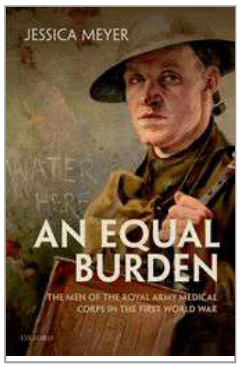


An Equal Burden: The Men of the Royal Army Medical Corps in the First World War
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# Eye Tests and Stretcher Drill

The recruitment and training of the RAMC ranks

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## Abstract and Keywords

This chapter examines the ways in which men were recruited to the Royal Army Medical Corps throughout the period 1914 to 1918 using both official documentation relating to recruitment policy and personal recollections of the recruitment process. It then examines training manuals, both official and unofficial, to explore how civilian recruits were turned into servicemen with particular forms of caregiving expertise. In particular, it examines how these men’s training distinguished them not only from civilian society but also arms-bearing combatant units through the focus on specific forms of training and knowledge acquisition. In doing so, it explores questions of chance and continuity in the identity of the Corps, demonstrating how the status of military medicine altered over the course of the war, with consequences for the subjective masculine identities of the men who served in the ranks of the RAMC.

*Keywords:* recruitment, training, dilution, nurses, doctors, conscientious objectors, specialization, improvisation, manpower crisis, drill

On 6 August 1914 David Randle McMaster wrote to his parents to tell them of

> a circular down from Head Office this morning asking for the names of clerks who would volunteer to join the Territorial forces at present + saying that it would not be predudicial [*sic*] to their position in the bank if any one wished to volunteer, + they would receive full salary.

> Now I probably know more about ambulance work than a good many men in the Field Ambulance Corps (Territorials) owning to my Red Cross + Scout Training. As far as knowledge of First Aid goes I think I am qualified to serve in either the Ambulances or the Royal Army Medical Corps. …
>
> This is the best possible work which I could do in any case. Firstly if the Territorials are ordered to the front, the Ambulance is bound to go too, but whereas the other brances [sic] would be combatants the latter branch would be non-combatants. There would be little risk though I should work as hard as anybody else, though not to destroy others.
>
> Secondly, if the other Territorials are not required for actual service the ambulance would probably get a good deal of experience in the hospitals to which they are attached, in any case.
>
> I am quite willing to do my share in the defence of the country and I am quite certain that I could serve in one of those corps + possibly as a commissioned officer as they are giving commissions free to qualified persons.[1]

McMaster was mistaken in his belief that his first-aid training would assist him in gaining a commission in either the RAMC or the RAMC(T), as commissions in these units were reserved for those holding medical **(p.54)** qualifications. His letter, however, points to the range of motivations that might drive the only son of elderly, nonconformist parents, raised in the pleasure culture of war which defined Victorian and Edwardian Britain,[2] to volunteer his services to his country in a non-combatant role.[3] Caught between concerns of family, conscience, and national duty, McMaster chose to enlist with the RAMC as a non-combatant, serving first with the 24th (1st Wessex) Field Ambulance and then with the 2/1st Wessex Field Ambulance until his demobilization in 1919, never rising above the rank of corporal.

McMaster’s letters to his parents, which he wrote regularly throughout his service, are an important source for understanding the motivations of rankers who served with the medical services during the war, not only because of their detail and frankness, but also for the light they shed on the process of recruitment and training that he underwent. Both processes were unique to the Corps, reflecting the ambiguities around the status of medical care as a branch of military service explored in Chapter 1. In particular, the dual imperatives of medical expertise and military discipline, and the ambiguous gender status of medical care provision in wartime[4] had a profound effect on how the ranks of the corps were recruited and the training they received before being sent into action. These processes differentiated the men of the RAMC not only from combatant troops but also, very explicitly, from their own officer corps, a group of men whose recruitment was itself hotly debated throughout the war.[5]

This chapter explores the ways in which the manpower of the RAMC was recruited and maintained over the course of the war, looking at how this process differed from the recruitment of combatant units. In particular, it examines the continuing role of voluntary organizations which, as we saw in Chapter 1, had such an important role to play in the overall provision of medical services. In doing so, it considers the ways in which recruitment to the medical services was explicitly gendered, particularly as women took on an increasing number of caregiving roles further and further along the chain of evacuation, and the 'dilution' of **(p.55)** home and Base hospital services increased. It then turns to how men were trained to undertake the specific role of medical caregiver within the context of the armed forces. By exploring the training of non-commissioned ranks in comparison with that of professionally trained medical officers and military nurses, the chapter argues that such training provided RAMC men of the ranks with a specific semi-professional identity which distinguished them from their combatant comrades. By locating this training within the gendered debates of men's abilities to fulfil roles of military medical caregiving raised by the recruitment process, the chapter will explore the tensions that maintaining an appropriately trained military corps of male caregivers created throughout the war.

## Recruitment

### Doctors and Nurses

A range of social pressures created by the nature of military medical services have already been identified by historians examining the recruitment and work of doctors and nurses in the war. Ian Whitehead, for instance, has shown how the recruitment of trained medical professionals to fill the RAMC officer corps in wartime created tensions between military and civilian authorities. On the one hand, medical men were, like so many, moved to volunteer their services when war broke out.[6] On the other, the medical needs of the civilian population had to be met: 'That the release of all young doctors might prove incompatible with the maintenance of a safe level of civilian medical provision was apparent to the profession. Kitchener's dictum that those men engaged in work essential to the prosecution of the war effort should not enlist was felt to apply to a proportion of young doctors.' At the same time, 'Once it became clear that Kitchener's predictions of a long war were not mere pessimism, the authorities at the War Office began to see the folly of turning away older doctors, who were demonstrably capable of performing military service.'[7]

The competition for the expertise of the medical profession between the military authorities and civil society intensified with the heightening of the **(p.56)** manpower crisis from 1915 and the introduction of conscription in 1916.[8] The Military Service Acts (1916) acknowledged this by 'vest[ing] in the national organization of the medical profession the responsibility for selecting practitioners who could be spared from their civil work to serve as Medical Officers in the Army'.[9] The Central Medical War Committee (CMWC), the

Scottish Medical Service Emergency Committee (SMSEC), and the Committee of Reference appointed by the Royal Colleges of Physicians and of Surgeons between them took on the role of the Military Service Tribunals in cases of doctors' appeals against military service.[10] They also managed the enrolment scheme under which 'the War Office guaranteed not to call up any doctor who enrolled himself as willing to accept a commission in the RAMC; … medical practitioners who failed to enrol were liable to compulsory *combatant* service'[11] (my emphasis).

Nonetheless, problems remained. In August 1917 the CMWC informed the War Office that, due to the impossibility of supplying both the Army's stated needs and providing civilian healthcare, including public-health requirements, the supply of potential medical officers had been exhausted. The resulting commission of enquiry into the AMS recommended reductions in the number of field ambulance MOs and staff at convalescent depots and on hospital trains.[12] As a result, the dilution of medical roles, including those doctors, by the employment of women was stepped up, with, for example, 200 extra nursing sisters being trained and deployed as anaesthetists in 1918.[13] Nonetheless, the demand for medical officers continued, increasing 'momentum towards compulsory mobilization of the civil [medical] profession; proposals were made for the redistribution and concentration of civil practice to ensure the most efficient use of medical personnel. … There can be little doubt that **(p.57)** these proposals would have brought Britain to the verge of a wartime national health service that might have laid the foundations for a full-scale reorganization of medical care in the post-war years' if the war had not ended in November 1918.[14]

The pressures that war put on trained female medical practitioners were less acute in terms of their recruitment than those on men but were, perhaps, even more socially and politically significant. The conclusions of the Report of the Commission on Medical Establishments in France (1917) may have formalized the process of overseas dilution of medical services, but the recruitment of women into the nursing services, both professional and voluntary, had already profoundly altered the way in which female medical caregivers were employed in the context of war.[15] While the majority of Territorial Force Nursing Service (TFNS) nurses served in the twenty-five TF hospitals and numerous auxiliary hospitals in Britain,[16] a significant number served overseas in Base hospitals, where they supplemented the work of the QAIMNS and QAIMNS(R), the reserve force which expanded rapidly during the war.[17] The women of QAIMNS, 'well-educated and expertly trained gentlewomen, and as such considered fit to work alongside doctors of the Royal Army Medical Corps in military hospitals both in the United Kingdom and abroad',[18] were, from 1916, increasingly deployed further up the line at Casualty Clearing Stations (CCSs).

In moving closer to the front line than had been planned for in the years before the war,[19] these women increasingly took on the work of military medical caregiving in situations where 'Boundaries merged and dissolved … and nurses often took on the work of surgeons'.[20] Similarly, **(p.58)** female doctors such as those serving with the Scottish Women's Hospitals who, having been turned down by the British War Office, offered their services instead to allied nations including France and Serbia, found themselves serving directly in the front line, where their work did not simply relieve their male colleagues for military service but rather supplemented that service directly.[21] Such experiences placed enormous pressure on the individual women involved, but also allowed them to both develop their professional skill and lay claim to status as medical professionals in ways in which they had not been able to prior to the war.[22]

Doctors were not the only women who volunteered to provide medical services outside the structures of the military nursing services in the early days of the war. The British Red Cross Society (BRCS) found itself 'besieged by thousands of women demanding the right to serve their country' as nurses, the highest profile and most socially acceptable form of service for women in wartime.[23] From September 1915 women were increasingly employed to substitute for and dilute male labour in military hospitals. These women 'were registered as dispensers, clerks, cooks, and cleaners, at weekly rates of pay varying from 18*s.*6*d.* for a cleaner to 35*s.* for a head cook or head clerk and 30*s.* for a dispenser, with allowances of £4 for dress. They were placed under the control of the matron when on duty in wards, and under the head cook when employed as kitchen staff.'[24] In January 1916, these women were divided into two classifications, 'general service women', including clerks, telephonists, laboratory assistants, storekeepers, dispensers, and cooks, and 'labour staff', including cleaners, scrubbers, and kitchen maids. These latter were employed by a hospital's commanding officer, drawing from the local population, while 'general service women' were employed through the British Red Cross and were distinguished from the nursing volunteers by the designation VAD(GS). This atomization of women's wartime labour in the medical context, which maps on to the class distinctions in civilian labour in hospitals before the war, demonstrates the complexity of such labour, extending well beyond that of the trained nurse **(p. 59)** or nursing volunteer whose histories and relationships dominate both the historiography and historical memory.[25]

### Enlistment and the Manpower Crisis

While recruitment to the ranks of the RAMC was never as politically or socially fraught as that of either medical officers or female doctors and nurses, the process was, nonetheless, profoundly influenced by the manpower crisis which shaped both these processes and, indeed, many of Britain's strategic considerations throughout the war.[26] In the case of the ranks of the RAMC, however, it was neither the political importance of their civil role nor the socially transgressive nature of their war service which complicated recruitment. Rather,

it was their military status as non-combatants which had the most powerful influence on the shape of policy relating to their recruitment and reinforcement.

As we have seen, the status of military medical service personnel, including medical officers, within the military hierarchy was ambiguous at best in the years before the war. Despite growing awareness of the importance of the role of medical service personnel in clearing battlefields and conserving combatant manpower though sanitation and first aid,[27] RAMC personnel of all ranks were considered by the military authorities to be decidedly less useful than combatants. This was reflected in the lower status of the Territorial RAMC relative to the Territorial Army, as indicated by Archibald Whyte's recollections of his enlistment with the 3rd East Anglian Field Ambulance in 1908:

> My eagerness [to enlist with the Territorials], alas, was only equalled by the indifference of the military authorities who were not at all excited at the prospect of recruiting a somewhat undersized and short-sighted lad. The London Scottish turned me down flat, as did the Artists Rifles, and both the 6th. and 7th. Battalions of the Essex regiment were no more encouraging, and my dreams of military glory began to fade.
>
> Then one evening on the top of a tram I saw a number of soldiers who were obviously just home from camp, but these were no ordinary Terriers; they had a Geneva Cross on their arms, while on their shoulders were the **(p. 60)** mystic letters 3rd. E.A.F.A.RAMCT. Until then it had never occurred to me that the Territorial Army consisted of anything else but infantry and artillery, but here was concrete evidence of the existence of an additional service.[28]

It can also be seen, in the early years of the war, in the continued use of regimental bandsmen as regimental stretcher bearers.[29] Bandsmen were often underage or less physically fit than their comrades,[30] but were nonetheless deemed strong enough to bring the wounded in from no man's land to the Regimental Aid Post (RAP), even if they were not deemed strong enough to fight.[31] By carrying out strictly non-combatant work, as set out by the Geneva Conventions, the employment of these men on the battlefield was rationalized in relation to rules which, at the time, allowed young men to enlist as full-time soldiers at 18 and serve overseas at 19.[32]

With the overseas deployment of the Territorial and New Armies in 1915 and 1916, the selection of men for regimental stretcher bearer duties as an extension of other ceremonial duties within the regiment was abandoned in favour of a system whereby volunteers within the regiment were given special training by the regimental medical officers (RMOs). This method was, in its way, as haphazard in selecting men with appropriate skills for medical caregiving as employing bandsmen.[33] However, in units where the RMO was conscientious

about his training duties, the role of regimental stretcher bearer could give these combatant servicemen a particular shared identity as medical service personnel.[34]

While the recruitment and training of regimental stretcher bearers was the responsibility of RMOs working within the structures of the regiment **(p.61)** to which they were attached, the recruitment of men to the RAMC was a Corps matter, dealt with within the wider structures of the British Army and overseen by the War Office. Thus, as the official history of the Medical Services noted, 'The recruiting of personnel for the Army Medical Services did not differ in its general aspect from the recruiting of the army generally.'[35] Given that the raising of the new armies in the first year of the war 'depended largely on a process of improvised decision-making at departmental level',[36] this process looks, in retrospect, somewhat chaotic. While posts at home vacated by RAMC Regulars sent overseas were initially filled, as planned,[37] by men from the RAMC(T) and the Home Hospital Reserves of the St John Ambulance Brigade and St Andrew's Ambulance Association, the requirements of the expeditionary force soon drew on these reserves as well. In 1914, 'Three new cavalry field ambulances, the 6th, 7th and 8th, were sent to France … , the 6th and 7th being formed of volunteers from various territorial force units.'[38] Later, 'Territorial force divisions went overseas with their own field ambulances, second line field ambulances being formed to replace those first line field ambulances which had been allotted to regular army divisions', while 'The divisions of the new armies when they mobilized for service overseas were accompanied by three field ambulances each, mobilized, with one or two exceptions, from the various training centres and depôts of the R.A.M.C. which had been formed to meet the expansion of the corps.'[39] Such demands for medical units to serve overseas quickly depleted the trained reserves of the AMS.

It was not simply the creation of the new armies which increased demand on the AMS. Changing plans for evacuation involved the creation of a new class of military medical unit, the Motor Ambulance Convoy (MAC) in late 1914, staffed by three MOs and fourteen RAMC Other Ranks working with 120 Royal Army Service Corps (RASC) drivers and mechanics.[40] This development, along with innovations such as mobile laboratories and the increasing importance of specialist sanitary squads,[41] placed demands on the AMS for non-commissioned manpower which pre-war planning had not accommodated for.

As a result, for the first three months of the war active recruiting to the RAMC was carried out without restriction, alongside the mobilization of reservists such as Archie Whyte and Walter Bentham, formerly of the Royal Garrison Artillery. In total, 26,336 men voluntarily enlisted with **(p.62)** the Corps in this period.[42] This demand for men enabled those such as George Swindell, at 5 foot 2 1/8 inches considered too short for any form of combatant service, to fulfil their wish

to enlist for active service. As Swindell recalled, when going to enlist with a friend,

> I was five feet two and one eighth inches, Jimmy was five feet, eleven and half inches, the recruiting officer, grabbed Jimmy by the arm, come along you are just the size we want, but looking at me with a look of pity and scorn, in a rather loud tone remarked we want men here, go away and grow. … I gave up hope, and was just leaving the Office, when the Sergeant came and called me back, the Officer had just had an order from the War Office, 20,000 men required at once for the Royal Army Medical Corps, height not less than five feet, three inches, so in I went, in the seventh heaven of delight.[43]

This was after the recruiting MO let him stand on his tiptoes while being measured.

J. B. Bennett's case was similar:

> [I] tried to enlist in the East Surrey Rifles and … failed the sight test (Astigmastism), having been caught out on the blind side of the hexagonal test chart despite memorising the visible faces. I had pocketed my normal spectacles. I appealed and obtained a second test without success.
>
> Nothing daunted, I pursued my endeavours at recruiting centres in London for four wearying days and failed similar tests with the addition of height. In a last effort I went to the local Drill Hall following a recruiting 'tip off' on Sat. 9th. September and succeeded with the 3rd East Anglian Field Ambulance, with which I served throughout the war, having evaded the sight test. The N.C.O. left me to answer a 'phone call in an adjoining room and forgetfully asked me if I had read the sight testing panel. My affirmative was accepted and so I passed the test that I never had.[44]

Indeed, the level of blind-eye turning on the part of recruiting MOs recalled by RAMC servicemen in their post-war memoirs clearly reflects similar practices throughout the military in those hectic early days.[45]

**(p.63)** However, while the recruitment of doctors and nurses illustrates the tensions that the manpower crisis created between the civil and military authorities in terms of demand for labour, the recruitment of men to the ranks of the RAMC illustrates the more specific tensions that the manpower crisis caused within the military itself and, in particular, between 'teeth' and non-combatant arms of the military services. It was the combatant branches, with their devastating losses and consequent need for reinforcement, as well as their greater significance to military planning in wartime, which had the greatest demand for new recruits. This directly affected the process of recruiting to the explicitly non-combatant RAMC. As the *General History* would later note, 'owing

to the demands for men as reinforcements to the combatant ranks, the recruiting for the Royal Army Medical Corps was restricted not only in numbers but also in categories as the war went on, and had to be supplemented in hospital services to a great extent by women'.[46] In the early years of the war, recruitment to the unit was episodic, with the initial period of unrestricted enlistment being followed by a two-month hiatus before it was 'resumed between 8th January and 10th March, 1915, and again for a few days at the end of April and the beginning of May of the same year. After the 3rd May, 1915, general recruiting for the Corps ceased altogether except for a short period between the 24th October and 4th November, 1915, during which time 8,639 recruits were obtained.'[47] After 1916, reinforcement of the Corps was governed by the Military Services Act, with the War Cabinet assuming direct control of the allocation of manpower.[48] As a result, 'Although 6,700 recruits of the highest national service group were posted to the R.A.M.C. in the summer of 1918, men allotted to it … were chiefly men of a category of fitness lower than that required for combatant units'.[49]

Even more significant than the limits put on recruitment to the Corps, however, was the changing nature of the men recruited throughout this period. While the unit had initially attracted white-collar workers, 'men whose occupation in civil life was that of clerks, school masters and students of all descriptions',[50] as well as clergymen who were officially discouraged by the Church of England hierarchy from enlisting in **(p.64)** combatant service,[51] the closing of direct recruitment meant that the choice to serve in the unit was no longer available to volunteers after 1914. Instead, emphasis was increasingly placed on recruiting men with 'special qualifications such as dispensers, laboratory attendants, nurses, masseurs, mental and operating room attendants, sanitary inspectors, splint makers, electro mechanics, and men holding first aid and nursing certificates'.[52] Military hospitals based in asylums and poor-law infirmaries, such as East Leeds Military Hospital, recruited most of their staff from the pre-war civilian personnel of the institution,[53] so that the class profile of the Corps shifted away from the lower middle and middle classes, who had initially volunteered for its ranks, towards a more working-class profile.[54]

Nor was it only the class of the men recruited to the RAMC which changed after 1915. The overall fitness of recruits to the unit also began to be systematically downgraded. Where men such as Swindell and Bennett may have enlisted on a wave of war enthusiasm, taking advantage of doctors' willingness to turn a blind eye to their physical insufficiencies, from mid-1915 the recruitment of men previously deemed unfit became official policy:

> [I]n July of that year provision was made for the employment in hospitals at home of men of the regular and territorial force, who were permanently

> unfit for service abroad, in order to release men of the R.A.M.C. for medical units overseas.
>
> This shortage of high category men was accentuated by an order issued on 23rd March, 1915, by which a number of men of the R.A.M.C. were transferred to infantry battalions to meet demands for reinforcements to the expeditionary force. To replace them, members of the R.A.M.C.(TF) between the ages of 17 and 19, or 40 and 50, that is, the too young and the too old for field service, were authorized in May, 1915, for enlistment in the R.A.M.C. if suitable for work in general hospitals, and men between the ages of 19 and 39 serving in the R.A.M.C.(TF) general hospitals, were **(p. 65)** encouraged to re-enlist in the regular R.A.M.C., or take on an imperial service obligation.[55]

In other words, the reserve units were being ‘combed out’ of men fit enough to serve either overseas or as combatants, with their replacements in the home reserve being drawn from categories of men whose age and health would previously have been considered less than suitable for any form of military service. This form of ‘combing out’ continued throughout the war, as can be seen in the regular announcements of transfers to combatant units in the pages of *The ‘Southern’ Cross*, the journal of the 1st Southern General Hospital, Birmingham.[56] Similarly, the recycling of injured men who, upon physical rehabilitation, were deemed unfit for further combatant service, back into military medical service as a way of filling the gaps left by the ‘comb-outs’ had a further knock-on effect on the overall health and fitness of the Corps. As Ward Muir, an orderly serving at the 3rd London General Hospital, Wandsworth, noted, in 1916:

> [A]s far as our unit was concerned it had already … been combed out five times; and this in spite of the fact that … our Colonel declined to look at any recruit who was not either over age or had been rejected for active service. The unit was thus made up even then, of elderly men and of ‘crocks.’ [This was before the start of the Derby Scheme and, of course, considerably before the introduction of Universal Service.][57]

### Conscription and the Military Services Acts (1916)

Yet even these tactics were not sufficient to allay the growing manpower crisis,[58] which ultimately saw the introduction of the Military Service Acts in 1916. Under conscription, the relationship between the RAMC and the RAMC(T) was modified so that ‘officers and men under 41 years of age became available for posting where required, and existing Territorial Force medical units lost their territorial designation and were given **(p.66)** consecutive numbers as R.A.M.C. units’.[59] Age was not the sole category to be degraded by the conscription process. As the official history noted, the men allotted to the Corps in this period

> were chiefly men of a category of fitness lower than that required for combatant units, with the result that men of the highest category already in the Corps were gradually drafted into the field medical units; their places in the medical units on the lines of communication and at home being taken by new recruits of lower categories, and by invalids from overseas discharged from hospital as unfit for general service, or by women.[60]

In fact, as with the substitution of men of lower fitness, the employment of women in home hospitals and units along the lines of communication started earlier than this quotation suggests. Trained military nurses served as far forward as CCSs from October 1914,[61] while VAD units were posted to Base hospital units by the BRCS from 1915 onwards.[62] 'The employment of women in military hospitals at home in order to replace non-commissioned officers and men transferred to other medical units commenced in September, 1915.'[63]

This transition in recruitment practice was reflected in the history of the 1st Southern General Military Hospital, which described how, in 1916:

> Many changes occurred in the personnel of the Hospital, the chief being that of the replacement of men by women. Not only were men replaced by women, but the actual number of the male personnel was reduced, so that more work had to be done by those who remained. The trained Nursing Staff was also diluted by more V.A.D. Probationers.[64]

Nor was it only nursing staff who were substituted. 'The General Service Women first entered the Hospital in April, 1916, and gradually replaced the men in all the offices where it was possible. This was done in each Section of the Hospital, commencing with Headquarters.'[65] The employment of these women was slightly different from that of nursing staff, with four female clerks employed to undertake the work of three male clerks, making their employment a form of dilution rather than substitution.

The experience of this particular unit of the RAMC(T), as summarized by the unit's unofficial history, is instructive:

> **(p.67)** The R.A.M.C.T. has greatly changed since the Hospital was mobilized, and very few of the original members now remain. At first the Unit was increased in size by direct enlistment, and their numbers gradually became more until they reached the maximum at the end of 1915. From that time onwards all the men fit for General Service were drafted to other Units for service overseas, and others, unfit, were drafted in to replace them. Later they have been replaced by the General Service Women, who have taken over a large part of their work. … Since mobilization, 808 men have been enlisted, returned from overseas, or drafted from other Units. The present strength is 388, and the difference in

> the figures is made up chiefly by the number of men who have been transferred to other Units for service overseas. Nine of the Unit have received commissions, and five have been released for munitions work.[66]

By 1918, an editorial in the journal was noting that ‘many of the RAMC personnel have … gone’.[67] The shape of this particular unit reflects the trends of recruitment and redeployment by the RAMC more broadly, with overseas service, either in combatant or medical units, given priority in the deployment of manpower. The health of the unit also declined over the years, as reflected in the obituary of Staff Sergeant E. C. White, who served ‘as a Dispenser; for, as he told the writer of this note at the time, “whilst he did not feel strong enough for foreign service, yet he was anxious to help to the best of his abilities”’. The obituary writer argued that, in offering his service in spite of physical frailty and subsequently dying in that service, White ‘had laid down his life for his country, no less than the soldier in the trenches’.[68]

The impact of dilution and substitution practices on units of the Corps serving overseas was far less dramatic, although the combing-out process for combatant servicemen occurred in these units as well. Those men identified as sufficiently fit were offered inducements, such as officers’ commissions, to transfer to combatant units. Frank Ridsdale recorded the commissioning of a comrade, Beevors, on 5 October 1916 with the comment, ‘we shall miss him greatly … but we know it is an honour to the 2nd Northern [General Hospital, Leeds, where he trained] for another of the boys to rise from the ranks’.[69] David Randle McMaster, meanwhile, applied for a commission in the artillery in 1917. He was turned down but urged to reapply without giving a preferred unit of service, which, he **(p.68)** noted, ‘would more or less invite them to put me in the infantry’. In a soul-searching letter to his parents he wrote:

> To apply for a commission merely to gratify personal vanity would certainly be wrong and in my particular case would be heartless and cruel to you—which I would not be for all the world. The only possible justification of further application would be in a sense of duty. Is it my duty to accept a commission since officers are wanted and since I am considered by the O.C. to be a fit person? Is it my duty to the country? Is it my duty to you?—though the two questions are really one since we only fight for our own loved ones. I have asked the O.C. if he considers it my duty to apply again to which he replied ‘Yes’. Col. Clarke said I ought to take a commission. It might be urged that I am already doing my duty in the R.A.M.C.but from his answer the O.C. considered I should be doing my duty more fully as an officer.[70]

Ultimately, for McMaster, the inducement of promotion to officer rank was not sufficient for him to take a role that would cause additional anxiety to his elderly parents.

Where such comb-outs did occur, as in the case of Beevors, posted medical units were reinforced by the reserves combed out from home service and those whose health, often following wounding and convalescence, precluded a return to front-line combatant service. Dilution of overseas units via the employment of women also occurred with increasing frequency through, for example, the appointment of female anaesthetists at Base hospitals and CCSs.[71] As the war continued, more women were brought in to work at the Base hospitals, in a range of roles, as well as forming the entire nursing staff.[72] However, although the official employment of women in caregiving roles overseas by the British voluntary and military medical services did expand during the war, it remained limited.

### Voluntary Service Provision

In spite of the increased employment of military nurses and women in auxiliary medical roles, CCSs remained firmly under the authority of **(p.69)** the RAMC. Base hospitals caring for British servicemen, either in France or other theatres of war, by comparison, were increasingly run by units other than the RAMC. Allied and Imperial units such as the Canadian and Australian AMSs ran many hospitals,[73] while from 1917 six general hospitals were taken over by the United States Army Medical Corps. However, as the *General History* notes, 'two voluntary units from the United States, one from Harvard and the other a Chicago unit, had been accepted by the Army Council for duty with the British medical service in France in July 1915'.[74] Such supplementation is just one example of the variety of voluntary services which bolstered the work of the RAMC from 1914 onwards, forming a key element in the provision of military medical care through their delivery of hospital units, ambulance services, and the staff and supplies for ambulance trains and barges. The voluntary groups working with the British armed forces[75] were officially coordinated and supplied by the Joint Committee of the British Red Cross and Order of St John of Jerusalem. According to the post-war report on the work of this committee, although never more than just over 1,000 at any one time,[76] the male orderlies it employed in France 'were the basis of our whole work there'.[77] These men worked as clerks, storekeepers, builders, carpenters, painters, and plumbers in the Stores Department, providing a significant element of the BRCS's work of supplying medical stores and 'soldiers' comforts'. They also ran the Society's transport department, as well as serving alongside doctors, nurses, and female VADs at the ten hospitals administered by the BRCS and the three Red Cross-staffed hospital trains, Nos 11, 16, and 17. Between October 1914 and March 1915, 120 BRCS men were responsible for the stretcher bearing work at Boulogne, and BRCS orderlies and mechanics worked as volunteer night-time bearers during the heaviest fighting of the Battle of the Somme.[78]

In addition to the work directly organized by the BRCS, the Committee also oversaw the work of other voluntary bodies providing medical **(p.70)** support, comprising the many privately funded hospitals and motor ambulance convoys which were formed almost as soon as war was declared. These included,

perhaps most famously, the Friends Ambulance Unit (FAU), a unit formed of young men, several of them Quakers, who wished to contribute to the war effort but whose political or religious beliefs made them reluctant to enlist in the armed forces.[79] While the men of this unit had been serving overseas from 1914 under the auspices of the BRCS, the introduction of the Military Service Acts gave a more official recognition to cultural associations between objection to combat and medical care provision through an increased level of formal association with the War Office:

> During the passing of the [first] Military Service Act four leaders of the Friends Ambulance Unit had been called into consultation by the War Office, and asked to collaborate in arranging work of 'national importance' for members of the Society coming under the Act; so that all Quakers coming before the tribunals to be set up for conscientious objectors could be referred to the Friends Ambulance Unit. … [The Unit] advertised its willingness to help the government, and allowed its principal field … to accept honorary commissions in the Army to facilitate their work.[80]

Military Service Tribunals, set up to hear appeals against conscription, meanwhile,

> were dealing peremptorily with conscientious objectors. Most applicants faced outright dismissal or, at best, were offered the minimum exemption (that is, from combatant [as opposed to more general military] service) … many Tribunals appear to have regarded the non-combatant certificate as the 'correct' exemption. It met—or seemed to them to meet—the requirements of pacifist principles while releasing other men for front-line duty.[81]

Many objectors thus found themselves conscripted into non-combatant forms of service deemed of national importance, including service with the Non-Combatant Corps (NCC), whose duties included stretcher bearing and hospital portering.[82]

**(p.71)** What is significant about the recruitment of men, and more particularly men who articulated some form of objection to military service, to voluntary medical units throughout the war is the continuing challenge that these units in turn posed to the *raison d'être* of a specific military medical corps and the non-commissioned men serving within it. If voluntary units—units made up of women and of men unsuited for military service—were capable of providing the caregiving labour that RAMC rankers undertook, was there a reason for retaining enlisted men when combatant units were crying out for manpower? Corder Catchpool, FAU member and later 'absolutist' conscientious objector, noted the extent to which military and voluntary care provision replicated each other:

> I went out to relieve the suffering caused by war, to show sympathy with men who had obeyed a call of duty different to my own, and in a labour of love, to share the dangers and hardships to which they were exposed. For nineteen months I was spared to continue this work at the front. Meanwhile, however, the medical services had been completely organised. Voluntary units were either dispensed with, or practically absorbed into the regular armies. The wounded no longer lacked help.[83]

While, from Catchpool's perspective, the alignment of military and voluntary medical aid presented problems for the positioning of such aid as purely humanitarian, from the perspective of the RAMC it once again raised the question of the status of medical care provision as an appropriate masculine undertaking in time of total war. The pressures of the manpower crisis forced the RAMC to compromise both its military and masculine identity through expanding the age range and lowering the health qualifications for recruits and through female dilution. Its alignment with voluntary medical care providers and, later, its supplementation by conscientious objectors to combatant service placed it in an apparently ambivalent relationship to military authority and structures of discipline. Yet the Corps expanded throughout the war and, as we shall see, emerged with its identity as a specifically military unit strengthened, in spite of the challenges which wartime recruitment posed. By the end of the conflict, George Swindell could write that he had 'joined one of the finest Corps in the British Army', a sense of identity which developed in large part from the specific training of RAMC recruits, a training that combined medical **(p.72)** knowledge and military practice to form a unique semi-professional identity for the Corps.

## Training

The training for men in the RAMC fell roughly into three categories—training in sanitation and the prevention of disease, training in the care of the sick and wounded, and military training—as reflected in the sections of the Royal Army Medical Corps training manual, issued in 1911 and in general use throughout the war. According to this volume, the importance of the first of these categories lay in the fact that 'the efficiency of an army, as a fighting organization, depends largely on the health of the individuals which compose it; therefore, a knowledge of the causes and conditions which contribute to sickness, as a means of military inefficiency, and also of the principles and methods by which disease may be prevented is essential to every soldier'. It was therefore 'desirable that everyone should have some idea of the main facts',[84] with men being instructed in water purification, food hygiene, and sanitation both in camp and on the march. By 1914 the RAMC(T) had already established specialist sanitary companies which had their own specific training regimen.[85] These were incorporated into the work of the RAMC, along with the rest of the RAMC(T) from 1915, and were expanded upon throughout the course of the war. By 1918 the Corps contained sixty-six sanitary companies, each made up of twenty-five men and an officer, on

the Western Front alone. They served under their own Assistant Director of Medical Services (ADMS) (Sanitation), giving them a specific identity within the Corps, distinct from that of the men serving with units providing care rather than preventing the spread of disease.

This distinctive identity was reinforced by the fact that ‘as skilled manpower became short, doctors [in sanitation companies] were replaced by non-medical officers with relevant skills, such as in pharmacy or engineering. By 1917, only one in four sanitary sections was commanded by an MO, who acted as a supervisor for the other three.’[86] The increased role of the Native Labour Corps in sanitation companies in theatres other than the Western Front similarly indicates that the work of these units was viewed by the military authorities as less medical than that of caregiving units, and more of a logistical consideration. Increasingly, prevention of illness was viewed as the responsibility of the individual soldier, whatever **(p.73)** his unit of service, whether combatant or non-combatant. Despite the ongoing importance of sanitation to the role of the Medical Corps, as the war went on and the armed forces expanded in size and knowledge, this facet of their work was increasingly viewed and treated as distinct from medical care provision in terms of practice, administration, and status. Nonetheless, as we will see in Chapter 3, cleaning remained a significant element of the work of RAMC rankers of all establishments along the chain of evacuation.

Of the other two categories of training given to RAMC rankers, based on the space allocated to each in the training manual, military training would appear to be of lesser importance. Out of 430 pages, 9 are devoted to military training, with half of these concerned with the military training of medical officers. By comparison, in their report on a plan to provide additional nursing training to RAMC orderlies through the QAIMNS, the Advisory Board for Army Medical Services and Nursing Board noted that, ‘Whatever the role a non-commissioned officer or man is called upon to play, training in nursing is first insisted upon.’[87] A total of 160 of the manual’s pages are devoted to patient care, with subjects covered including ‘Dressing and Healing Wounds (including the First Field Dressing)’, ‘Attendance on Infectious Cases’, and ‘The Serving of Patients’ Food’. The level of medical detail included is high, certainly greater than that of the 1908 *First Aid to the Injured*, the manual of the St. John Ambulance Association written to accompany its first-aid courses. Outlines of anatomy and physiology are accompanied by detailed diagrams and illustrations (Figure 2.1). While the language is clearly designed to be accessible, with cricket analogies used to illustrate energy transfer, for example,[88] there is little accommodation made either to educational level or potential squeamishness. The discussion of treatment and illustration of wounds are detailed and graphic, as can be seen in the illustration of a compound fracture of a tibia. (Figure 2.2) The exposure to and subsequent knowledge of medical subjects thus expected of Regular and Territorial RAMC rankers were above those expected of the voluntary first-aid

provider, who was specifically instructed to ‘on no account take upon himself the duties and responsibilities of a Medical man’.[89] By contrast, the men of the RAMC were responsible for ‘the nursing of the sick and the dispensing of **(p.74)** medicine’, as well as ‘various duties connected with the charge of equipment, the requisitioning for fuel, light, provisions, and all necessary supplies and repairs, the cooking and expenditure of diets, the custody of patients’ kits, the cleanliness of the hospital and its surroundings, and the preparation of the accounts, abstracts, and vouchers of expenditure’.[90]

**(p.75)** The higher standard of training expected of both Regular and Territorial RAMC rankers is important to note, given the fact that the RAMC(T)’s own training programme was provided by the St John Ambulance Association which, along with the BRCS, also created syllabi for the first-aid training of VAD units. Despite the disagreements between the two organizations, these pre-existing training programmes provided an initial level of continuity when the RAMC(T) was absorbed into the Regular medical services after 1916. Given the numbers of men who were either recalled from the Reserves or were mobilized with the rest of the Territorial Army in 1914, the number of men in the RAMC who had undergone this civilly organized training increased significantly. In addition, the initial mobilization of the RAMC(T) for home hospital service enabled them to reinforce the part-time training their members had received prior to the outbreak of war with the experience of active hospital work in wartime. Archie Whyte described his RAMC(T) training before the war thus:

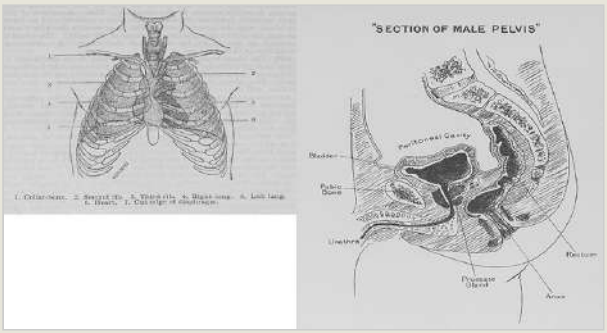



*Fig. 2.1.* ‘The thorax or chest’ and ‘Section of male pelvis’; *Royal Army Medical Corps Training Manual*, pp.277, 300 (facing).

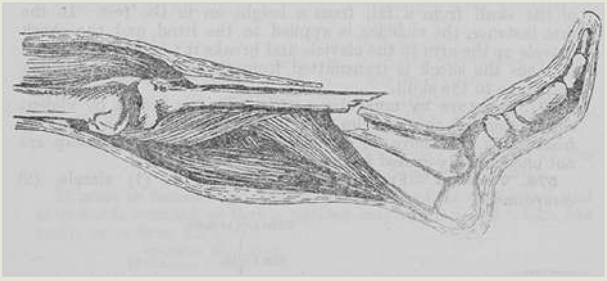


*Fig. 2.2.* ‘Compound fracture of tibia’; *Royal Army Medical Corps Training Manual*, p.338.

> First Aid and some instruction in nursing were obvious subjects of study, but in addition we were supposed to know something about field-sanitation, field cookery, the general principles covering the medical services in time of war. Then there was the pitching of large marquees,

> operating tents and bell tents; and on top of this a complicated system of drills; foot drills, stretcher exercises, and, above all, the loading of stretchers on to ambulance wagons, an operation that had to be carried out by numbers and which ultimately in practice was never used at all, and indeed the novelty of these various exercises tended to blind one to the fact that they were largely based on South African War experience, and although the possibility of motor transport was envisaged in the RAMC training manual of 1911 it is interesting to note that out of 43 pages devoted to different means of transporting wounded only three lines are deemed sufficient to mention that motor-ambulances exist in the Army—one can almost hear the snort of disgust that even that amount of information brought forth![91]

He went on to note, however, that 'it would be quite unfair to say that the training given was either useless or bad; on the contrary it was reasonably detailed and when we ultimately served in the field we had to admit that although there were many things on which we had received no instruction there were undoubtedly still more on which our training had been of real use.'[92] For Whyte this included the week he spent at the 1st Eastern General Hospital in Cambridge on a week's instructional course, which predominantly involved dressing the wounds in the freezing open wards **(p.76)** pioneered at this institution. From this experience, 'We obtained a tremendous amount of benefit … the only regrettable thing about it was that it was all too short.'[93]

If the opportunities for enhancing the training of Territorial reserves in a home hospital setting were beneficial but too short, initial training of those who enlisted in the early years of the war appears to have been reasonably thorough, although perceived as too general. David Randle McMaster sent his parents details of his first few weeks of training after he volunteered early in August 1914. A copy of orders for the day ran:

| | |
|---|---|
| 6-30 | Parade |
| 7-30 | Breakfast |
| 9-00 | Parade with everything clean |
| 11-00 | Lecture by Officer on 1st Aid |
| 12-30 | Dinner |
| 2-00 | Parade for drill + bandaging |
| 3-30 | Dismiss[94] |

A later letter went into more detail:

> We have to work fairly hard. The first parade is held at 6.30 a.m. for physical exercise. … This continues till 7.15 and is calculated to give one an appetite for breakfast at 7.30. After the meal boots, buttons belts etc have to be cleaned + kit removed from tents and lined up tidily for inspection at 8.30.
>
> At 9 a.m the morning parade is held. … It might take the form of stretcher drill, (as it did to-day) or pitching an ambulance encampment. This may be followed by a lecture on some medical subject, + dinner succeeds at 12.30.
>
> At 2 the afternoon parade is held. … It might take the form of company drill or a route march. This finishes at about 4 and we have an hour before tea. After this we are free, although of course we never know when we might get an alarm.
>
> We have to be in our tents by 9.30 + 'lights out' is sounded at 10.15, after which no talking is allowed.

He included examples of drills, noting that 'This morning we had stretcher drill in carrying wounded off the field to the ambulance wagons, while yesterday we pitched a field hospital encampment.'[95]

**(p.77)** It was not until the following month that he was moved to the role of hospital orderly, attending to between fifteen and twenty patients a day suffering from pleurisy, colds, and minor wounds. He proudly reported that he had the opportunity to dress 'a badly cut thumb and appl[y] fomentations to a man suffering from boils'.[96] The benefits of this new role were that not only was he 'immune from fatigue duties and I do not attend parades',[97] but he also felt that 'One week of such practical experience is worth a month's ordinary training … and I am doing my best to make use of the short time I have left here.'[98] These developments echo the experiences of J. B. Bennett, whose training at Peterborough involved

> route marches lectures clinics both with the unit and at the local hospital including X-rays, massage, ward duties and bandaging … [all of which] enabled most of us to take our examination for corps pay (4d. per day) and prepared us for our first experience of running a hospital. This arose when Brook Street Primary school was commandeered and under the supervision of our officers was converted to a military Hospital exclusively staffed from the unit. We successfully treated many cases both medical and limited surgical without a single loss.[99]

As both McMaster's and Bennett's experiences demonstrated, medical training, both theoretical and practical, was an important part of the enlisted men's early experience of the RAMC, not least because a higher rate of pay was contingent upon being able to demonstrate specialist medical knowledge.[100] However, it is

important to note that the military work of parading, route marching, and fatigues was also a key element of men's experiences of this period. Initial training involved a process by which these men were being turned from non-medical civilians into soldiers as well as medical care providers. The emphasis placed on the more general military training and inculcation of fitness through route marching could, as McMasters demonstrates in his letters, be perceived as too great in relation to their medical training, reflecting the belief of a number of these men that the RAMC was a unit with a specific identity which required a focus on specialist training and practical experience in hospitals. However, it also accorded with the more general grousing about **(p.78)** fatigues and route marches among recruits to combatant units during initial training.[101]

As well as outlining general initial training, the RAMC training manual instructed that 'To enable men to undertake [their] duties efficiently they must of necessity undergo not only a course of preliminary technical training, but continuous training throughout their service, so that in war their duties may be performed with the thoroughness and efficiency which must be the aim and object of every soldier of the Corps.'[102] However, where initial training was generally perceived as being useful if rather unbalanced by the men who underwent it, the provision of continuous training was seen as problematic because it was delivered erratically and inconsistently. Bennett, who was posted to Gallipoli in August 1915, received additional training en route in the form of lectures on diseases while on board ship.[103] George Swindell, by comparison, recalled that, at his initial posting in France, 'All we did … were a few fatigues, and guards, and many of us were studying in our spare time, the R.A.M.C. manuals, to teach, and refresh our memories, how to carry and bandage wounded, which we believed was the way we should carry on.'[104] In addition to the formally issued training manual, Swindell might have made reference to any number of privately published manuals, such as S. T. Beggs's *Guide to Promotion for Non-Commissioned Officers and Men of the Royal Army Medical Corps* (1914), a condensed version of the official manual laid out in an examination style, and Georges M. Dupuy's *The Stretcher Bearer: A Companion to the R.A.M.C. Training Book, Illustrating the Stretcher-Bearer Drill and the Handling and Carrying of the Wounded* (1915), a heavily illustrated supplement which provided visual reinforcement of the official manual's directions. The existence of such literature, and the implication of Swindell's recollections that such studies were self-motivated rather than officially instituted, indicate the extent to which the official declaration of the need for continuous specialist training was often an aspiration rather than a reality. The demands of modern warfare, and the changing nature of medical care provision over the course of the war, as will be discussed in Chapter 4, meant that the development of RAMC rankers' skills following their initial training occurred primarily through hands-on experience in the field and through self-education rather than additional formal training.[105]

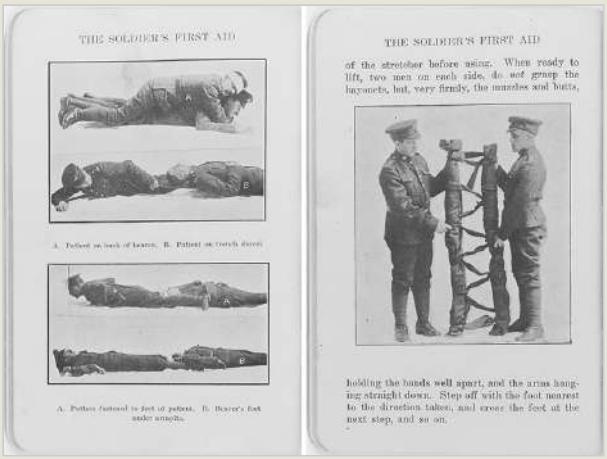
**(p.79)** At the same time combatant servicemen were increasingly developing medically related knowledge and skills. They were required to attend regular lectures on subjects such as the use of first field dressings and sanitation, such as those given ‘by F. F. McCabe … to troops at Le Havre, in which he emphasized the soldier’s responsibility in just about every matter of health, from oral hygiene and personal cleanliness, through to ventilation and conservancy of his living quarters’.[106] Soldiers certainly learned to value personal cleanliness, for psychological as much as physical reasons.[107] Their willingness to assume responsibility for their physical health through a knowledge of medical practice is demonstrated by the publication of volumes such as *The Soldier’s First Aid: A Simple Treatise on How to Treat a Sick or Wounded Comrade* (1917), written by a self-proclaimed Quartermaster Sergeant in the RAMC. Intended ‘to supply the need for a manual, simple and direct, and written in language which can easily be understood by all’, R. C. Wood’s book claimed to ‘make the reader competent to render skilled assistance to his comrade sin the hour of need’.[108] Although it is impossible to tell how widely read such volumes were, their very existence indicates the extent to which first aid, which was part of the stock-in-trade of the RAMC ranker, was viewed by the military as a non-specialist skill set which could and should be acquired by all responsible servicemen.[109]

While the skill base of RAMC rankers in terms of knowledge of first aid and medicine increasingly merged with that of their combatant equivalents over the course of the war, the same cannot be said for these men’s roles as transport providers. Developments of medical care provision involved the creation of specialist transport units such as the MAC and the integration of non-combatants from other specialist units into RAMC establishments, namely the men of the RASC who provided expertise in the running and maintenance of mechanical transport. However, the work of RAMC rankers in clearing the battlefield meant that their role in providing all forms of transport along the chain of evacuation remained of great relevance. The importance of this role is reflected in the amount of time devoted to drill in the syllabus laid out for camp training in the *Training Manual*.[110] While drill for combatant servicemen included target **(p.80)** practice and bayonet drill, as well as the physical training which had reached its apogee as a facet of military training in the years before the war,[111] for RAMC servicemen drill focused on the skills of stretcher bearing, tent pitching, and loading and unloading ambulance waggons.

While the increased industrialization of warfare threw the utility of aspects of military training such as combat drill into question as the war proceeded, the skills inculcated by medical drill were never in question. Even manual stretcher bearing, which was open to potential challenge from the increased mechanization of transport,[112] remained an important skill. Stretcher drill continued to involve at least an hour a day of exercises and lectures related to the removal of the sick and wounded from battlefield to base as part of initial training throughout the war.[113] As part of this drill men were to be ‘exercised in

carrying the loaded stretcher over various obstacles, and taught the methods most suitable for the safe carriage of the patients'.[114] Exercises were, therefore, to be carried out over 'rough ground', with 'special attention … [being] paid to the carriage of the stretcher so as to keep it level and avoid jolting or unnecessary swaying'.[115] The privately produced manual *A Guide to Promotion for Non-Commissioned Officers and Men of the RAMC* included a seven-question interrogation of how a stretcher should be carried up and down hill, as well as over uneven ground, with emphasis placed on the fact that 'under all circumstances' the stretcher should be carried in a horizontal position. This was to be achieved 'By practising the carriage of stretchers over uneven ground until the bearers become trained and habituated to perform this duty with ease and dexterity and comfort to the patient.'[116] The guide also contains a six-step description of how to carry a loaded stretcher across a ditch, with the emphasis again placed on maintaining the stretcher in as horizontal a position as possible under all circumstances.[117] The knowledge that such drill instilled in bearers was reflected in George Swindell's comment about 'a lot of the pioneer battalion, [who] were told off to help us, six to a stretcher, to our four to a stretcher. This was not being because we were stronger, but because we were trained, to carry it the easiest way.'[118] Increasingly, the specialist expertise of the **(p.81)** RAMC ranker came to be located in their transportation skills rather than their medical knowledge.

While the acquisition of such expertise appears from texts such as *A Guide to Promotions* to derive from an explicit set of rules laid down to be followed, it is worth noting that one particular skill not merely acknowledged but actively encouraged by the official training manual and other volumes was that of improvisation. The manual devotes an entire (if short) chapter to the subject, detailing specifics of how to improvise a variety of medical equipment, including tourniquets, splints, carriage, sanitation, and shelter, in the field.[119] R. C. Wood, meanwhile, notes in his introduction to *The Soldier's First Aid* that 'Improvisation is the special feature dwelt upon [in the book], showing the best and most efficient use that may be made of the material at hand in the treatment of the patient.'[120] This included the use of clothing to substitute for dressings and the ability to create stretchers out of puttees, greatcoats, and rifles, as well as the various methods used to carry wounded men without a stretcher at all (Figure 2.3). Nor were medicine and transport the only fields within which men were instructed to improvise. A sterilizer could be manufactured from 'two biscuit tins and a butter tin',[121] while the training manual deemed it 'essential that officers and men should know how to construct simple shelters for themselves and the wounded who may be in their charge. Instructions regarding the construction of bivouacs and shelters will be found in the Manual of Field Engineering.'[122]


THE SOLDIER'S FIRST AID

THE SOLDIER'S FIRST AID

of the stretcher before using. When ready to lift, two men on each side, do not grasp the bayonets, but, very firmly, the muzzles and butts,

holding the hands well apart, and the arms hanging straight down. Step off with the foot nearest to the direction taken, and cross the feet at the next step, and so on.

*Fig. 2.3.* 'Collecting the wounded under fire' and 'improvised stretcher'; *The Soldier's First Aid*, pp.78, 92.

As this last instruction indicates, the expertise expected of military medical personnel was broad as well as specialized, requiring familiarity with manuals of instruction beyond those assigned for their own field. In addition to medical knowledge, physical skills, and familiarity with engineering, RAMC servicemen received training in the laws of war, through lectures on the Geneva Convention and in a variety of military skills unrelated to direct combat. For example, the visualization of landscape was a central element to the process of medical evacuation. Stretcher bearers had to be able to identify and note 'ground suitable for moving wounded to or over',[123] while officers had to be able to evaluate landscapes in order to successfully locate aid posts and dressing stations, as well as communicating these locations and landscapes to those who would need to traverse them. RAMC officer training included lectures on 'The **(p.82)** working of the lines of communication, with special reference to the evacuation of the wounded, provision of hospitals, etc., selection of routes for evacuation of sick and wounded, and the general principles which regulate their choice' and 'Map reading and simple field sketching … the object in view being to enable an officer to reach a point indicated by reference to a map, to describe the proposed site of a hospital, etc., or to send in a rough sketch of such things as a dressing station, a hospital site, or a building with its surroundings and approaches, according to the accepted methods.'[124] For both officers and men, therefore, the ability to evaluate and communicate the landscapes over which evacuation and within which treatment would occur were vital skills.

While the development of such skills might be considered general, applicable to all branches of the armed services, the ability to evaluate and negotiate landscapes acquired particular specialist significance as the war progressed. Delays in the evacuation of the wounded caused by **(p.83)** problems of negotiating landscapes had significant consequences both for individual wounded men and battlefield logistics.[125] Yet the shifting nature of the landscape defined the speed of the evacuation process. Bearers used damaged buildings, groups of trees, and even dead and rotting corpses as landmarks for their journeys. On the Western Front, as land was fought over and bombarded again and again, this intimate landscape could alter on a daily, or even an hourly,

basis, affecting men's ability to move through it successfully. Lost bearer units were not uncommon, delaying the speed with which a wounded man was collected and transported successfully to a point where he could be treated, thereby affecting the ultimate success of such treatment.[126] The bearers of the 6th London Field Ambulance '[r]egularly … lost our way [on the Somme], the one and only landmark being High Wood. … I recall one journey when my squad toiled for seven solid hours carrying one case from the aid post near Eaucourt to High Alley.'[127] Swindell recalled a similarly featureless landscape where 'there were no dug-outs, or anything in it, the two sides of the valley, were just earth colour, not a bit of colour for hundreds of yards, the shell holes, linked, and over lapped, the whole length'.[128] These descriptions highlight the hardship of the labour of stretcher bearing, but also show bearers reflecting on the skills they developed in negotiating such problematic landscapes, skills which they had trained for through drill but which were only fully established through practice.

## Conclusion

The training of RAMC servicemen thus tried to address the complex interface between the requirements of medical care and military necessity that defined one of the paradoxes of military medical service in wartime. As the *Training Manual* put it, the goal of RAMC training was to develop 'the initiative and self-reliance of the NCOs [non-commissioned officers] **(p.84)** and men to best fit them for the performance of the *various* duties in war'.[129] (my emphasis). This, the manual acknowledges, meant that 'it is not possible or desirable to lay down any hard and fast rules. Force of circumstances, as well as general surroundings and geographical position at the time, all enter largely into these matters.'[130] Nonetheless, the training involved in drill and instruction remained a necessary part of the creation of a cohesive unit with specific skills and knowledge relating to the provision of medical care in wartime, as was reflected in men's experiences. In giving a diverse group of recruits the structure and training to improvise care in the extremes of war, the RAMC developed over the course of the war into a unit with a specific non-combatant identity based on a particular skill set attained by no other unit. While in no way defined as professional by the demarcationary practices of either exclusion or examination, as discussed in Chapter 1,[131] the possession of a unique range of skills and the knowledge to use them innovatively, acquired both through initial training and practical application, provided the men of the RAMC with the foundations on which to base their claims to appropriate masculine service in wartime. At the same time, the lack of clear professional boundaries around the work that these men were trained to undertake had the power to leave rankers stranded between the authority of their medically trained officers and the trained nurses whose role was increasingly socially validated and the dominant masculinity[132] of their military-trained comrades in 'teeth' units.

Training thus reinforced the ambiguities of unit identity which were evident in the process of recruitment. In both cases, the most important factor in creating such ambiguities was the non-combatant nature of the unit. While non-combatant training gave the men of the ranks of the RAMC a particular skill set relative to both military training and medical caregiving, the impact of non-combatance was more negative in terms of the recruitment process. The physical fitness and age range of recruits to the Corps changed over the course of the war in response to the military's need for combatant manpower. At the centre of recruitment policy, however, was the consistent understanding that these recruits were valued less highly as physical specimens of manhood than combatant troops were. Recruitment to the RAMC thus posed a consistent challenge to hegemonic ideals of wartime masculinity, particularly service masculinity, whatever the specific parameters for recruitment at work at any given time.

**(p.85)** These negative connotations were reinforced by the involvement of voluntary humanitarian services in the process of both recruitment and training. The strong association with non-military sources of care provision in wartime, and with organizations that also recruited and trained women and conscientious objectors for caring roles, raised questions about the purpose of a male military medical unit in the context of a society engaged in total war. Over the course of the war, the men of the RAMC sought to answer these questions through the work they undertook along the chain of evacuation from front line to home front. How this labour and men's experiences of it were shaped by space and time forms the subject of Chapters 3 and 4.

Notes:

([1]) Randle, letter to Mother and Father, TS transcript, 6 August 1914, Letters of David Randle McMaster, RAMC/023, Army Medical Services Museum, Keogh Barracks, Aldershot.

([2]) Michael Paris, *Warrior Nation: Images of War in British Popular Culture, 1850–2000* (London: Reaktion Books, 2000), pp.83–109.

([3]) For further discussion of the conflicting motivations of young British men of religious convictions who volunteered for medical service in wartime, see Jessica Meyer, 'Neutral Caregivers or Military Support?: The British Red Cross, the Friends' Ambulance Unit, and the Problems of Voluntary Medical Aid in Wartime', *War and Society* 34 (May 2015): 105–20.

([4]) Harrison, *The Medical War*, p.4.

([5]) Whitehead, *Doctors in the Great War*, pp.32–106.

([6]) On the social and cultural complexities of the voluntary system, see Gregory, *The Last Great War*, pp.73–81.

([7]) Whitehead, *Doctors in the Great War*, p.33.

([8]) Keith Grieves, *The Politics of Manpower, 1914–18* (Manchester: Manchester University Press, 1988), p.1.

([9]) Whitehead, *Doctors in the Great War*, p.60.

([10]) James McDermott, *British Military Service Tribunals, 1916–1918: 'A very much abused body of men'* (Manchester: Manchester University Press, 2011), pp.15–16.

([11]) Whitehead, *Doctors in the Great War*, p.60. The Military Services Act complicated the voluntary arrangement by which doctors holding a temporary commission in the RAMC were engaged for twelve months or until the end of the war, whichever was shorter, forcing those at the end of their year's service to re-enrol immediately on the understanding that they would not be selected for a second period of service unless they either actively re-engaged or no equally eligible doctor was available. This situation required the voluntary cooperation of all eligible doctors. (Ibid., pp.60–1.)

([12]) Ibid., p.79.

([13]) This was in addition to the increasing number of trained female doctors who were used by the War Office to 'relieve male doctors in home hospitals and act as locum-tenentes.' (Ibid., p.107.)

([14]) Ibid., pp.83–4.

([15]) Hallett, *Veiled Warriors*, pp.179–84.

([16]) Auxiliary hospitals refer to those 'established and equipped by voluntary aid organizations and private individuals' (McPherson, *History of the Great War*, Vol. 1, p.83), which came under the authority of the Joint War Committee of the British Red Cross and Order of St John. They were distinct from both the established military hospitals and the Territorial Forces hospitals which mobilized in 1914. Both of these were administered directly by the War Office. See Chapter 4, pp.149–50.

([17]) Sue Light, 'The Territorial Force Nursing Service 1908-1921: An Outline', http://www.scarletfinders.co.uk/92.html#_edn8, last accessed 9 February 2016.

([18]) Sue Light, 'Before the War', *The Fairest Force*, http://www.fairestforce.co.uk/3.html, last accessed 9 February 2016.

([19]) 'Suggestions for the Reorganisation of the RAMC', undated, WO 30/114/9, TNA. The rapid expansion of the reserve forces of the military nursing service increased the range of social classes of those who served in these roles and

consequently received more formal, professionalized training, although the demands of wartime service served to squeeze the time available for these women to gain experience in home hospitals before overseas deployment.

([20]) Hallett, *Containing Trauma*, p.46.

([21]) British women doctors did serve with authorization if not necessarily the authority of the War Office. The Women's Hospital Corps (WHC), for example, established a hospital at the Hôtel Claridge in Paris, which was soon being treated as an auxiliary hospital by the RAMC. The War Office then invited the unit to establish a hospital at Wimereux. (Whitehead, *Doctors in the Great War*, p.107).

([22]) Hallett, *Containing Trauma*, pp.1–2; Whitehead, *Doctors in the Great War*, pp.120–2; Leneman, 'Medical Women at War'.

([23]) Hallett, *Veiled Warriors*, p.33.

([24]) Macpherson, *History of the Great War*, Vol. 1, p.141.

([25]) Watson, *Fighting Different Wars*, pp.59–104. On the historical memory and commemoration of women's wartime work, see Deborah Thom, 'Making Spectaculars: Museums and How We Remember Gender in Wartime', in Braybon, *Evidence History and the Great War*, pp.48–66.

([26]) Grieves, *The Politics of Manpower*, p.2; Winter, *The Great War and the British People*, pp.25–48.

([27]) War Office, *Royal Army Medical Corps Training* (London: His Majesty's Stationary Office, 1911; repr. 1915), p.1.

([28]) A. L. G. Whyte, 'Memoirs of the Great War, 1914–18', TS memoir, pp.1–2, Papers of Archibald L. G. Whyte, Liddle/WW1/GS/1728, LC.

([29]) Mayhew, *Wounded*, p.18.

([30]) This compares with soldier orderlies from the Crimean War, 370 of whom were reappointed retired servicemen 'aged between forty and forty-five … [and] physically unequal to the work'. (Furneaux, *Military Men of Feeling*, p.195).

([31]) Jay Winter argues that the definition of 'fitness for military service … was ambiguous in the extreme. Partly this uncertainty was due to the state of diagnostic medicine at the time; partly, to the pressure of work in processing millions of recruits in a short space of time. But it was also due to the difficulty of having to establish for the first time a medically-defensible standard of military fitness … which would give the army the men it needed.' (*The Great War*

*and the British People*, p.50.) The pre-war use of bandsmen would seem to indicate that elements of this ambiguity predate wartime recruitment practices.

([32]) Richard van Emden, *Boy Soldiers of the Great War* (London: Bloomsbury, 2008), pp.6, 19.

([33]) Mark Harrison has pointed out that the British method of supplying stretcher bearers was unreliable in comparison to those employed in these roles in the French and German armies, which both possessed regimental services supplying permanent bearer corps to each division. (Harrison, *The Medical War*, p.19.)

([34]) Mayhew, *Wounded*, pp.18–19.

([35]) Macpherson, *History of the Great War*, Vol. 1, p.138.

([36]) Grieves, *Politics of Manpower*, p. 8.

([37]) Macpherson, *History of the Great War*, Vol. 1, p.27.

([38]) Ibid., p.49.

([39]) Ibid., p.50.

([40]) Harrison, *The Medical War*, p.26.

([41]) Ibid., pp.124–42.

([42]) MacPherson, *History of the Great War*, Vol. 1, p. 138.

([43]) Swindell, ‘In Arduis Fidelus’, p.1.

([44]) J. B. Bennett, ‘Memories of Gallipoli, August 1915-December 1915 at Sulva Bay and Anzac’, TS memoir, pp.1–2, Papers of J. B. Bennett, LIDDLE/WW1/GS/0119, LC.

([45]) Winter, *The Great War and the British People*, p.50; Gregory, *The Last Great War*, pp.30–3. Blind-eye turning also predated the war, with Whyte recalling that his medical assessment in 1908 included the sergeant major ‘[h]olding up an ordinary sight-testing card with letters of various sizes [and] … ask[ing] me how many I could read. When I replied, “None”, he told me I was expected to read a number of the letters without glasses, whereas I was wearing mine. Taking a step towards me he asked how many I could read then, but I still had to give the same reply. Taking another pace forward he said, “For Christ’s sake, read a letter and I’ll pass you”, so I immediately said “B”, and that is how I was finally accepted as a recruit to the 3rd. East Anglian Field Ambulance, R.A.M.C. (T).’ (Whyte, ‘Memoirs of the Great War’, pp.2–3.)

([46]) Macpherson, *History of the Great War*, Vol. 1, p.138.

([47]) Ibid., pp.138–9. The late-1915 spike may have reflected the increased demands being placed on the medical services by the levels of illness suffered during the Gallipoli Campaign (February 1915–January 1916).

([48]) Winter, *The Great War and the British People*, p.41.

([49]) Macpherson, *History of the Great War*, Vol, 1, p.139.

([50]) Ibid., p.138.

([51]) Edward Madigan, *Faith Under Fire: Anglican Army Chaplains and the Great War* (Basingstoke: Palgrave Macmillan, 2011), pp.45–6. Madigan points out that only a small percentage of the 600 Church of England clergymen who applied for commissions as military chaplains in the first three months of the war were successful, leaving many to seek non-combatant service elsewhere (p.48).

([52]) Macpherson, *History of the Great War*, Vol. 1, p.138.

([53]) Ibid., p.140.

([54]) This shift reflects the overall social make-up of the British armed forces during the war, which, as Jay Winter has shown, ‘were not a cross-section of British society. Rather, the higher up in the social scale a man was, the greater were the chances that he would serve from early in the war’ (Winter, *The Great War and the British People*, p.25).

([55]) Macpherson, *The History of the Great War*, p.140.

([56]) ‘Notes from Old Friends’, *The ‘Southern’ Cross: The Monthly Journal of the 1st Southern General Hospital, Birmingham* 1 (June 1916): 148; ‘History of the 1st Southern General Hospital’, *The ‘Southern’ Cross* 2 (July 1917): 166–7; ‘Obituary: Private Edward Guy’, *The ‘Southern’ Cross* 2 (October 1917): 254; ‘Obituary: Private W. F. Prince’, *The ‘Southern’ Cross* 3 (1918): 44; ‘Obituary: Private C. T. Hillman’, *The ‘Southern’ Cross* 3 (1918): 81; ‘Obituary: Private R. T. Astell’, *The ‘Southern’ Cross* 3 (1918): 143; ‘Obituary: Private W. H. Jones’, *The ‘Southern’ Cross* 3 (1918): 144.

([57]) Ward Muir, *Observations of an Orderly: Some Glimpses of Life and Work in an English War Hospital* (London: Simpkin, Marshall, Hamilton, Kent, & Co., Ltd, 1917), p.152.

([58]) F. W. Parry, *The Commonwealth Armies: Manpower and Organisation in Two World Wars* (Manchester: Manchester University Press, 1988), p.24

([59]) Macpherson, *History of the Great War*, Vol. 1, p.144.

([60]) Ibid., p.139.

([61]) Sue Light, ‘The Work of the Nursing Staff in Connection with the Casualty Clearing Stations in 1914, Early 1915 and at a Later Date’, http://scarletfinders.co.uk/10.html, last accessed 15 February 2016.

([62]) *Reports by the Joint Committees,* p.81.

([63]) MacPherson, *History of the Great War*, Vol. 1, p.141.

([64]) ‘History of the 1st Southern General Hospital’, *The ‘Southern’ Cross* 2 (June 1917): 139.

([65]) Ibid.: 166.

([66]) Ibid.: 166.

([67]) ‘Editorial’, *The ‘Southern’ Cross* 3 (1918): 27.

([68]) E.C.B., ‘Obituary: Staff-Sergt. E. C. White, R.A.M.C.T.’, *The ‘Southern’ Cross* 3 (1918): 44–5.

([69]) Frank Ridsdale, Diary, 5 October 1916, Papers of Frank Ridsdale, LIDDLE/WW1/GS/1355, LC.

([70]) Randle, Letter to Mother and Father, 25 February 1917, Letters of David Randle McMaster.

([71]) W. G. Macpherson, *History of the Great War*, Vol. 2, p.166.

([72]) Some hospitals, such as the famous voluntary hospital at the Abbaye de Royaumant, were run entirely by the women who volunteered with the Scottish Women’s Hospitals. Significantly, however, these units served under the authority of non-British voluntary and medical services—in the case of Royaumant, the French Red Cross. The Scottish Women’s Hospitals also worked in Macedonia, Greece, Corsica, Romania, Russia, and, most notably, Serbia over the course of the war. (http://scottishwomenshospitals.co.uk/, last accessed 27 November 2017.)

([73]) Andrew Macphail, *The Medical Services* (Ottawa: Minister of National Defence, under the direction of the General Staff, 1925); Arthur G. Butler, *The Australian Army Medical Services in the War of 1914–1918*, 3 vols (Melbourne: Australian War Memorial, 1938–43).

([74]) Macpherson, *History of the Great War*, Vol. 2, p.84.

([75]) Many voluntary units were initially rejected for overseas service by the War Office, so offered their services instead directly to Allied nations. These

included, most notably, Belgium, France, and Serbia, with many serving under the authorization of national Red Cross Associations of these nations.

([76]) In total, 35,342 male VADs served in BRCS and St John Ambulance units over the course of the war. This compares with the 90,651 female VADs supplied by the Committee. (*Reports by the Joint Committees*, p.190.)

([77]) *Reports by the Joint Committees*, p.342.

([78]) Ibid., p.341.

([79]) The journalist Geoffrey Winthrop Young, one of the founder members of the unit, recalled his first introduction to the idea of the unit: ‘On a day’s rest in London from my news-seeking, Philip J. Baker came to tell me of the conflict between traditional principles and the call of their country which many young Friends (especially at Cambridge) were finding themselves, and of his intention to form them into a trained ambulance corps for field work.’ (Geoffrey Winthrop Young, *The Grace of Forgetting* (London: Country Life Ltd, 1953), p.182.)

([80]) Young, *The Grace of Forgetting*, pp.183–4.

([81]) McDermott, *Military Service Tribunals*, p. 41.

([82]) Bibbings, *Telling Tales About Men*, p. 29.

([83]) Corder Catchpool quoted in John Ormerod Greenwood, *Quaker Encounters: Volume 1: Friends and Relief* (York: William Sessions Limited, 1975), p.183. An ‘absolutist’ conscientious objector refused to undertake any form of military service or obey military orders. Many were arrested when, upon being conscripted, they refused the order to put on military uniform. (Bibbings, *Telling Tales About Men*, p.102.)

([84]) War Office, *Royal Army Medical Corps Training*, p.13.

([85]) Harrison, *The Medical War*, p.9.

([86]) Ibid., p.126.

([87]) Advisory Board for Army Medical Services and the Nursing Board, ‘Conjoint Report of the Advisory and Nursing Boards’, p.2.

([88]) War Office, *Royal Army Medical Corps Training*, p.294.

([89]) James Cantlie, *First Aid to the Injured: Arranged according to the revised syllabus of the first aid course of the St. John Ambulance Association*, 30th edn (London: The St John Ambulance Association, 1916), p.20. On the relationship

between professional medical men and first-aid providers, see Frampton, ‘Amateur Surgeon or Dutiful Citizen?’

([90]) War Office, *Royal Army Medical Corps Training*, p.269.

([91]) Whyte, ‘Memoirs of the Great War, 1914–18’, p.3.

([92]) Ibid., pp.3–4.

([93]) Ibid., p.12. On the innovation of the Cambridge ward system, see Reznick, *Healing the Nation*, pp.46–51.

([94]) Randle, Letter to Mother and Father, n.d., Letters of David Randle McMaster.

([95]) Randle, Letter to Mother and Father, 29 August 1914, Letters of David Randle McMaster.

([96]) Randle, Letter to Mother and Father, n.d., Letters of David Randle McMaster.

([97]) Ibid.

([98]) Randle, Letter to Mother and Father, 21 September 1914, Letters of David Randle McMaster.

([99]) Bennett, ‘Memories of Gallipoli’, p.4, Papers of J. B. Bennett.

([100]) Advisory Board for Army Medical Services and Nursing Board, ‘Cojoint Report of the Advisory and Nursing Boards’, pp.55–6.

([101]) Meyer, *Men of War*, p.18.

([102]) War Office, *Royal Army Medical Corps Training*, p.269.

([103]) J. B. Bennett, Diary, MS, 4 August 1914, Papers of J. B. Bennett.

([104]) Swindell, ‘In Arduis Fidelus’, p.77.

([105]) This was also the case with VAD nurses, reflecting the state of non-professional medical care within the military medical services for both sexes. There were, however, exceptions, with some individual medical officers taking great pains to train the men under their command. (Mayhew, *Wounded*, p.49.)

([106]) Harrison, *The Medical War*, p.132.

([107]) Meyer, *Men of War*, p.65.

([108]) R. C. Wood, *The Soldier's First Aid: A Simple Treatise on How to Treat a Sick or Wounded Comrade* (London: Macmillan, 1917), Preface.

([109]) Frampton, Sally, 'Amateur Surgeon or Dutiful Citizen? The First Aid Movement in the Nineteenth Century', *Remedia*, 2 November 2015.

([110]) War Office, *Royal Army Medical Corps Training*, pp.10–11.

([111]) James D. Campbell, *'The Army Isn't All Work': Physical Culture and the Evolution of the British Army, 1860–1920* (Farnham: Ashgate, 2012), pp.105–12.

([112]) See Chapter 4, pp.139–43.

([113]) War Office, *Royal Army Medical Corps Training*, pp.10–11.

([114]) S. T. Beggs, *Guide to Promotions for Non-Commissioned Officers and Men of the Royal Army Medical Corps* (London: Gale & Polden Ltd, 1914), p.61.

([115]) War Office, *Royal Army Medical Corps Training*, pp.211, 221.

([116]) Beggs, *Guide to Promotions*, 165–6.

([117]) Ibid., pp.166–7.

([118]) Swindell, 'In Arduis Fidelus', p.224.

([119]) War Office, *Royal Army Medical Corps Training*, p.367.

([120]) R. C. Wood, *The Soldier's First Aid: A Simple Treatise on How to Treat a Sick or Wounded Comrade* (Toronto and London: Macmillan, 1917), preface.

([121]) H. M. W. Gray, *The Early Treatment of War Wounds* (London: Joint Committee of Henry Frowde and Hodder & Stoughton, 1919), p.25.

([122]) War Office, *Royal Army Medical Corps Training*, p.249.

([123]) Ibid., p.9.

([124]) Ibid., pp.5–6.

([125]) Carden-Coyne, *The Politics of Wounds*, pp.25–8.

([126]) Damage to the landscape affected motor transport as much as manual carries. Shell-damaged roads, as well as the priority given to moving men and munitions up to the front over those being evacuated away from it, created delays and disruptions. As a consequence, ambulance journeys could be fatal, with poorly sprung ambulances, many converted from private motor cars, and the pavé roads of northern France and Flanders often combining to turn the

movement of the evacuation process through the landscape into a painful, even lethal, experience for the patient. (Carden-Coyne, *The Politics of Wounds*, p.56.)

([127]) ‘Stretcher-Bearers on the Somme’, *6th London Field Ambulance (47th London Division) History*, TS, p.2, RAMC 801/20/5, WL.

([128]) Swindell, ‘In Arduis Fidelus’, p.215.

([129]) War Office, *Royal Army Medical Corps Training*, p.7.

([130]) Ibid., p.367.

([131]) Chapter 1, pp.47–8.

([132]) R. W. Connell, *Masculinities*, 2nd ed. (Cambridge: Polity Press, 1995), p.261.