

Keywords: medical services; medical evacuation; Polish campaign of 1939

Słowa kluczowe: służba zdrowia; ewakuacja medyczna; kampania polska 1939

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Introduction

This article continues the first part of the study, which comprehensively examined the capacity of the Polish healthcare system on the eve of the outbreak of World War II, including methodological considerations. The second part focuses entirely on the preparations and plans for mobilising and utilising the healthcare system in war-time conditions.

Tasks of the healthcare system during war

Any discussion of the organisation and operational planning of the healthcare system in wartime must begin by revisiting a fundamental question: what role are health services expected to play during armed conflict? Answers to this question can be found in numerous publications and manuals from the interwar period. In one such document – a 1933 manual titled “Zaopatrywanie i ewakuacja w ramach pułku piechoty” [“Supply and Evacuation within an Infantry Regiment” – we read: *The medical service ceases to be a mere adjunct to combat and becomes one of the most vital factors for victory; its fundamental operational basis and primary task is to maintain the army’s numerical strength through:*

- protecting the army’s health,
- treatment – namely, restoring to military service all those who have lost their capacity for duty, whether as a result of wounds, gas injuries, or illness [1].

The concept of “protecting the army’s health” encompasses broadly understood preventive measures, including the prevention of infectious diseases (vaccinations, isolation of the sick, sanitary supervision of water sources and food, etc.), as well as soldiers’ health education, periodic examinations, and ongoing medical care. Although, for obvious reasons, war shifts the focus of medical services toward treatment, prevention does not lose its importance. Quite the opposite. During military operations the risk of epidemics increases, wartime conditions are not conducive to hygiene, and soldiers are more likely to engage in risky behaviours, including sexual ones. The army, exposed to the hardships of combat and long marches, sleep deprivation, and adverse weather conditions, becomes vulnerable to disease, injuries, and psychophysical exhaustion.

With regard to treatment priorities, combat injuries were only ostensibly paramount. Statistics from the fronts of the First World War clearly demonstrated that the principal source of losses was not wounds but disease. However, the Polish Campaign of 1939 was brief, and the fighting was violent and dynamic; consequently, the treatment of combat injuries assumed primary importance.

If a wounded soldier did not die immediately from his injuries, he faced the risk of developing complications. Two fundamental clinical issues arise here: haemorrhage and infection. For the wounded to survive, appropriate countermeasures in both areas had to be taken at an early stage of treatment and evacuation. The limitations of medicine at the time (including the field of medical evacuation) meant that if a massive haemorrhage developed as a result of a wound, the patient had little chance of survival. In practice, transport to a field hospital for bleed-

ing casualties constituted a form of selection: survival depended largely on whether the haemorrhage was not immediately fatal.

Greater possibilities for surgical intervention existed in cases of wound infection. By its very nature, a combat wound is contaminated. Fragments of uniform and equipment, as well as debris from the skin surface, enter the wound together with the projectile or shrapnel. If not properly protected by a dressing, the wound is at risk of secondary contamination. This is particularly dangerous when soil – rich in bacteria – enters the wound. Among the most perilous are streptococcal infections and those caused by anaerobic bacteria, leading to gas gangrene and tetanus. World War I marked a turning point in the management of combat wounds. A certain standard of care was developed at that time. At this point, it is worth returning once again to the previously cited manual: *Bacteriological studies conducted during the Great War [World War I – author’s note] revealed that within 24 to 36 hours, the entire area surrounding a wound is already deeply infected. Consequently, after this period, surgical intervention produced poorer recovery outcomes. From this follow some of the main guidelines for the medical service, as well as for commanders who in any way participate in directing medical units or influence the regulation of their work, namely:*

- every wounded soldier should be brought as quickly as possible to a qualified surgeon,
- every wounded soldier should be operated on as soon as possible – no later than 24–36 hours after being wounded.

If, as a result of a large influx of wounded or considerable transport distances, it proved impossible to operate on all casualties within the above-mentioned time frame, initial wound debridement was to be performed. This procedure consisted in the excision of tissues crushed by the projectile and those that had become infected. With a properly applied dressing, the wound could remain stable for 4–5 days, by which time the casualty had to reach a qualified surgeon [1].

The above argument can be summarised as follows: for the wounded, rapid surgical intervention is critical. To make this objective achievable, the following are required:

- surgical personnel equipped with appropriate instruments and materials;
- an efficient evacuation system based on effective means of transport;
- established operational principles for the system, including the triage of the wounded;
- non-surgical personnel responsible for initial wound care, medical triage, and care during transport;
- coordination and command, enabling system management and a flexible response to the evolving situation on the front lines.

As it turned out, the Polish healthcare system was unprepared for war in most of the aforementioned areas.

Doctrinal principles of the medical service in the field

The principles governing the operation of the medical service under field conditions were set out in the “Regulamin służby zdrowia w polu” (“Regulations for Medical Service in the Field”), introduced for official use in 1929 and re-issued in 1932 [2]. The document was complemented by

a series of instructions addressing, among other matters, the operation of military medical facilities, the functioning of medical services within military units, the management of military medical facilities during wartime, and the organisation of hospital trains. Relevant guidance was also included in the quartermaster regulations [3–7].

The foundation on which the system of medical assistance in the field was based was the principle of staged evacuation and treatment, with triage of the wounded and sick carried out at every stage to determine evacuation and treatment priorities. With each successive echelon, the scope of medical intervention increased. The scheme envisaged evacuation from lower to higher levels by the medical formations of the next echelon (Fig. 1).

The overall medical operations of large units (infantry divisions and cavalry brigades) were the responsibility of the chief medical officer (head of the medical service). At the infantry division level, the principal medical sub-unit was the medical company; in a cavalry brigade, it was the mounted medical platoon. Infantry divisions were also to include a small field hospital, although hospitals were generally operational-level (army-level) formations.

First aid on the battlefield was provided by the medical patrols of infantry companies (or artillery batteries) or by cavalry squadron medics. Transport of the wounded to the battalion or regimental aid station (BAS/RAS)

took place on stretchers carried with special straps or on transport carts. In cavalry units, evacuation from the front line was conducted on a medic's horse or using special cavalry stretchers – a sheet stretched between horses. During assaults or under heavy enemy fire, so-called ‘casualty nests’ were organised, making use of natural terrain cover or shell craters. Deployment of the BAS/RAS was the responsibility of the infantry battalion or cavalry regiment physician. At the BAS, patients underwent their first medical examination. The physician established an initial diagnosis, implemented necessary treatment (checking or applying dressings, emergency haemorrhage control, immobilisation of fractures, administration of preventive sera and circulatory stimulants), issued a preliminary evacuation card, and made an initial decision regarding evacuation priority.

From the BAS/RAS, the wounded were evacuated to the Main Aid Station (MAS) of the infantry division or cavalry brigade. Transport was the responsibility of the medical company of the infantry division or the mounted medical platoon of the cavalry brigade. The wounded were picked up from the so-called ‘wagon station’ – the furthest point reachable by medical wagons. Wagon stations were not organised in cavalry units. At this stage, transport was carried out by horse-drawn wagons (Fig. 2).

The wounded reached the MAS either directly or through Advanced Aid Stations (AAS), which were also deployed by the medical company. At the MAS, comprehensive medical triage was performed, and decisions were made regarding further evacuation. It is worth noting that, within this medical evacuation system, the regimental level of infantry was largely bypassed. The Chief Physician of the regiment organised an aid station only in the event of a gas attack; his primary responsibilities were coordinating the battalion medical service and organising evacuation routes at the regimental level. The direction of evacuation was essentially determined by the route of

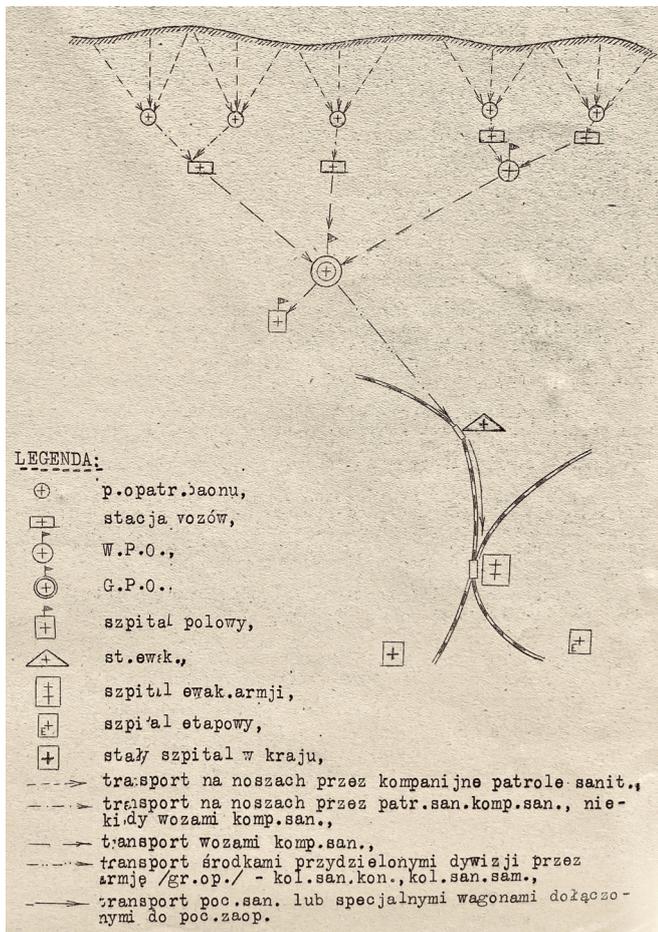


Figure 1. General scheme of medical evacuation. Source: “Zapopatrywanie i ewakuacja w ramach pułku piechoty” (“Supply and Evacuation within an Infantry Regiment”) [1]



Figure 2. The primary means of medical transport in the Polish Army at the tactical level in 1939 were horse-drawn vehicles, including simple supply wagons such as the wz. 19 (model 19) shown here. As part of the material mobilisation, peasant carts were also requisitioned; however, their technical condition very often left much to be desired. The photograph likely dates from the early 1930s. Source: National Digital Archives



Figure 3. The transport of the wounded at the operational level was to be carried out primarily by rail. Plans for mobilisation included assembling 36 permanent and semi-permanent hospital trains, which could be supplemented by improvised trains. The photograph shows one of the ambulance coaches at Poznań railway station. Source: National Digital Archives

the nearest railway line, where an evacuation station was established (Fig. 3 and Fig. 4).

The prevailing doctrine of the Polish Army assumed a manoeuvre-oriented character of combat. The organisational structure and operating principles of field ser-



Figure 4. Interior of the dressing and treatment room of one of the ambulance coaches. The train units were to be assembled by the Ministry of Communications, while medical and supply materials were to be provided by the reserve personnel of the regional hospitals, which were responsible for train mobilisation. However, the limited budget allocated for the purchase of the mobilisation materials significantly hindered this task. Source: National Digital Archives

vices, including the medical service, were theoretically aligned with these assumptions. This is well captured by the words of the introduction to the previously cited instruction: *The execution of supply and evacuation – especially in mobile warfare, with fluctuating and shifting fronts, in areas poor in quality roads, such as our eastern territories – will encounter numerous and varied difficulties. It is the commander's responsibility to anticipate these difficulties, overcome them, and undertake timely remedial measures* [1].

The Polish evacuation system did not adhere to a rigid model. At the operational level, it could be modified with relative flexibility by reinforcing the most critical directions with additional medical units. In practice, however, this flexibility remained largely theoretical. The lack of a fully developed command structure, severe deficiencies in communications, an insufficient number of motorised transport vehicles, and the reliance of evacuation on railway lines all hindered – and at times outright prevented – its implementation. It should also be noted that the organisational structure of the medical service was heavily weighted toward large, cumbersome hospital units transported by horse-drawn wagons, whose deployment required several hours. This significantly constrained the flexible deployment of hospitals in response to a changing tactical situation.

General plan for the operation and mobilisation of the medical service

Responsibility for preparing the medical service for war and for developing plans for its use rested with the General Staff of the Polish Army (Departments I and IV), in consultation with the Health Department of the Ministry of Military Affairs. The central authority overseeing the civilian medical service was the Health Service Department of the Ministry of Social Welfare, which also employed military representatives (Fig. 5).

Wartime preparations for the military health service encompassed three main areas:

- developing the wartime organisation of the medical service;
- planning for mobilisation;
- preparing wartime equipment tables and supply arrangements.

An inventory was also carried out of medical personnel subject and not subject to mobilisation (doctors, feldshers, dentists, nurses, and pharmacists), as well as hospitals, health centres, pharmacies, pharmaceutical depots, and other healthcare institutions. Maps were used to mark buildings suitable for conversion into field hospitals, as well as wells and railway sidings (Fig. 6).

In the final years of peace, cooperation between military authorities and the Ministry of Social Welfare proved inadequate. Among other shortcomings, a coherent programme for expanding civilian hospital infrastructure was neither developed nor implemented, and existing facilities were not prepared for wartime conditions. The causes were numerous, but the primary factor was insufficient funding. The situation was similar within the pharmaceutical industry. Only a few months before the outbreak of war was there an interventionist attempt to



Figure 5. Brig. Gen. Dr. Stanisław Rouppert – Head of the Health Department of the Ministry of Military Affairs until September 1939. Source: National Digital Archives

increase production, including that of sera. Among the few successes achieved were agreements regarding the preparation of medical supply depots by social insurance institutions [8]. Col. Dr. Babecki of the Health Service Department of the Ministry of Social Welfare assessed the state of the medical service bluntly: *The civilian healthcare system, much like the military, was unprepared for the event of war* [9].

The perception of the potential enemy left a distinct mark on strategic thinking about the anticipated conflict. For many years, the Soviet Union – rather than the Third Reich – had been regarded as the primary adversary. This strategic orientation had significant implications for the healthcare service as well. In the event of a war in the east, the geographical distribution of medical infrastructure would have been more favourable, with pharmaceutical production centres and hospital facilities located deep in the rear, beyond the enemy's immediate reach.

According to the 'W' ('War') Quartermaster Plan, the territory of Poland was divided into the 'Home Area,' under government jurisdiction, and the 'War Zone,' under the authority of the Commander-in-Chief. An 'Operational Area' was further designated within the War Zone for



Figure 6. As part of preparations for war, an inventory was carried out of personnel and sanitary infrastructure, as well as facilities and installations that could be used by the medical service. On this original map, prepared by the Field Resources Section of the Staff of Corps District No. 8, the locations of hospitals and other healthcare facilities, chemical-pharmaceutical plants, and pharmacies and chemists within Corps District No. 8 are marked. Source: Central Military Archives, ref. I.303.7.600

the activities of individual field armies [10]. With regard to medical administration, the Home Area fell under the jurisdiction of the Head of the Health Department of the Ministry of Military Affairs, Brig. Gen. Dr. Stanisław Rouppert, while the Head of the Health Service of the High Command was responsible for all medical matters within the War Zone. Col. Dr. Ksawery Maszadro, Commandant of the Medical Officer Cadet School in Warsaw, was appointed to this position.

The mobilisation of medical units was carried out primarily by regional hospitals, the Sanitary Training Centre, and the Main Sanitary Depot. Selected infantry regiments were tasked with mobilising medical companies for their respective divisions, while designated cavalry regiments were to mobilise mounted medical platoons for cavalry brigades. Furthermore, motor ambulance columns were to be mobilised by armoured battalions. Regional Polish Red Cross (PCK) districts were responsible for activating their own structures (Tab. 1, Fig. 7 and Fig. 8).

According to the plan, mobilisation was divided into alarm mobilisation (covert, silent) and general mobilisation. Priority in achieving combat readiness was given to medical units providing direct support to frontline formations, namely the medical companies of infantry divisions and the mounted medical platoons of cavalry brigades as part of the alarm mobilisation. At a relatively early stage of the alarm mobilisation, it was also planned to activate some field hospitals, war hospitals,

Table 1. Medical units included in the mobilisation plan. Compiled based on Rybka and Stepan [13]

Medical units	Mobilising unit	Ogólna liczba
Advanced surgical units	Sanitary Training Centre	5
Convalescent homes	Regional hospitals	10
Polish Red Cross rescue teams	Polish Red Cross districts	325
Corps district disinfection units	Regional hospitals	10
Polish Red Cross disinfection and bathing units	Polish Red Cross districts	37
Motor ambulance columns	Armoured battalions	17 (including 14 Red Cross units)
Horse-drawn ambulance columns	Supply train divisions	30
Sanitary companies	Regional hospitals, infantry regiments, Border Protection Corps battalion, Infantry Officer Cadet School, Infantry Reserve Training Centre	44
Railway disinfection stations	Regional hospitals	15
Medical service reserve centres	Regional hospitals	4
Mounted medical platoons	Cavalry regiments	12
Ambulance trains	Regional hospitals	36
Field bacteriological and chemical units	Regional hospitals, Sanitary Training Centre	62
Field disinfection and bathing units	Regional hospitals	59
Field sanitary depots	Regional hospitals	5
Polish Red Cross medical and food stations	Polish Red Cross districts	121
Independent sections of field hospitals	Regional hospitals	21
Main sanitary depots	Main Sanitary Depot No. 1, 10. Regional Hospital in Przemyśl	2
Evacuation hospitals	Regional hospitals	7
Field hospitals	Regional hospitals	52
War hospitals	Regional hospitals, Sanitary Training Centre	77
Mobile military hospitals	Regional hospitals	5
Surgical teams	Regional hospitals, Sanitary Training Centre	42

surgical teams, and hospital trains, which were classified as the so-called “yellow group.” Responsibility for mobilising these units rested with the regional hospitals in Warsaw, Grodno, Krakow, Lwów, Poznań, Toruń, and Przemyśl. In the second phase, following the announcement of general mobilisation, medical units at the op-



Figure 7. The Polish Red Cross (PCK) played a vital role in the country’s medical security plans for the event of war. According to mobilisation plans, the PCK was expected to mobilise, among other units, over 300 rescue teams. The photograph shows medical rescue demonstrations organised in the Krakow Market Square in June 1936. Source: National Digital Archives

erational level (army) were to be mobilised, followed by additional supporting echelons [11–13].

The general health service operational plan assumed that the wounded would be triaged and treated under field conditions and then evacuated according to the previously described scheme. Final triage was to be conducted at army evacuation hospitals. Patients unfit for further evacuation were to remain in the War Zone (in field hospitals of large units or at the army level) until their clini-



Figure 8. For military use, the Red Cross was also to provide 37 disinfection and bathing units. The photograph shows the supply wagons of one such unit moving through the streets of Krakow in June 1938. Source: National Digital Archives

cal condition stabilised sufficiently to permit transport. Definitive treatment was intended to be provided in military hospitals deep within the operational area and in the country's interior. Transport to the interior was to be carried out primarily by rail [11].

In the period preceding the war, an evacuation plan was prepared for patients from regional hospitals in Toruń, Poznań, Łódź, Krakow, and Warsaw to hospitals situated deeper within the country. During the covering operations intended to secure the general mobilisation and troop concentration, these facilities were to serve as temporary evacuation hospitals until the functional evacuation hospitals of the individual armies could be mobilised. Plans for utilising civilian hospitals remained unclear. However, the military reserved the right to requisition selected facilities, and the relevant documentation was submitted to the Ministry of Social Welfare [11, 12].

It was also envisaged that, during wartime operations, the supply of medical units with medical materials would be managed centrally from the two main sanitary depots. In addition, five field sanitary depots were expected to reach operational readiness by the fifteenth day of mobilisation [11, 12].

Analysis of the sources indicates that Col. Dr. Maszadro had not participated in preparations of the medical service for war prior to assuming his post. After the campaign, he testified: *I took no part in the preparatory work for the war, and no tasks pertaining to my designated position were entrusted to me. On 27 August, I was summoned to the General Staff, where I was instructed to familiarise myself with the O.d.B. (Ordre de bataille – author's note) prepared by the Staff. (...) Together with Col. Dr. Łaski and Maj. Zakrzewski, I reviewed the health service arrangements drafted by the General Staff for the event of war. However, I was given no precise data regarding the O.d.B. of units in the field, no tactical situation, and no forecasts. Nor was I provided with the personnel rosters for the armies or divisions* [14]. Lt. Col. Dr. Władysław Gergovich, Head of the Health Service for the Krakow Army, found himself in a similar predicament, reporting as follows: *As the Chief Medical Officer of OK V [Corps District No. 5 – author's note], I was unable during that period (two months, including two weeks of relocation leave) to examine in detail the overall mobilisation of the medical service of the Corps District. In my view, replacing the Chief Medical Officer of the Corps District two months before the war, and in particular excluding him from preparatory work in the staff of the future army, could not have had a positive effect on the functioning of the army's medical service, especially in the first days of the war* [11]. A similar account

was provided by Maj. Dr. Feliks Schneider, Deputy Head of the Health Service of the Pomeranian Army [15].

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