

JESSICA MEYER

AN EQUAL BURDEN

THE MEN OF THE ROYAL ARMY MEDICAL
CORPS IN THE FIRST WORLD WAR

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You who, in Nissen or in shack
In dug-out, tent or bivouac
From Wypers to Jerusalem
Just stuck it out and played the game
Of picking up and patching 'em:
M.O.s, Non-Coms and Other Ranks,
To you this book: fill in the blanks!

David Rorie, 'Dedication',
A Medico's Luck in War, 1929

This book is dedicated to my parents
Joanna Anderson (1945–2018) and John P. Meyer
with love.

J. M.

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List of Abbreviations

ADMS	Assistant Director of Medical Services
ADS	Advance Dressing Station
AFSU	American Field Service Unit
AHC	Army Hospital Corps
AMD	Army Medical Department
AMS	Army Medical Services
BMJ	British Medical Journal
BRCS	British Red Cross Society
CBRCC	Central British Red Cross Committee
CCS	Casualty Clearing Station
CMWC	Central Medical War Committee
FA	Field Ambulance
FANY	First Aid Nursing Yeomanry
FAU	Friends Ambulance Unit
GOC	General Officer Commanding
ICRC	International Committee of the Red Cross
LAC	London Ambulance Corps
MAC	Motor Ambulance Convoy
MDS	Main Dressing Station
MO	Medical Officer
NAMNC	Navy and Army Male Nursing Co-operation
NAS	National Aid Society
NCC	Non-Combatant Corps
NCO	Non-Commissioned Officer
QAIMNS	Queen Alexandra's Imperial Military Nursing Service
RAMC	Royal Army Medical Corps
RAMC(T)	Territorial Army Medical Corps
RAP	Regimental Aid Post
RASC	Royal Army Service Corps
RMO	Regimental Medical Officer
SMSEC	Scottish Medical Services Emergency Committee
TA	Territorial Army
TF	Territorial Force
TFNS	Territorial Forces Nursing Service
VAD	Voluntary Aid Detachment
VC	Victoria Cross

Unarmed they bore an equal burden,
Shared each adventure undismayed;
Not less they earned the Victor's guerdon,
Not least were these in the crusade.

R. B. P., 'Hymn to the Fallen of the
Royal Army Medical Corps', 1947

Introduction

In his memoir of service in the First World War, George Swindell, sometime Royal Army Medical Corps (RAMC) stretcher bearer, recalled that, after he had enlisted, ‘the sergeant met me coming out, come here my lad, shake hands, you have joined one of the finest Corps in the British Army’. Swindell had, by his own admission, ‘not the slightest idea what kind of work, or what duties of the Corps I had joined were’,¹ yet, on the evidence of his narrative, he came to agree with the sergeant.

While Swindell, like many of his comrades in the RAMC during the war years, came to believe passionately in the utility of his contribution to the war effort and the value of a medical service to the military, this view was not necessarily one that was widely accepted in Britain during the war years. The Crimean War had left a legacy of disdain for male military medical caregivers² which continued to shape the status of the Army Medical Services (AMS) over the next half-century. Even after their embodiment as a Royal Corps in 1898, members of the Corps felt compelled to continuously articulate the value of their work well into the twentieth century. As late as 1947 the ‘Hymn to the Fallen of the RAMC’ addressed the unease which persisted around the war work of a unit that undertook military service unarmed and with the aim of saving rather than taking life. The explicit statement that the sacrifice made by the men of the Corps who had died was ‘not less’ than others, that these men were ‘not least’ of the fallen of war, points to the underlying anxiety that the Corps’ work in bringing mercy, relieving wounds, and assuaging torment was not sufficient to lay claim to the full heroism associated with male military duty and sacrifice.³ Central to this sense of insufficiency was the explicit construction of the medical services as a non-combatant unit, a fact that, throughout the global wars of mass mobilization that shaped the first

¹ George Swindell, ‘In Arduis Fidelus: Being the story of 4 ½ years in the Royal Army Medical Corps’, TS memoir, RAMC 421, WL, p.3.

² Ian R. Whitehead, *Doctors in the Great War* (London: Leo Cooper, 1999), pp.6–10; Holly Furneaux, *Military Men of Feeling: Emotion, Touch, and Masculinity in the Crimean War* (Oxford: Oxford University Press, 2016), p.204.

³ Jessica Meyer, *Men of War: Masculinity and the First World War in Britain* (Basingstoke: Palgrave Macmillan, 2009).

half of the twentieth century, would profoundly influence its identity and that of the men who served in it.

The anxieties around the unarmed nature of military medical service had particular pertinence for men like George Swindell, who served in its ranks for the temporary period of wartime mobilization. Unlike the Corps officers, who were required to hold medical degrees, the men of the ranks were not professional medical men.⁴ Unlike servicemen in ‘teeth’ units, those which bore arms, they struggled to draw on the fictive kinship of the regimental system.⁵ As a result, across the four and a half years of the First World War, their service, whether as volunteers or conscripts, could be and was called into question by military authorities and British wartime society more broadly. In a conflict where manpower shortages entailed both increased demand for universal male service to the state centring on the figure of the combatant soldier,⁶ and the consequent increase in employment of women to free men for military service,⁷ the role and status of men whose unarmed service involved the preservation of life, including that of the foe, remained problematic. Yet as recognition of the importance of medicine to military success increased,⁸ these men were able to develop a sense of cohesive cohort identity which allowed them to lay claim to a significant form of military service and therefore social recognition. By the end of the war, the significance of the work of male military medical care providers, rankers as well as officers, was something which could be celebrated by both the state and the military as a key aspect of the Allied victory.⁹ This book examines how this change in status occurred, as well as the limits and ambiguities which persisted in relation to the social position of these men. In exploring how the work of the men of the ranks of the RAMC during the First World War was understood and represented in British society, and how this shaped the status of military medicine as an appropriate form of masculine service in wartime, it demonstrates the complex impact of total war on medicine as a gendered practice.

* * *

⁴ Whitehead, *Doctors in the Great War*, pp.15–16.

⁵ David French, *Military Identities: The Regimental System, the British Army, and the British People, c.1870–2000* (Oxford: Oxford University Press, 2005), p.98.

⁶ Nicoletta F. Gullace, *The Blood of Our Sons: Men, Women, and the Renegotiation of British Citizenship During the Great War* (Basingstoke: Palgrave Macmillan, 2002).

⁷ Lucy Noakes, *Women in the British Army: War and the Gentle Sex, 1907–1948* (London: Routledge, 2006), pp.64–71.

⁸ Whitehead, *Doctors in the Great War*, p.4.

⁹ Ana Carden-Coyne, *The Politics of Wounds: Military Patients and Medical Power in the First World War* (Oxford: Oxford University Press, 2014), pp.44–52; Furneaux, *Military Men of Feeling*, p.203.

Military medicine during the First World War currently forms a dynamic field of study, particularly at the intersections of social history and the history of medicine. Indeed, the early histories of medicine during the war were crucial, as Mark Harrison notes, in ‘establishing the history of medicine as a specialism in its own right’, particularly through the exploration of the development of specific medical fields such as venereal disease, war neurosis, and ‘imperial’ medicine.¹⁰ Such studies continue to thrive and play an important role in developing our understandings of the complex interplay between medicine and the military in the context of total war.¹¹ In doing so, they help to demonstrate ‘how the dynamics of modern capitalism and modern militarism were inextricably bound together. More than this, it allows to be seen how modern physiological medicine as it emerged during the late nineteenth century was constitutive with, or part and parcel of, those same dynamics.’¹²

While historians of physiological medicine have long incorporated the war into their analyses, the military as a space in which medicine was developed as social as much as scientific practice has, until more recently, been less well explored.¹³ Over the past twenty years, however, an increasing range of scholarly studies have begun to emerge, examining how the competing interests of the military services and medical practitioners have shaped patient experience in modern conflicts, as well as the impact of war on civilian medicine.¹⁴ While these have disputed whether changes in medical policy were the direct results of modern conflicts or ‘part of much larger and long-term international process, whereby health care became collectivized as part of the State’s response to the problems of mass industrial society’,¹⁵ as with the medical histories of war such works have tended to view the relationship between war and medicine as one of

¹⁰ Mark Harrison, ‘The Medicalization of War—The Militarization of Medicine’, *Social History of Medicine* 9 (August 1996): 268, DOI: 10.1093/shm/9.2.267.

¹¹ See, for example, Joel D. Howell, “‘Soldier’s heart’: the redefinition of heart disease and specialty formation in early twentieth-century Great Britain”, *Medical History* 29 (January 1985): 34–52, DOI: 10.1017/S0025727300070502; Peter Leese, *Shell Shock: Traumatic Neurosis and the British Soldier of the First World War* (Basingstoke: Palgrave Macmillan, 2002); Marjorie Gerhardt, *The Men with Broken Faces: Gueules Casées of the First World War* (Oxford: Peter Lang, 2015); Roger Cooter, *Surgery and Society in Peace and War: Orthopaedics and the Organisation of Modern Medicine, 1880–1948* (Basingstoke: Macmillan, 1993); Mark Harrison, ‘The British Army and the Problem of Venereal Disease and Egypt during the First World War’, *Medical History* 39 (April 1995): 133–59, DOI: 10.1017/S0025727300059810; Kim Pelis, ‘Taking Credit: The Canadian Army Medical Corps and the British Conversion to Blood Transfusion in WWI’, *Journal of the History of Medicine and Allied Sciences* 56 (July 2001): 238–77, DOI: muse.jhu.edu/article/15267.

¹² Roger Cooter, ‘Medicine and the Goodness of War’, *Canadian Bulletin of Medical History* 7 (Fall 1990): 154–5, DOI: 10.3138/cbmh.7.2.147.

¹³ Harrison, ‘The Medicalization of War’, 269.

¹⁴ Ibid., 269–70.

¹⁵ Ibid., 270.

both disciplinary and social progress. In relation to the First World War, for example, the fact that wounds overtook disease as the cause of death among military servicemen has been held up as evidence of the improvement of social awareness of sanitation, as well as medical knowledge in the military context.¹⁶

The concept of progress has thus tended to shape analyses of the relationship between medicine and the military. These have, in turn, been positioned as part of the development of modernity, defined by Roger Cooter and Steve Sturdy as ‘a constellation of social processes and forms . . . includ[ing] growth, differentiation and integration of bureaucracy and other organizational and managerial systems; the standardization and routinization of administrative action; and the employment of experts to define and order such systems’.¹⁷ Michael Brown has argued that constructions of medicine as progressive and modern form part of historic trends in medical writing, in which heroic narratives were developed around individual doctors and areas of medical practice during the nineteenth century.¹⁸ While Brown suggests that the ‘military paradigm’ of medical representation ‘shaped an active, public, and overtly masculine identity’ for the discipline, it is worth noting the part such narratives also played in aligning medicine with contemporary understandings of progress and modernity, understandings in which the British military played an important part. As Cooter and Sturdy note, ‘medicine’s involvement in war, in particular, provided a crucial moment for the emergence of many of the material and social technologies that we now see as quintessentially modern’.¹⁹

The tendency of medical histories of the First World War to adopt narratives of heroic progress in depictions of wartime developments has meant that the ‘modernity’ of developing practice in this period was, until recently, ‘rarely questioned; often it is assumed to be historically and sociologically unproblematic—a culturally and politically undifferentiated phase of cultural evolution, or even a material force equivalent to “industrialization”’.²⁰ Such narratives are, however, increasingly being problematized, particularly the domination of the literature ‘by

¹⁶ Mark Harrison, *The Medical War: British Military Medicine in the First World War* (Oxford: Oxford University Press, 2010), pp.292–3.

¹⁷ Roger Cooter and Steven Sturdy, ‘Of War, Medicine and Modernity: Introduction’, in *War, Medicine and Modernity*, ed. Roger Cooter, Mark Harrison, and Steve Sturdy (Stroud: Sutton Publishing Limited, 1998), p.1.

¹⁸ Michael Brown, ‘“Like a Devoted Army”: Medicine, Heroic Masculinity, and the Military Paradigm in Victorian Britain’, *Journal of British Studies* 49 (July 2010): 592–622, DOI: 10.1086/652000. See also Deborah Lupton, *Medicine as Culture: Illness, Disease and the Body in Western Societies* (London: Sage Publications, 1994), pp.61–4.

¹⁹ Cooter and Sturdy, ‘Of War, Medicine and Modernity’, p.17. ²⁰ Ibid., p.5.

practitioner-centred accounts of how medicine has benefited from and been advanced by war... [creating] triumphalist reckonings [which] are as implicitly militarist as they are naively positivist and partial'.²¹ Indeed, recent medical histories of the war, such as Leo van Bergen's *Before My Helpless Sight* (2009), have suggested that, far from being progressive, medical care in the First World War was inadequate, with 'too few doctors, nurses, hospitals, operating theatres, drugs and instruments, and too many sick and wounded.' As a result, 'many died who would have lived had it been possible to treat them in time'.²² Further, van Bergen suggests that wartime caregivers themselves were brutalized by their experiences of military care, resulting in medical and technological progress constructed on a foundation that included the mistreatment of patients.²³

Ana Carden-Coyne has similarly argued that the rationalization of care provision which developed over the course of war had the effect of politicizing patients and their pain through the harsh implementation of systems of power and authority. '[P]atients', she argues, 'saw their time in hospital as brutalizing and disempowering, implicating doctors and nurses in the war machine', while 'Surgeons found they had no effective political or institutional tools with which to resolve the intense crisis of humanity that the war and militarization brought about'.²⁴ She goes on to note, however, that patients continued to find agency, mitigating their anxiety through both rebellion and subversion. Doctors were as likely to be 'thoroughly engaged with the technical and medical problems they encountered as they worked to provide the best wound treatment' as they were to be dehumanized by their encounter with the brutality of industrialized war. Indeed, for Carden-Coyne the progressive nature of medical care in the war was, ultimately, epitomized by 'The transition of the moribund ward to the resuscitation tent... [which] symbolized not just medical innovation and a new understanding of the identification and treatment of wound shock, but, crucially for the history of society and warfare, a much greater emphasis on the value of the patient, even when his life-saving treatment was challenging and required more time and resources'.²⁵ This perspective on medical developments in wartime is echoed more recently by Fiona Reid, who argues that:

What is most clear from the collective experience of war and medicine in the years 1914–1918 is that the men who had stayed alive during the war years

²¹ Ibid., p.6.

²² Leo van Bergen, *Before My Helpless Sight: Suffering, Dying and Military Medicine on the Western Front, 1914–1918*, tr. Liz Waters (Farnham: Ashgate, 2009), p.328.

²³ van Bergen, *Before My Helpless Sight*, pp.359–61.

²⁴ Carden-Coyne, *The Politics of Wounds*, pp.338–9.

²⁵ Ibid., p.339.

had developed a clear conception of the moral links between war and medicine. Men of all nationalities came out of the trenches with the firm belief that because they had gone to war they deserved good state-funded medical and social care, not just during the conflict but afterwards too.²⁶

Both Carden-Coyne and Reid build on Roy Porter's call for the incorporation of patient perspectives into the writing of medical history, in combination with readings of official documentation, both military and medical, to demonstrate how 'During the First World War...the military used medicine as an institution of state power'²⁷ for both good and ill. This, in turn, sheds light on the relationships between both the state and providers of care, and patients and their carers in the context of a society at war. This combined methodology has also been used by Mark Harrison in his pivotal volume, *The Medical War* (2010), which examines the full sweep of military medical development in the British Army between 1914 and 1918, including examinations of medicine beyond the Western Front and the place of sanitation in the development of military medicine. This work, as Harrison himself notes, is in part a synthesis of an existing body of literature which has explored systemic developments in military medicine within specific campaigns.²⁸ By integrating official histories and military narratives with patient and practitioner perspectives, Harrison illuminates the wider social significance of military medicine. In demonstrating how medicine 'was an essential effort of *military* operations and of wartime experience' (my emphasis), he shows how 'Medical care...was widely recognized as an important factor in morale',²⁹ something also demonstrated by Carden-Coyne from the perspective of patients negotiating the pain of wounds, treatment, and convalescence.³⁰ Where Harrison and Carden-Coyne focus on British, Dominion, and Imperial troops in their analysis, Reid takes her cue from van Bergen to extend this approach to European comparisons, looking at the medical services of Britain, France, and Germany. All these studies, therefore, tie the history of military medicine into the broader trend in the social history of warfare in the First World War, in which studies of

²⁶ Fiona Reid, *Medicine in First World War Europe: Soldiers, Medics, Pacifists* (New York: Bloomsbury Academic, 2017), p.198.

²⁷ Carden-Coyne, *The Politics of Wounds*, p.4. Carden-Coyne additionally utilizes Foucault's theory of 'biopower' in her discussions (*ibid.*, pp.6–13).

²⁸ Harrison, *The Medical War*, p.14. In relation to theatres outside the Western Front, Harrison notes in particular the work of Michael Tyquin, *Gallipoli: The Medical War: The Australian Army Medical Services in the Dardanelles Campaign of 1915* (Kensington, NSW: New South Wales University Press, 1993) and Eran Dolev, *Allenby's Military Medicine: Life and Death in World War I Palestine* (London: I. B. Tauris, 2007).

²⁹ Harrison, *The Medical War*, p.2.

³⁰ Carden-Coyne, *The Politics of Wounds*.

military morale have become an important fulcrum for understanding both the conflict's trajectory and its wider social significance.³¹

While studies of wartime morale have become an important element of transnational and comparative histories of the war, particularly in relation to strategic and operational histories,³² the social history of military medicine is currently dominated by single-state studies, many of which focus on the histories of British and Dominion forces. The comparative approach taken by van Bergen and Reid is the exception rather than the rule, reflecting more limited historiographies of military medicine in relation to other belligerent nations. While notable histories of medicine in the war do exist,³³ the equivalent of the sheer range of literature produced in relation to the British, Australian, and Canadian war effort has not, as van Bergen notes, yet been produced.³⁴ In taking a social history of military medicine approach to the question of the role and experiences of medical rankers during the war, therefore, this book concentrates on the anglophone literature. It does so, however, in the full acknowledgement that this category of men was in no way unique to the British armed forces and that there is potential for such analysis in relation to the non-combatant male caregivers of other belligerent forces during the war.³⁵

Another important approach taken by more recent histories of medicine in the British armed forces during the war has centred neither on official narratives nor the voices of patients but rather on those of practitioners. Ian Whitehead's *Doctors in the Great War*, for example, looks at the recruitment, training, and practice of British medical officers, and the conflicts between the British Medical Association and the British military

³¹ Key recent texts in the study of morale during the war include Hew Strachan, 'Training, Morale and Modern War', *Journal of Contemporary History* 41 (April 2006): 211–27, <http://www.jstor.org/stable/30036383>; Leonard V. Smith, *The Embattled Self: French Soldiers' Testimony of the Great War* (Ithaca: Cornell University Press, 2007); and Michael Roper, *The Secret Battle: Emotional Survival in the Great War* (Manchester: Manchester University Press, 2009).

³² See, for example, Alexander Watson, *Enduring the Great War: Combat, Morale and Collapse in the German and British Armies, 1914–1918* (Cambridge: Cambridge University Press, 2008) and Jonathan Boff, *Winning and Losing on the Western Front: The British Third Army and the Defeat of Germany on the Western Front* (Cambridge: Cambridge University Press, 2012).

³³ For France, see Sophie Delaporte, *Les Médecins dans la Grande Guerre 1914–1918* (Paris: Bayard, 2003). For Germany, see Heather R. Perry, *Recycling the Disabled: Army, Medicine and Modernity in WWI Germany* (Manchester: Manchester University Press, 2017).

³⁴ van Bergen, *Before My Helpless Sight*, pp.28–9.

³⁵ At least one such study is already being undertaken by Laura Boyd, whose PhD research at the University of Leeds is looking comparatively at the work of these men in the French and British armed forces.

over the status of these men (and a small number of women³⁶) in relation to both medical practice and military service in wartime. Importantly, Whitehead's work reflects not only the way in which the war shaped medical treatment of soldiers, but also its impact on civil medicine through the recruitment of practitioners away from positions such as public officers of health, as well as from private practice.³⁷ In doing so, he addresses the debates over the relationship between war, modernity, and progress, while illuminating the social histories of a particular category of individuals caught up in the historical moment.

In a similar vein, Christine Hallett's studies of the British women engaged in wartime nursing practices, *Containing Trauma* (2009) and *Veiled Warriors* (2014), show how the work undertaken by both Voluntary Aid Detachment (VAD) volunteers and trained military nurses had ramifications for the status and practice of nursing in civil society.³⁸ Her argument, like that of Janet Watson,³⁹ serves to nuance discussion of the role of trained and volunteer nurses in influencing the broader changes to women's place in British society. The nature of such change has been the subject of much historiographic debate in histories of women in the war since Arthur Marwick's assertion in 1965 that, as a result of the war, 'women of all classes shared in a similar kind of emancipation'.⁴⁰ In distinguishing between the different kinds of nursing service undertaken by women, including that of women doctors, both Hallett and Watson show the complexity of such service for women's subjectivities and identities, in terms of class, national identity, and age, within this particular category of women war-workers. Like Whitehead, their work complicates the categorization of medical services by giving voice to a range of practitioners. Building on the textual studies of nurses' writing

³⁶ Leah Leneman, 'Medical Women at War, 1914–1918', *Medical History* 38 (1994): 160–77, DOI:10.1017/S0025727300059081.

³⁷ Whitehead, *Doctors in the Great War*.

³⁸ Christine E. Hallett, *Containing Trauma: Nursing Work in the First World War* (Manchester: Manchester University Press, 2009); Christine E. Hallett, *Veiled Warriors: Allied Nurses of the First World War* (Oxford: Oxford University Press, 2014).

³⁹ Janet S. K. Watson, *Fighting Different Wars: Experience, Memory, and the First World War* (Cambridge: Cambridge University Press, 2004), pp.59–104; Janet S. K. Watson, 'War in the Wards: The social construction of medical work in First World War Britain', *Journal of British Studies* 41 (2002): 484–510, DOI: 10.1086/341439.

⁴⁰ Arthur Marwick, *The Deluge: British Society and the First World War*, 2nd ed. (Basingstoke: Macmillan, 1991; 1st edn, 1965), p.134. For a critique of Marwick's argument and a discussion of the related historiographic debates, see Gail Braybon, 'Winners or Losers: Women's Symbolic Role in the War Story', in *Evidence, History and the Great War: Historians and the Impact of 1914–18*, ed. Gail Braybon (New York: Berghan Books, 2003), pp.86–112.

by scholars such as Margaret R. Higonnet, Angela K. Smith, and Hazel Hutchinson,⁴¹ Hallett's and Watson's work demonstrates how both the medical and cultural labour of nursing had not only social implications for British society but also emotional ones for the women themselves and the patients they cared for.

This emotional facet of medical caregiving has, in turn, formed the subject of Carol Acton and Jane Potter's *Working in a World of Hurt* (2015), which explores the trauma and resilience of military medical caregivers in Britain and America across the major conflicts of the twentieth century. In locating the work and experience of medical caregiving within psychological theories of trauma and resilience, Acton and Potter again extend the methodologies used by literary scholars in their reading of nurses' narrative to encompass a wider range of wartime medical practitioners. They thus expose some of the tensions between maintaining morale and bearing witness to the horrors of war which Samuel Hynes has identified as central to the narratives of combatant servicemen.⁴² In doing so, they demonstrate the important continuities and emotional linkages between patient and caregiver in the practice and experience of military medicine which Santanu Das explored in his literary analysis of touch in wartime.⁴³

Underpinning many of these cultural analyses of medical caregiving is the understanding of wartime caring, like wartime violence, as a fundamentally gendered practice.⁴⁴ The ambivalence over military medical practice which, Harrison speculates, makes '[m]edicine... such a compelling subject, perhaps, because it exemplified the uneasy compromises that many people were forced to make in wartime; it represented a semblance of humanity amidst remorseless destruction'⁴⁵ has, in Britain, long been

⁴¹ Margaret R. Higonnet, 'Introduction', in *Nurses at the Front: Writing the Wounds of the Great War*, ed. Margaret R. Higonnet (Boston: Northeastern University Press, 2001), pp.vii–xxxviii; Angela K. Smith, *The Second Battlefield: Women, Modernism and the First World War* (Manchester: Manchester University Press, 2000); Hazel Hutchinson, 'The Theatre of Pain: Observing Mary Borden in *The Forbidden Zone*', in *First World War Nursing: New Perspectives*, ed. Alison S. Fell and Christine E. Hallett (London: Routledge, 2013), pp.139–55.

⁴² Samuel Hynes, *The Soldiers' Tale: Bearing Witness to Modern War* (New York: Penguin Books, 1997), p.30.

⁴³ Santanu Das, *Touch and Intimacy in First World War Literature* (Cambridge: Cambridge University Press, 2005), pp.175–203.

⁴⁴ On the gendering of wartime violence see Joanna Bourke, *An Intimate History of Killing: Face-to-Face Killing in Twentieth-Century Warfare* (London: Granta Books, 1999) and Raphaëlle Branche et al., 'Writing the History of Rape in Wartime', in *Rape in Wartime*, ed. Raphaëlle Branche and Fabrice Virgili (Basingstoke: Palgrave Macmillan, 2012), pp.1–16.

⁴⁵ Harrison, *The Medical War*, p.1.

constructed in gendered terms as one way of eliding these inherent contradictions. It was, after all, Florence Nightingale who declared in her *Notes on Nursing* that 'Every woman is a nurse'.⁴⁶ This was in stark contrast to the understanding at the time that no woman could be a soldier and, by implication, a state-authorized killer.⁴⁷

As Holly Furneaux has demonstrated, however, such an understanding was by no means universal in the nineteenth century, with the male military hospital orderly occupying an important, if increasingly contested, space in cultural definitions of the 'military man of feeling'.⁴⁸ Yet the ideological dominance of the nurse as both the appropriate caregiver and the appropriate role for women to occupy in time of war, which emerged from Nightingale's campaigning in the wake of the Crimean War, has continued to shape the historiography of gender and war. Gail Braybon pointed out in 2003 that 'women's wartime history was, and often still is, overlaid with myth', including the myth of the dedicated female VAD volunteer as an emblematic figure.⁴⁹ As recently as 2012, however, Barton C. Hacker has argued that, far from being mythic,

Throughout the last half of the nineteenth century and into the early twentieth, by far the greatest military role for middle-class women was nursing and succoring the wounded, for which women were perceived to have a special talent. In taking on this service, they reasserted women's claim to nurse sick and wounded soldiers.⁵⁰

This perception of nursing as the most significant wartime role for women, particularly in the context of the total wars of the twentieth century, has been challenged by women's historians for many years, with histories of women's work in munitions factories, on the land, and in a range of civil auxiliary roles all serving to complicate monolithic narratives of the war as 'liberating' for women.⁵¹ More recently, histories

⁴⁶ Florence Nightingale, *Notes on Nursing: What it is and what it is not* (New York: D. Appleton and Company, 1860), preface.

⁴⁷ Bourke, *An Intimate History of Killing*, p.1.

⁴⁸ Furneaux, *Military Men of Feeling*, pp.187–216.

⁴⁹ Braybon, 'Winners or Losers', p.88.

⁵⁰ Barton C. Hacker, 'Reformers, Nurses, and Ladies in Uniform: The Changing Status of Military Women (c.1815–1914)', in Barton C. Hacker and Margaret Vining (eds.), *A Companion to Women's Military History* (Leiden: Brill, 2012), p.142.

⁵¹ Deborah Thom, *Nice Girls and Rude Girls: Women Workers in World War I* (London: I. B. Tauris, 1998); Angela Woollacott, *On Her Their Lives Depend: Munitions Workers in the Great War* (Berkeley: University of California Press, 1994); Krisztina Robert, "All That is Best in Modern Woman?": Representations of female military auxiliaries in British popular culture, 1914–1919', in *British Popular Culture in the First World War*, ed. Jessica Meyer (Leiden: Brill, 2008), pp.97–122; Susan R. Grayzel, *Women and the First World War* (Abingdon: Routledge, 2013); Jane Potter, *Boys in Khaki, Girls in Print: Women's Literary*

of wartime domesticity have added detail and nuance to social historians' points about the totality of the war's impact. These show how war shortages and bereavement, as well as changing patterns of employment opportunity for both men and women, shaped the domestic labour which continued to be the almost exclusive preserve of women.⁵² In doing so, they further elaborate the complexity of war as a gendered experience in Britain.

At the same time, historians of masculinity have increasingly used the war as a subject through which to take up the challenge of destabilizing the status of women as the 'carriers' of gender⁵³ by problematizing of the concepts of 'manliness' and 'masculinity' in the context of war. Building on works such as Joanna Bourke's *Dismembering the Male* (1996) and George Mosse's *The Image of Man* (1996), a generation of historians has helped to illuminate both the ways in which 'the military [serves] as a source of masculine authority and a privileged arena of male activity' and how 'the encounter of pre-war assumptions about the conduct of war with the reality of the industrialized battlefield...destabilized the stereotypes of masculinity that had played an important part in mobilising the populations for war in 1914'.⁵⁴ Given the mass mobilization that total war entailed in Britain, such studies have often focused on combatant masculinities in the first instance, privileging the historic voice of 'the man

Responses to the Great War 1914–1918 (Oxford: Oxford University Press, 2005); Sharon Ouditt, *Fighting Forces, Writing Women: Identity and Ideology in the First World War* (London: Routledge, 1994).

⁵² *The Home Front in Britain: Images, Myths and Forgotten Experiences since 1914*, ed. Maggie Andrews and Janis Lomas (Basingstoke: Palgrave Macmillan, 2014); Adrian Gregory, *The Last Great War: British Society and the First World War* (Cambridge: Cambridge University Press, 2008).

⁵³ John Tosh, 'What Should Historians Do with Masculinity?: Reflections on nineteenth-century Britain', *History Workshop Journal*, 38 (1994): p.180, <http://www.jstor.org/stable/4289324>. See also Michael Roper and John Tosh, 'Introduction: Historians and the Politics of Masculinity', in *Manful Assertions: Masculinities in Britain since 1800*, ed. Michael Roper and John Tosh (London: Routledge, 1991), pp.1–24; Heather Ellis and Jessica Meyer, 'Introduction', in *Masculinity and the Other: Historical Perspectives*, ed. Heather Ellis and Jessica Meyer, (Newcastle upon Tyne: Cambridge Scholars Publishing, 2009), pp.1–22; John H. Arnold and Sean Brady, 'Introduction', in *What is Masculinity?: Historical Dynamics from Antiquity to the Contemporary World*, ed. John H. Arnold and Sean Brady, (Basingstoke: Palgrave Macmillan, 2011), pp.1–16.

⁵⁴ John Horne, 'Masculinity in Politics and War in the Age of Nation-States and World Wars, 1850–1950', in *Masculinities in Politics and War: Gendering Modern History*, ed. Stefan Dudink, Karen Hagemann, and John Tosh (Manchester: Manchester University Press, 2004), pp.31–2. See also Roper, *The Secret Battle*; Meyer, *Men of War*; Gullace, *Blood of Our Sons*; Watson, *Fighting Different Wars*; Ana Carden-Coyne, *Reconstructing the Body: Classicism, modernism, and the First World War* (Oxford: Oxford University Press, 2009); Gabriel Koureas, *Memory, Masculinity, and National Identity in British Visual Culture, 1914–1930: A Study of 'Unconquerable Manhood'* (Aldershot: Ashgate, 2007).

who was there'.⁵⁵ It is only more recently that studies of the men who didn't fight have started to unpick the specifically gendered challenges faced by men who experienced war as civilians or who challenged the association between dominant masculinities and military service through their status as conscientious objectors. Laura Ugolini, in her study of middle-class civilian men in Britain, has pointed to the ambivalence experienced by men in reserved occupations about their masculine status in wartime society. Their work aided the war effort but, by doing their duty out of uniform they laid themselves open to challenges to their masculine identity by a society which often judged appropriate war service by the wearing of a uniform.⁵⁶ By contrast, for non-absolutist conscientious objectors to war, their non-combatant service, often in uniform, was perceived and represented as shaped by their principles rather than their labour. As these principles were, as Lois Bibbings has shown, the subject of extensive social criticism throughout the war, the result was numerous cultural constructions of these men's masculinity as problematic, suspect, and deviant.⁵⁷

Yet in spite of this growing range of analyses of British First World War masculinities, categories of men remain comparatively neglected as the subject of gender analysis. One of these is those who voluntarily enlisted for military service yet challenged the hegemonic masculinity of the combatant by serving in specifically non-combatant roles. For the men of the Labour Corps, the Army Service Corps, and, above all, the Army Medical Corps, who wore uniforms but did not carry (or manipulate) weapons, the disconnect between appearance and role in relation to their wartime service has yet to be fully explored in terms of the ways in which it shaped both their subjective masculine identity and its representation in British culture. For the men of the Medical Corps in particular, this disconnect was heightened by the dominance of the association between women and wartime medical care provision, presenting specific challenges that may not have been as relevant to non-combatant units whose work was more directly associated with either manual labour or mechanical and technological innovations that could be more clearly coded as male.

⁵⁵ Hynes, *The Soldiers' Tale*, pp.1–30.

⁵⁶ Gullace, 'Blood of Our Sons', pp.92–924; Laura Ugolini, *Civvies: Middle-Class Men on the English Home Front, 1914–18* (Manchester: Manchester University Press, 2013), pp.127–8; Laura Ugolini 'War-stained: British Combatants and Uniforms, 1914–18', *War & Society*, 33 (2014): 155–71, DOI: 10.1179/0729247314Z.00000000036; Lois Bibbings, *Telling Tales About Men: Conceptions of Conscientious Objectors to Military Service During the First World War* (Manchester: Manchester University Press, 2009), p.102.

⁵⁷ Bibbings, *Telling Tales About Men*; Sabine Grimshaw, 'Representation and resistance: The representation of male and female war resisters of the First World War', PhD diss., University of Leeds, 2017.

That an association with medical care had the potential to pose challenges to masculine identities in the context of mass industrialized war and its aftermath has, to a certain extent, been demonstrated by studies focusing on the perspectives of wartime patients and the post-war disabled which have explored the impact of wounds and impairment on gender and gender relations. Carden-Coyne's work, for example, demonstrates how the power relationships between patients and nurses in wartime military hospitals, which revolved around the physical pain of the former and its mitigation by the latter, were shaped by cultural understandings of gendered divisions of labour and appropriate gender relations.⁵⁸ Power relationships between patients and doctors in these spaces can also be read through a gendered lens to expose how masculinity in this period was structured by the 'othering' of age, rank, and race as well as sex.⁵⁹ Histories of disability, meanwhile, have contributed to understandings of masculinity as a subjective identity through explorations of the fears of emasculation which accompanied men's bodily encounters with medical care,⁶⁰ and the potential mitigation or exacerbation of such anxieties through state intervention.⁶¹

* * *

Focusing on doctors and patients as gendered actors has thus shown the significance of medical care as a site for the creation and reinforcement of male identity in wartime that deserves scholarly exploration equal to that of the study of nurses for the understanding of women's roles and gender relations in wartime. Yet concentrating on those who held qualifications in care provision, the recipients of care, and the female nurses and medical volunteers of the VAD offers only partial insight. Men who provided medical care in a military context in the era of the First World War

⁵⁸ Carden-Coyne, *The Politics of Wounds*, pp.242–51, 286–97.

⁵⁹ Jessica Meyer, 'Separating the Men from the Boys: Masculinity and maturity in understandings of shell shock in Britain', *Twentieth Century British History* 20 (January 2009): 1–22, DOI: 10.1093/tcbh/hwn028; Joanna Bourke, *Dismembering the Male: Men's Bodies, Britain, and the Great War* (London: Reaktion Books Ltd, 1996), pp.67–70; Joanna Bourke, 'Effeminacy, Ethnicity and the End of Trauma: The sufferings of "shell-shocked" men in Great Britain and Ireland, 1914–39', *Journal of Contemporary History* 35 (January 2000): 57–69, DOI: 10.1177/002200940003500106.

⁶⁰ Wendy Jane Gagen, 'Remastering the Body, Renegotiating Gender: Physical disability and masculinity during the First World War, the case of J. B. Middlebrook', *European Review of History: Revue Européenne d'histoire* 14 (December 2007): 525–41, DOI:10.1080/13507480701752169; Julie Anderson, "'Jumpy Stump': Amputation and trauma in the First World War', *First World War Studies* 6 (August 2015): 12, DOI: 10.1080/19475020.2015.1016581.

⁶¹ Deborah Cohen, *The War Come Home: Disabled Veterans in Britain and Germany, 1914–1939* (Berkeley: University of California Press, 2001); Perry, *Recycling the Disable*; Koureas, *Memory, Masculinity and National Identity*, pp.91–142.

remain underexamined, although, viewed through the lens of the gender disruption created by war,⁶² their roles and status gain in significance. On the one hand, they challenge narratives of the natural dominance of women in caring roles, while on the other they complicate patient engagement with medical care as emasculating through their non-patient, non-hegemonic male presence in spaces of care. Additionally, as uniformed servicemen who served at all points from the front-line trenches through to home hospitals without bearing arms, they posed important questions to cultural and individual definitions of wartime masculinity in a conflict where such definitions were profoundly challenged in a myriad of ways.⁶³

This book serves to fill this gap in both the gender and medical histories of Britain during the First World War through its examination of the work, experiences, perceptions, and representations of the men of the RAMC in the conflict. Using sources including official documents, personal narratives, material objects, and visual images, it deploys the tools of cultural history, particularly close reading and textual and object analysis, to explore what these men did, how they understood their labour as a facet of their subjectivities and status in wartime society, and how they and their role were perceived by those around them, including doctors, nurses, patients, military authorities, and civil society. By focusing on these men as male actors in a society mobilized to violence and caregiving along predominantly gendered lines,⁶⁴ it complicates histories of masculinity and the war which have tended to focus on narratives of combat to the exclusion of non-combatant labour. In doing so, it not only identifies the specific contribution that this category of men made to the history of the British war effort, it also expands historical understandings of what it meant to be a man and a serviceman in British society during the war years.

* * *

While gender forms the primary variable for this analysis, and cultural history provides the primary methodology, this approach does present some problems of scope, principally relating to the complex of identity markers, of which gender is only one. Race, class, and age all intersect with the lived experience of gender in ways which demand acknowledgement yet are beyond the scope of this study. In focusing on the work of the men

⁶² Joan Scott, 'Rewriting History', in *Behind the Lines: Gender and the Two World Wars*, ed. Margaret Randolph Higonnet, et al. (New Haven: Yale University Press, 1987), pp.25–7.

⁶³ Meyer, *Men of War*, pp.161–7.

⁶⁴ Margaret R. Higonnet and Patrice L. Higonnet. 'The Double Helix', in *Behind the Lines*, ed. Higonnet et al., p.35.

of the British Army Medical Services, it considers these men as a category encompassing a range of ages and social categories, although not races. It seeks to complement work currently being undertaken on medical provision in the First World War where race is foregrounded,⁶⁵ without necessarily analysing the regionality which underpinned the Corps' own racial identity as a British military establishment.⁶⁶

Class and age form more significant areas of analysis at different points in the discussion, reflecting the significance of these social parameters for British military masculine identity in this period,⁶⁷ and for the provision of medical treatment.⁶⁸ However, while the age profile of the RAMC was explicitly delineated in ways which affected the masculine status of the unit as a whole to individuals within it, as will be discussed in Chapter 2, the class structure of the unit presents additional methodological problems. Class does not map as neatly on to rank, as was the case for the British Army more broadly.⁶⁹ While the requirement that officers of the Corps held medical degrees undoubtedly meant that the officer corps was dominated by middle-class professionals, it also excluded a range of middle- and upper-class men from holding commissions. As Ward Muir, himself a middle-class orderly at the 3rd London General Hospital, noted of a fellow Corporal in the unit:

Khaki is an unparalleled disguise, especially the “issue” garments of Tommy Atkins.... Corporal Macdonald... is something of an aristocrat on his native heath, which is North of the Tweed; and the tan of his cheeks and the clearness of his blue eyes was acquired, like his soft Highland accent, on the open country of his own estate. He drives his ass-cart well because he once could drive a four-in-hand well. He is driving an ass-cart because *noblesse oblige*: if Britain did not want him as a fighter—those white hairs

⁶⁵ Hilary Buxton, ‘Disabled Empire: Race, Rehabilitation, and the Politics of Healing Non-white Colonial Troops, 1914–1940’, PhD diss., Rutgers University. See also Bourke, ‘Effeminacy, ethnicity and the end of trauma’ and Carden-Coyne, *The Politics of Wounds*, pp.196–214.

⁶⁶ For the distinctiveness of Army Medical Services as part of differing Imperial and Dominion expeditionary forces, see Frederick Walter Noyes, *Stretcher bearers...at the double! History of the Fifth Canadian Field Ambulance which Served Overseas during the Great War of 1914–1918* (Toronto: The Hunter-Rose Company, Limited, 1937) and Alexia Moncrieff, ‘“We are entitled to some control”: The Australian Army Medical Corps in the First World War’, PhD diss., University of Adelaide, 2017.

⁶⁷ Roper and Tosh, ‘Introduction’, in *Manful Assertions*, ed. Roper and Tosh, pp.11–16; Ugolini, *Civics*, pp.3–4.

⁶⁸ Elaine Showalter, *The Female Malady: Women, Madness and English Culture, 1830–1980* (London: Virago, 1987), pp.174–5; Meyer, ‘Separating the Men From the Boys’.

⁶⁹ J. M. Winter, *The Great War and the British People* (Basingstoke: Macmillan Education Ltd, 1986), pp.83–4.

of his were looked askance at—he had to find some other service. . . . So . . . he enlisted as an orderly and tackled the orderly's distasteful tasks.⁷⁰

In short, the particularities of recruitment to a non-combatant unit make attempts to generalize about the background of the ranks of the Corps, and the implications that this may have had for their subjective understanding of masculinity in relation to their war service, difficult. Equally problematic are attempts to read class relations within the Corps in a similar manner to the way in which the class of nurses has often been categorized.⁷¹ Distinguishing between middle-class volunteers, lower-middle-class trained practitioners, and working-class general service providers does not appear as relevant for their male military equivalents.⁷²

Given the importance of class in shaping individual subjectivities in relation to masculine identities,⁷³ the somewhat fluid social make-up of the Corps presents difficulties in analysing how its wartime work shaped and was shaped by concepts of appropriate masculinities. One way to address the question of how distinct personal experiences were incorporated into men's private narratives of their lives and subjective understandings of themselves as men is, as Graham Dawson, Michael Roper, and Wendy Gagen have all demonstrated, through detailed psycho-biographical studies of individual men. Such an approach, as John Tosh suggests, 'does not . . . mean renouncing cultural analysis. But it does direct our attention to forms of representation which arose directly from social experience.'⁷⁴ Too tight a focus on the individual, without due consideration for the material of the wider culture in which quotidian lives were lived, however, not only raises questions about the representativeness of the subject of analysis, but also has the potential to limit our understanding of the wider forces, both social and cultural, which shape historic masculinities. As Roper has pointed out, 'personal accounts of the past are

⁷⁰ Ward Muir, *The Happy Hospital* (London: Simpkin, Marshall, Hamilton, Kent & Co., 1918), p.63.

⁷¹ Watson, 'War in the Wards'; Hallett, *Containing Trauma*, p.12.

⁷² Indeed, as Sue Light and Alison Fell have both suggested, such divisions were not necessarily as clear-cut in the case of women's medical services as Watson in particular has suggested (Sue Light, 'A Suitable Woman for the Job', *The Fairest Force*, <http://www.fairestforce.co.uk/37.html>, last accessed 19 December 2017; Alison Fell, 'Afterword: Remembering the First World War Nurse in Britain and France', in *First World War Nursing*, ed. Fell and Hallett, pp.186–8.)

⁷³ John Tosh, 'The History of Masculinity: An Outdated Concept?', in *What is Masculinity*, ed. Arnold and Brady, p.24; Martin Francis, 'The Domestication of the Male? Recent research on Nineteenth- and Twentieth-Century British Masculinity', *Historical Journal* 45 (2002): pp.637–52, <http://www.jstor.org/stable/3133500>.

⁷⁴ Tosh, 'The History of Masculinity: An Outdated Concept?', in *What is Masculinity*, ed. Arnold and Brady, p.24.

never produced in isolation from . . . public narratives, but must operate within their terms. Remembering always entails the working of past experience into available cultural scripts.⁷⁵

This book, therefore, uses close readings of personal narratives, official documentation, and wider cultural production to tell the story of the unit as a whole throughout the war. Using analytic tools which illuminate how ‘the telling of the tale itself shapes the tale that is told’,⁷⁶ it locates these sources in the contexts of audience and dissemination to explore how the construction of the identities of the men of the RAMC was shaped by both personal experience and wider cultural forces. Rather than giving primacy to familial relations in order to more fully understand gendered subjectivities, as suggested by both Roper and Tosh,⁷⁷ by contextualizing this range of source material in relation to author and audience, representation and reception, this work exposes not just the individual subjective understandings of wartime masculinity of a range of servicemen, but also the relationship between masculinity as a subjective identity on the one hand and a social ideal and cultural code on the other. This in turn helps to address the other two problems Tosh identifies with the recent dominance of the cultural turn in histories of masculinity, namely ‘the privileging of representation over experience . . . and the abstraction of power relations’.⁷⁸ In seeking to balance readings of representation with those of experience, I show how gender functioned as a power relationship, both metaphorically and as lived experience, between men and men as well as between men and women in wartime sites of medical care provision.

This approach is useful not only in relation to histories of masculinity but also gender histories of medicine, which have also grappled with challenges raised by the dominance of the ‘cultural turn’.⁷⁹ In particular, the problems identified by Tosh have relevance to the ways in which the figure of the care provider has been analysed in gendered terms as

⁷⁵ Michael Roper, ‘Re-remembering the Soldier Hero: The psychic and social construction of memory in personal narratives of the Great War’, *History Workshop Journal* 2000 (January 2000): p.183, DOI: 10.1093/hwj/2000.50.181.

⁷⁶ Meyer, *Men of War*, p.11.

⁷⁷ Michael Roper, ‘Slipping Out of View: Subjectivity and emotion in gender history’, *History Workshop Journal* 59 (March 2005): p.67, DOI: 10.1093/hwj/dbi006; Tosh ‘The History of Masculinity’, pp.28–30.

⁷⁸ Tosh, ‘The History of Masculinity’, p.23.

⁷⁹ Peter Mandler, ‘The Problem with Cultural History’, *Cultural and Social History* 1 (2004): 94–117, DOI: 10.1191/1478003804cs0002df; Colin Jones, ‘Peter Mandler’s “Problem with Cultural History”, or, Is Playtime Over?’, *Cultural and Social History* 1 (2004): 209–15, DOI: 10.1191/1478003804cs0012df; Peter Mandler, ‘Problems in Cultural History: A reply’, *Cultural and Social History* 1 (2004): 326–32, DOI: 10.1191/1478003804cs0023df; John Tosh, *The Pursuit of History: Aims, Methods and New Directions in the Study of History*, 6th edn (London: Routledge, 2015), pp.205–28.

historically contingent. While social histories seeking to understand the agency of patients have tended to structure caregiving along the gender dichotomies of male dominance and female frailty, reflecting historical representations across the modern period, more materially based analyses of domestic medical practice and care have increasingly exposed the range of women's roles as care providers.⁸⁰ Studies of caregiving in these terms have, however, not only tended to focus on women as the gendered category whose engagement with medical practice most clearly exposes the tensions between representation and lived experience, but also on the early modern period as that in which medicine emerged as a discrete social and cultural practice. In focusing on the modern period, and on the work of a category of men whose relationship with medical care was defined by neither professionalism nor patient status, this book shows how cultural context and social experience interacted to shape a historically specific moment of caring.

It does this through the reading not only of texts but also images. Many of those included in this book will be familiar to historians of the First World War, particularly those with interests in medicine and caregiving. Their familiarity reflects both their significance in representing medical care provision in British culture at the time and their accessibility to historians in the years since. It does not, however, preclude gaining new insight from them. In reinterpreting images, such as the hospital magazine cartoons which appear in Chapter 5, in terms of their representation of RAMC rankers as a specific category of analysis, I will build on the broader analyses of hospital cultures by Carden-Coyne and Reznick which also examine these images.⁸¹ Considering questions of audience in relation to images from widely circulated training manuals, meanwhile, enables more nuanced discussion of training in terms not merely of medical progress but also individual practice.

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This book, therefore, examines the work of the men of the RAMC through chapters which are structured both thematically and chronologically. The first two chapters address the question of the organization and

⁸⁰ Hilary Marland, 'Women, Health and Medicine', in *The Oxford Handbook of the History of Medicine*, ed. Mark Jackson (Oxford: Oxford University Press, 2013) p. 494; Margaret Pelling, 'Compromised by Gender: The Role of the Male Medical Practitioner in Early Modern England', in *The Task of Healing: Medicine, Religion and Gender in England and the Netherlands 1450–1800*, ed. Margaret Pelling and Hilary Marland (Rotterdam: Erasmus, 1996), pp.101–33.

⁸¹ Carden-Coyne, *The Politics of Wounds*; Jeffrey S. Reznick, *Healing the Nation: Soldiers and the Culture of Caregiving in Britain During the Great War* (Manchester: Manchester University Press, 2004).

make-up of the Corps before and during the war. Chapter 1 surveys the formation and reformation of the army medical services as a recognized unit in the second half of the nineteenth century, locating the social and political debates around the unit in the context of reforms to the military and medicine as professions. It additionally identifies the ways in which these debates were shaped by the foundation and growth of the humanitarian voluntary aid movement in Europe. Using social theories of professional definition, the chapter situates the unit within historic debates around the disruptive role of war in shaping the gender order for both women and men. It argues that the reforms to military and medicine as gender-demarcated professions constructed a space within the military in the years before the outbreak of war in 1914 that, for the men who served in the unit, was socially ambiguous.

This ambiguity, which was particularly acute in relation to the non-combatant nature of the unit, was to play an important role in the recruitment of non-commissioned ranks to the Corps from 1914, and in their subsequent training. As Catriona Pennell has shown, as with many other complexities which shaped British responses to the outbreak of war, the desire to enact violence was by no means universal.⁸² Yet the narrative of combat as the appropriate role for men to take in wartime remained dominant, with important repercussions for men who found themselves enlisted in non-combatant services.⁸³ Through readings of both official recruitment policy as it developed over the course of the war and the training literature which resulted to turn civilian volunteers and conscripts into military medical-care providers, Chapter 2 explores the central questions of change and continuity in the identity of the Corps throughout the war years. In particular, it demonstrates how the status of the Corps in relation to both the military and medicine changed, or failed to change, between 1914 and 1918, with consequences for the subjective masculine identities of the men who served in its ranks.

While these two chapters focus on questions of who the ranks of the Corps were, Chapters 3 and 4 concentrate on what the Corps did. Using official publications and personal narratives, both contemporaneous and retrospective, created by RAMC servicemen, they examine the chain of evacuation along the line of communication which formed the primary remit of RAMC work throughout the war.⁸⁴ Each examines a different

⁸² Catriona Pennell, *A Kingdom United: Popular Responses to the Outbreak of the First World War in Britain and Ireland* (Oxford: Oxford University Press, 2012), p.227.

⁸³ Gullace, 'Blood of Our Sons'; Ugolini, *Civvies*, pp.193–8.

⁸⁴ Emily Mayhew, *Wounded: From Battlefield to Blighty* (London: The Bodley Head, 2013); Carden-Coyne, *The Politics of Wounds*, pp.24–37; Harrison, *The Medical War*, pp.16–64.

theme which shaped these men's work—those of diverse spaces and change over time. Chapter 3 utilizes Jeffrey Reznick's concept of sites of healing⁸⁵ to identify the primary roles of carrying, cleaning, and caring undertaken by RAMC rankers in different spaces and at different points in the process of medical evacuation. It shows how these different roles were undertaken and consequently defined in relation to encounters with others within these spaces, as well as by the spaces themselves. In doing so, it nuances and deepens our understanding of gendered relationships within these spaces, as well as the range of labour associated with appropriate masculine service in wartime.

Chapter 4 revisits the chain of evacuation, this time from the perspective of how RAMC Other Ranks' work was influenced by strategic and technological changes, both military and medical, which developed over the course of the war. By exploring how such change over time affected the working practices of the men of the RAMC, it interrogates the question of whether the war was good for medicine from the perspective of the non-professional male medical care provider.⁸⁶ In doing so, it contributes to wider debates over the relationship between war, medicine, and modernity, suggesting that many of the aspects of change associated with progress had a more ambiguous impact on the lived experience of the men whose practice they shaped. This ambiguity was reflected in the impact that such developments had on the status of the ranks of the RAMC as both care providers and servicemen throughout the war.

Chapter 5 centres on the question of the social positioning of RAMC rankers as care providers, using a range of cultural representations to explore how these men perceived their own work and standing, and how this status was perceived by those they encountered in their caring roles. Drawing on theories of representation which I have previously used to examine the masculine status of British First World War servicemen more generally,⁸⁷ the chapter examines a range of cultural texts, including cartoons, poetry, hospital magazines, and memoirs to demonstrate the multiple ways in which the work of RAMC rankers was perceived and understood throughout the war. In doing so, it builds on the analyses of Reznick and Carden-Coyne that have used hospital magazines in particular to explore the experiences and understandings of the wounded and disabled within the military medical care system in relation to nurses and doctors.⁸⁸ By

⁸⁵ Reznick, *Healing the Nation*, pp.1–2.

⁸⁶ Cooter, 'Medicine and the Goodness of War'.

⁸⁷ Meyer, *Men of War*, pp.11–12; Roper and Tosh, 'Introduction', pp.14–15.

⁸⁸ Reznick, *Healing the Nation*, pp.65–98; Carden-Coyne, *The Politics of Wounds*, pp.232–8.

foregrounding the representations of the relatively neglected stretcher bearer and medical orderly in these discussions, this chapter complicates constructions of power relationships within the military medical care system. The range of representations explored, and the gendered nature of their construction, demonstrate the complexity of cultural constructions of gender and gender relations in British society during the war more broadly.

As a whole, therefore, the book examines how the First World War affected British understandings of military service, medical professionalism, and the status of military medical provision through its analysis of the role and experiences of a group of men whose primary identities were neither military nor medical. By looking at how these men understood their temporary wartime roles, and how society represented the work they undertook, it demonstrates how the multiple masculinities of a society at war complicated and nuanced relationships between categories of actors, including male medical professionals, female care providers, and combatant servicemen, as well as RAMC rankers themselves. In their negotiations of both their temporary identities and encounters with a range of others, the men of the RAMC played an important role in cementing the status of their unit of service as a necessary, if not always unambiguously glorious, one. In doing so, through their physical and emotional labour and the subjective and representational constructions of their specific form of wartime masculinity, these men bore an equal burden to their combatant comrades, even if they never bore arms.

1

Bandage Wallahs and St John's Men

British military medicine before the First World War

In October 1854, *The Times* ran a series of articles by Thomas Chenery, their correspondent in Constantinople, decrying the insufficiency of the provision for the medical care of British soldiers serving in the Crimean War (1853–6). As well as a lack of surgeons, nurses, and even medical supplies, Chenery noted that ‘The worn-out pensioners who were brought out as an ambulance corps are totally useless, and not only are surgeons not to be had, but there are no dresser or nurses to carry out the surgeon’s directions and attend on the sick during intervals between his visits.’¹ Chenery’s articles, alongside those of his better-remembered colleague, William Howard Russell, sparked a public debate in Britain over the nature and effectiveness of medical aid in wartime which would continue throughout the second half of the nineteenth century. The result, according to Rebecca Gill, was ‘a surge in the effectiveness and status of medico-military arrangements and the ascension of the suffering of the common soldier into a moral cause’.² This led in turn to, on the one hand, the formation of a range of voluntary medical organizations, most notably the National Aid Society (NAS)—the forerunner to the British Red Cross Society (BRCS)—and, on the other, a series of official enquiries and reforms of the Army Medical Services (AMS) by the government, including the creation, at the instigation of Florence Nightingale and Jane Shaw Stewart, of a female military nursing service in 1861.³

All these developments formed part of a wider discussion of who bore responsibility for the health and well-being of soldiers in wartime. The

¹ Thomas Chenery, *The Times*, 13 October 1854, quoted in Thomas Scotland and Steven Hays, *Wars, Pestilence and the Surgeon’s Blade: The Evolution of British Military Medicine and Surgery During the Nineteenth Century* (Solihull: Helion & Company, Ltd, 2013), p.222.

² Rebecca Gill, *Calculating Compassion: Humanity and Relief in War, Britain 1870–1914* (Manchester: Manchester University Press, 2013), p.28.

³ For a discussion of Jane Shaw Stewart’s historically neglected role in the formation of this service, see Anne Summers, *Angels and Citizens: British Women as Military Nurses 1854–1914* (London: Routledge & Kegan Paul, 1988), pp.73–96.

civilian relief organizations which developed in response to Chenery's and Russell's outrage were '[c]onceived as a rapid, organized but *temporary* response to a shortfall in existing provision or disruption to the normal means of subsistence'⁴ (my emphasis). Nightingale, for instance, in pressing for the formation of an officially authorized trained nursing service, 'argued that the voluntary provision of medical aid diluted the state's responsibility for the wounded.'⁵ This argument was articulated in the context of the emergence of the voluntary-aid movement across Europe, formalized in Geneva in 1863 in the form of the International Committee of the Red Cross (ICRC). In Britain this movement initially found independent expression through the NAS which, under the influence of its leader, Robert Loyd-Lindsay, himself a veteran of Crimea, positioned itself as at the forefront of 'an autonomous, impromptu voluntary aid movement which prized the virtues of independence and amateurism . . . above all'.⁶ These conflicting positions were to shape the direction of British humanitarian aid in wartime throughout the second half of the nineteenth century.

The crisis of medical provision exposed by the Crimean conflict was not, however, only influential in shaping the development of voluntary medical aid in this period. It was equally significant in stimulating changes to the organization and practice of the military medical services with which voluntary aid was intimately entwined. The failures of care exposed by the reports of Chenery and Russell, and the work and campaigns of Nightingale, prompted first the creation of a Medical Staff Corps of men assigned exclusively to hospital work in 1855,⁷ and then a Commission of Enquiry which, in 1858, recommended a series of reforms to the construction of barracks, the organization of hospitals, the recording of statistics, the pay and promotion of medical officers (MOs), and the constitution of the Army Medical Department as a whole.⁸ While the Commission's report recognized the necessity of a reformed Army Medical Department, including the appointment of specific statistical and sanitary officers, 'it failed to correct the basic mistake of keeping general medical care on a strictly regimental footing.' As a result,

It took forty years to sort out the administrative confusion exposed by the Crimean War. Even the strange, and frequently changing, terminology (defining the various branches, departments, and units) appears, from the

⁴ Gill, *Calculating Compassion*, p.18.

⁵ Ibid., p.11.

⁶ Ibid., p.35.

⁷ Neil Cantlie, *A History of the Army Medical Department*, vol. 2 (Edinburgh and London: Churchill Livingstone, 1974), pp.149–50.

⁸ Report of the Commissioners Appointed to Enquire into the Regulations Affecting the Sanitary Condition of the Army, the Organization of Military Hospitals, and the Treatment of the Sick and Wounded; with Evidence and Appendix (London: His Majesty's Stationery Office, 1858), pp.lxxvi–lxxxi.

safe viewpoint of a century later, a clear sign of muddled planning. Not least among the confusion was the Gilbertian situation in which the Army Hospital Corps had no officers . . . while the Army Medical Department consisted of officers only.⁹

In such circumstances civilian voluntary medical aid continued to play a significant role in the planning for and provision of military medical services.

The development of both voluntary and military medical institutions has tended to be presented, in both cases, as linear narratives of progress from the crisis of Crimea, through the foundation of the RAMC in 1898 and of the BRCS in 1905, to the Haldane Reforms of 1906–12 and the creation of the Voluntary Aid Detachments as an officially sanctioned, voluntarily funded and trained medical reserve in 1909. According to Caroline Moorhead, the BRCS, although representative of ‘the major western power which had been the slowest to catch on to the whole Red Cross idea’ as an international enterprise, ‘took to the cause with flair and relish’¹⁰ after August 1914. The AMS, meanwhile, had, according to Holly Furneaux, by the eve of the First World War ‘become a source of national pride, used in propaganda material . . . which reassured the public about the care taken of soldiers’.¹¹ Histories of voluntary aid and humanitarianism have increasingly complicated such analyses, demonstrating both the intimate relationship between military and voluntary medical aid which developed, and the consequent extent to which the regulation and standardization of voluntary-aid organizations, at both national and international level, encouraged the militarization of charity and the development of ‘Red Cross patriotism’.¹²

There have been fewer critical studies of the development of the AMS into the RAMC. While the failures to bring the young Corps up to strength by the time of the Second Anglo-Boer War, which erupted within months of its establishment, have been extensively acknowledged, most histories have argued that the period that followed, most notably the Haldane Reforms of 1906–12, ensured that the RAMC was

⁹ Redmond McLaughlin, *The Royal Army Medical Corps* (London: Leo Cooper Ltd, 1972), pp.15–16.

¹⁰ Caroline Moorehead, *Dunant's Dream: War, Switzerland and the History of the Red Cross* (London: HarperCollins, 1998), p.208.

¹¹ Furneaux, *Military Men of Feeling*, p.203.

¹² John Hutchinson, *Champions of Charity: War and the Rise of the Red Cross* (Boulder: Westview Press, 1996); Gill, *Calculating Compassion*; Heather Jones, ‘International or Transnational? Humanitarian action during the First World War’, *European Review of History: Revue Européene d'histoire* 16 (2009): pp.697–713, DOI: 10.1080/13507480903262702.

relatively well prepared for the outbreak of war in 1914, not least in the strength of its Reserves.¹³ The focus on specifically military preparedness has left little room for exploration of the wider social and cultural significance of the formalization of a non-combatant unit within the military whose aim was as much the preservation of life and health as the taking of either, and whose work in theatres of war often intersected with that of voluntary-aid organizations in providing relief to civilians and prisoners of war. That such work was intensely contested by the military authorities has been acknowledged by Edward Spiers, who notes that the War Office, in spite of ongoing reforms, consistently undervalued the AMS as a military unit throughout the late nineteenth century: 'the War Office had never fully met the corps' concern about its status... [and] had left the corps over-worked and undermanned'.¹⁴

The contested status of the AMS as a military unit can, perhaps, best be exemplified by Sir Garnet Wolseley's order at the Royal Review at Phoenix Park, Dublin, in 1900: 'Go to the left and tell those medical people to return swords. Inform them that they are only civilian attendants upon sick soldiers'.¹⁵ This was the same military commander who, according to Rebecca Gill, along with Colonel Henry Brackenbury, a member of the Order of St John, 'had been quick to recognize the potential for a flexible, trained volunteer corps providing supplementary medical care and an outlet for the public's concern and generosity, even if medical staff further down the ranks were less than convinced'.¹⁶ Such a corps, in the reformists' view, would give the military authority over medical care provision while denying them the full military status demanded by the AMS.¹⁷ The civilianization of military medicine was thus as contested for the reforming army as the militarization of voluntary aid was for the burgeoning community of humanitarians. Looking at the history of both these processes in relation to each other is, therefore, vital to understanding the status of the RAMC and the men who served in its ranks on the outbreak of war in 1914.

¹³ Whitehead, *Doctors in the Great War*, pp.23–5; McLaughlin, *The Royal Army Medical Corps*, p.29.

¹⁴ Edward Spiers, *The Late Victorian Army 1868–1902* (Manchester: Manchester University Press, 1992), p.325.

¹⁵ Quoted in John S. G. Blair, *In Arduis Fidelis: Centenary History of the Royal Army Medical Corps* (Edinburgh: Scottish Academic Press, 1998), p.42. See also Whitehead, *Doctors in the Great War*, pp.15–16.

¹⁶ Gill, *Calculating Compassion*, p.176.

¹⁷ Whitehead, *Doctors in the Great War*, p.11.

Undertaking such an examination from a gendered perspective is particularly important in redressing current imbalances to the reading of both military medical caregiving and voluntary medical aid in wartime as dominated by women.¹⁸ Gill argues that, by the First World War, ‘The public image of aid work was . . . shorn of the associations with masculine chivalry that had been favoured by the NAS in the Franco-Prussian War [and] . . . was now feminized to such an extent that Katherine [sic] Furse, war-time Commandant of the VADs, could contend that “V.A.D. work is entirely for the sick and wounded. All such work is eminently work for women”’.¹⁹ This image reflected a numerical reality in the voluntary-aid sector, which, on the eve of the war, boasted 551 male VAD units, comprising a total of 23,561 men in comparison to the 46,791 women serving in 1,823 units.²⁰ Within the military, however, ‘The medical services remained predominantly a male preserve, with 3,707 of all ranks serving in the Royal Army Medical Corps on 1 October 1899 and another 1,009 in the Reserve’.²¹ This is in comparison to the seventy-two trained nurses recruited to the Army Nursing Service the previous year.²² By looking beyond the traditional narrative of the feminization of medical care in the context of war in the second half of the nineteenth century to question how male medical care units, both military and voluntary, developed as spheres of masculine undertaking in this period, we stand to gain a better understanding of the gendered social space and status within the military occupied by the RAMC as a unit and the men who served within it from the start of the First World War.

The complex negotiations that accompanied the development of the RAMC as a military medical unit between 1858 and 1914, and the gendered implications of this process, can best be understood within the wider social context of social and political reform which

¹⁸ Gill, *Calculating Compassion*, pp.186–97; Hacker, ‘Reformers, Nurses, and Ladies in Uniform’, pp.137–88.

¹⁹ Gill, *Calculating Compassion*, p.188.

²⁰ *Reports by the Joint War Committee and the Joint War Finance Committee of the British Red Cross and the Order of St. John of Jerusalem in England on Voluntary Aid Rendered to the Sick and Wounded at Home and Abroad and to British Prisoners of War, 1914–1919, with Appendices* (London: His Majesty’s Stationery Office, 1921), p.190.

²¹ Spiers, *The Late Victorian Army*, p.81.

²² Sue Light, ‘The Military Nursing Services’, <http://www.scarletpointers.co.uk/8.html>, last accessed 22 November 2017. There followed a period expansion of both the nursing service and the reserves from 1904, although, as Anne Summers has shown, recruitment rates varied significantly both geographically and between units (Summers, *Angels and Citizens*, pp.241–2). By the outbreak of war, the number of trained military nurses had increased to 272 members of the Queen Alexandra’s Imperial Military Nursing Service (founded 1902). The Territorial Forces Nursing Service, founded in 1908 as a nursing reserve, had an additional 2,117 members available for mobilization in 1914.

characterized the second half of the nineteenth century in Britain. In particular, the contested rise of the 'professional', a figure defined by W. J. Reader as 'very much a Victorian creation, brought into being to serve the needs of an industrial society',²³ is a useful framework for analysis, as medicine and the military were two occupations that were a particular focus for such professional reform and demarcation. Between 1858 and 1914 both underwent a series of reforms which introduced training and examination, rather than patronage, as routes to professional identity and seniority. In the process, demarcational boundaries were put in place which were exclusionary along the lines of both class and gender. These would shape the AMS, and subsequently the RAMC, the emerging identity of which as a unique medico-military corps drew on the definitional professional practices of both occupations.

To understand how this process worked in relation to the military, medicine, and military medicine, this chapter uses the concept of the 'professional project' as a concrete, historically contingent set of practices which 'consist of strategic courses of action which take the forms of occupational closure strategies and which employ distinctive tactical means in pursuit of the strategic aim or goal of closure'.²⁴ Such practices, as Anne Witz has demonstrated in relation to medicine in Britain in the nineteenth century, were gendered in terms of both the strategies employed by gendered categories of actors in defining occupational classes as professional areas of expertise, and the 'facilitating or constraining structures, which are patriarchal. Gendered strategies and patriarchal structures are mediated through the institutionalisation and organisation of male power within different sites of social, economic and political relations, within which the tactical means of strategic action are mobilized'.²⁵

The particular actions identified by Witz include credentialist practices, such as examinations, and exclusionary ones, such as the requirement of membership of accredited professional bodies, where membership was regulated. While Witz focuses her analysis on medicine and the ways in which such practices were used to segment caregiving practices along gendered lines, such practices were also used by the army in the

²³ W. J. Reader, *Professional Men: The Rise of the Professional Classes in Nineteenth-Century England* (London: Weidenfeld & Nicolson, 1966), p.2.

²⁴ Anne Witz, 'Patriarchy and the Professions: The Gendered Politics of Occupational Closure', *Sociology* 24 (November 1990): 675, DOI: 10.1177/0038038590024004007.

²⁵ Witz, 'Patriarchy and the Professions', 677. For other examples of the ways in which medical professions were defined by both classed and gendered demarcating practices, see Vanessa Heggie, 'Health Visiting and District Nursing in Victorian Manchester: divergent and convergent vocations', *Women's History Review* 20 (July 2011): 403–22, DOI: 10.1080/09612025.2011.567054.

early-to-mid nineteenth century within the context of social reforms aimed at opening up the higher tiers to the emerging middle classes. In the case of the military, however, divisions were created predominantly along lines of class. Moves towards professionalization, however reluctant, were at the expense of those with aristocratic connections, while remaining exclusionary of the working-class men of the ranks.²⁶ For the RAMC, which developed at the intersection of medicine and the military, both gender and class shaped the boundaries which defined it as a professional institution. It is, therefore, important to consider both parameters in any examination of the occupational space that the men who served in the unit occupied.

This chapter looks at the process of professional reform and consequent identity formation that took place in both the military and medicine between 1858 and 1914 to explore the intersections between class and gender that defined the boundaries of both these professional projects. This discussion includes consideration of the ways in which the rise of voluntary humanitarian aid during the period influenced the social and political position of military medicine as part of both the military and civil establishments. It then examines the process of medico-military reform that led to the formation of the RAMC in 1898, before finally turning to how the Haldane Reforms and the creation of the Royal Army Medical Corps (Territorial) (RAMC(T)) units complicated the identity of the RAMC as a trained medico-military unit on the eve of the First World War. Understanding the processes of late nineteenth-century reform to the unit in these terms provides important insight into the status of RAMC rankers as both non-combatant military servicemen and unqualified male caregivers on the eve of the First World War.

MILITARY REFORM

Although the history of military medicine as a specific discipline within the British armed forces can be traced back at least to the seventeenth century,²⁷ the most commonly identified starting point for narratives of the development of the British Army Medical Services into the Royal Army Medical Corps is the Crimean War.²⁸ This conflict was 'the first

²⁶ Edward M. Spiers, *The Army and Society, 1815–1914* (London: Longman, 1980), pp.146–50.

²⁷ McLaughlin, *The Royal Army Medical Corps*, p.2.

²⁸ Richard A. Gabriel and Karen S. Metz, *A History of Military Medicine, Vol. II: From the Renaissance through Modern Times* (New York: Greenwood Press, 1992), p.271.

time that the insufficiency of the system for nursing the army's wounded, as well as the inadequacy of supply lines and ordnance planning, was publicly exposed through a vocal press, notably [William] Russell's dispatches for *The Times*.²⁹ Russell's reports led Sidney Herbert, Undersecretary of State for War, to send Florence Nightingale and her staff of thirty-eight female volunteer nurses to Scutari, where they found poor hygienic conditions, a lack of medical supplies, and official indifference on the part of the military authorities.³⁰ As Nightingale herself would later write, 'The sanitary state of the Hospitals at Scutari was such that the sick had not a chance'.³¹

While Nightingale has generally been credited as the prime mover in the post-war reform of military medicine through her vigorous campaigning for a trained female nursing corps, the influence of Herbert should not be underestimated. Where Nightingale focused her attention on the training and provision of an exclusively female nursing unit, believing that 'Every woman is a nurse', Herbert, as a government minister, helped 'improve the health of the army as a whole and . . . the organization of the Medical Department in particular'.³² Herbert's reforms, however, took place within a context of wider military reform in response to the conflict. As Alan Ramsay Skelley notes, 'The Crimean War left a legacy of concern with the terms and conditions of service of the rank and file, which in later years . . . was to serve as impetus for a number of attempts at reform, not all of which were successful'.³³ Nor was it only Crimea that sparked such concerns. The Indian Mutiny (1857) and the French Invasion Scare of 1859 contributed to an atmosphere of anxiety which, according to Spiers, turned the six years at the end of the 1850s into:

a pivotal period in relations between the army and society. . . . Reformers, both military and civilian, campaigned for sweeping changes in the purchase system, the standards of military education, the social conditions of the rank

In Cantlie's two-volume *History of the Army Medical Department*, Crimea forms the starting point of Volume 2 and is of such significance that three chapters are devoted to the conflict.

²⁹ Furneaux, *Military Men of Feeling*, p.195.

³⁰ Florence Nightingale, *Notes on Matters Affecting the Health, Efficiency, and Hospital Administration of the British Army Founded Chiefly on the Experience of the Late War* (London: Harrison and Sons, 1858).

³¹ Florence Nightingale, *Measuring Hospital Care Outcomes: Excerpts From the Books Notes on Matters Affecting the Health, Efficiency, and Hospital Administration of the British Army Founded Chiefly on the Experience of the Late War, and Notes on Hospitals* (Oakbrook Terrace, Ill.: Joint Commission on Accreditation of Healthcare Organizations, 1999), pp.81–2.

³² Cantlie, *A History of the Army Medical Department*, p.196.

³³ Alan Ramsay Skelley, *The Victorian Army at Home: The Recruitment and Terms and Conditions of the British Regular, 1859–1899* (London: Croom Helm, 1977), p.17.

and file, and the organization of the reserve forces. Their campaigns, launched in the 1850s, would be sustained in some instances throughout the next decade.³⁴

As Spiers's description of the areas of concern targeted by reformers indicates, the army reforms were aimed at professionalizing the military both through the abolition of the explicitly class-based exclusionary patronage practice of purchase of commissions and, for the officer corps, the establishment of demarcationary practices of promotion based on education and competitive examinations. While proposals for the abolition of purchase were raised during the Crimean War by Sir George De Lacy Evans, they were strenuously resisted by the existing officer corps. Educational reforms were more successful. 'Sustained pressure' from the Prince Consort and Parliament in favour of educational reform for the officer corps ensured that new Staff College regulations 'emerged as one of the few tangible reforms of the post-Crimean period'. However, 'More fundamental reforms encountered increasing opposition during the late 1850s and early 1860s.'³⁵

While attempted reforms around the promotion and education of the officer corps were clearly aimed at reimagining the military as the 'profession of arms' in nineteenth-century professional terms, those aimed at improving the social conditions of the rank and file and the organization of the reserve forces were less clearly defined as part of a wider professional project. Indeed, the development of the Volunteer Force as an alternative to the militia as the home defence reserve after the 1859 invasion scare can be read as a move away from professionalization of the military through occupational demarcation to a more fluid understanding of military service incorporating the concept of the 'citizen soldier'.³⁶ Volunteers were initially envisioned as a force amenable to but not under military discipline, whose 'system of drill and instruction should not be "unnecessarily irksome". Proficiency in rifle shooting and drill should not be their aim.'³⁷ The result was that by the second half of the 1860s, 'Expected to defend the homeland, [the Volunteers'] capacity to do so was increasingly called into question.... Their lax discipline, lack of formal military organization, and independence from military authorities seemed almost anachronistic.'³⁸ The Volunteers thus acted as a contrast, highlighting the

³⁴ Spiers, *The Army and Society*, p.145.

³⁵ Ibid., pp.154–5.

³⁶ Matthew McCormack, *Embodying the Militia in Georgian England* (Oxford: Oxford University Press, 2015), pp.172–90; *Soldiering in Britain and Ireland 1750–1850: Men of Arms*, ed. Catriona Kennedy and Matthew McCormack (Basingstoke: Palgrave Macmillan, 2012).

³⁷ Spiers, *The Army and Society*, p.165.

³⁸ Ibid., p.168.

demarcation of the Regular Army as a professional body defined by the training provided and expertise demonstrated by all ranks, however limited this might, in reality, have been.

Evidence of the limits of reform in this period can be seen in the Cardwell Reforms of the early 1870s, particularly the attempts to reform recruitment to the ranks. The Army Enlistment Act (1870), which abolished the payment of bounties and sought to dissuade recruiting sergeants from enlisting 'men of bad character', was 'intended to modify the elements of fraud, deception and dissipation associated with the recruiting process. These measures, however, neither ensured a steadier supply of recruits nor raised the status and appeal of an army career.'³⁹ This was reflected in the difficulties that ex-servicemen had in finding employment following their six-year period of service. The reforms were more successful in relation to the recruitment of officers, with the abolition of purchase, although this ultimately failed to result in an increase in merit-based promotion due to the obstructionist attitude of the Duke of Cambridge.⁴⁰ The Localization Act (1872), however, did lead to closer cooperation between the regular, auxiliary, and reserve forces. This change was intended to improve both the class of men recruited to the regular forces and the practice of auxiliary and reserve units 'by enabling them to train periodically with the regulars'.⁴¹ However, this too failed to improve the social status of the military as a competitive professional career for either officers or men, something which continued to be the case throughout the final quarter of the nineteenth century. Despite the growing popular appeal of the military as a cultural force in the wake of the 'little wars of empire',⁴² military reform ossified and 'the army, as a career, retained its lowly appeal',⁴³ a fact reflected in Kipling's 1890 plea that the public 'prove it to our face / The Widow's Uniform is not the soldier-man's disgrace'.⁴⁴ The military as a professional project at the end of the nineteenth century would remain strictly limited for both officers and men, with the persistence of class-based demarcatory practices of exclusion outweighing attempts to introduce more credentialist systems of professional definition.

³⁹ Ibid., p.184. ⁴⁰ Ibid., p.194. ⁴¹ Ibid., p.197.

⁴² *Popular Imperialism and the Military*, ed. John M. MacKenzie (Manchester: Manchester University Press, 1992); Graham Dawson, *Soldier Heroes: British Adventure, Empire and the Imagining of Masculinities* (London: Routledge, 1994), pp.144–6.

⁴³ Spiers, *The Army and Society*, p.206.

⁴⁴ Rudyard Kipling, 'Tommy (The Widow's Uniform)', *St. James's Gazette*, 1 March 1890, ll.35–6.

MEDICAL REFORM

At the same time that military reform was attempting to renegotiate the class-defined, excluding boundaries of the profession of arms in relation to recruitment and career progression, the medical profession was undergoing reformation of its own boundaries along gender lines. The process of class-based professional reformation in medicine had begun somewhat earlier in the nineteenth century, with W. J. Reader arguing that 'the passing of the Apothecaries Act, in 1815, marked the emergence of the nineteenth-century general practitioner, in the sense of a practitioner holding recognized qualifications in medicine and surgery'.⁴⁵ The early nineteenth century, he suggests, was a period when 'Both professional ethics... and the modern idea of professional qualifications were merging from the mingled principles of craft-pride, job protection, division of labour, snobbery, service to clients, and genuine regard for the public interest'.⁴⁶

This interpretation of medical reform, like the sociological analysis undertaken by Noel and José Parry, emphasizes the class basis of the reformatory process, with 'The Medical Registration Act (1858) [as] the major landmark in the rise of the apothecary and of the surgeon from their lowly status of tradesmen and craftsmen and their assimilation into a unified medical profession with the higher status physicians'.⁴⁷ Subsequent reforms similarly used class divisions, most notably educational differences, as exclusionary principles of demarcation. Yet more recent analyses of the development of nineteenth-century medical practice as a professional project have shown how women's cultural status as primary care providers complicated definitions of professionalism along gender as well as class lines.

This process of gendered professional demarcation occurred at two levels. On the one hand, doctors sought to establish their professional remit by defining and controlling the inter-occupational boundaries between medical and adjacent caring practices, principally those, such as midwifery, dominated by women.⁴⁸ At the same time, 'Nursing became a target for reformers who wanted to transform what was... a menial lower-class occupation to a respectable middle-class calling',⁴⁹ in other words,

⁴⁵ Reader, *Professional Men*, p.41.

⁴⁶ Ibid., p.43.

⁴⁷ Noel Parry and José Parry, *The Rise of the Medical Profession: A Study of Collective Social Mobility* (London: Croom Helm, 1976), p.131.

⁴⁸ Witz, 'Patriarchy and the Professions': 683–5.

⁴⁹ Hacker, 'Reformers, Nurses, and Ladies in Uniform', p.141.

attempts were made to do for female-dominated care provision what the Apothecaries Act had done for doctors. Both these facets of the medical professional project involved strategies of dual closure, utilizing exclusionary tactics of registration and credentialism:

Both nurses and midwives waged long campaigns for state-sponsored systems of registration and aimed to regulate entry into nursing and midwifery by legitimating the practice of accredited nurses and midwives who had undergone a system of training and examination set down and monitored by a statutory regulatory body. Such a body would admit only accredited nurses onto a register of practitioners and would also have disciplinary powers to strike mal-practitioners off that register. . . . [B]oth nurses' and midwives' campaigns were spearheaded by elite groups of trained, middle class practitioners . . . whose aims to regulate the practice of nursing and midwifery were articulated as a quest for professional status, with its associated material and symbolic rewards. There were, then, prestige goals attached together with a vision of restructuring the class-base of nursing and midwifery.⁵⁰

Gender and class thus intersected in women's responses to masculine demarcation around the medical profession, which sought to exclude women from professional caring identities via credentialism.

Such strategies were not unproblematic, however. Despite the best efforts of the male medical profession at exclusion, women were qualifying as doctors by the end of the nineteenth century. The 'female professional project' that sought to raise the status of nursing and midwifery by defining them in professional terms via exclusion thus increasingly became:

both a problem and a pathway for women's entry into professional medicine. On the one hand . . . the presence of nurses in sick rooms, prisons, work-houses, asylums, and even military hospitals provided an obvious counter-argument to the idea that women should be barred from such sites because of the weakness and sensibility of their gender. . . . On the other hand the professionalization and gentrification of the nursing role in the second half of the nineteenth century meant that nurses became increasingly idealized as an archetypal, acceptable, and middle-class ideal of femininity.⁵¹

These tensions were bounded by class demarcations,⁵² but the reading of them as gendered spheres of conflict and negotiation demonstrates the multivalent ways in which nineteenth-century professional reform defined and was defined by social relations.

⁵⁰ Witz, 'Patriarchy and the Professions': p.685.

⁵¹ Vanessa Heggie, 'Women Doctors and Lady Nurses: Class, Education, and the Professional Victorian Woman', *Bulletin of the History of Medicine*, 89 (Summer 2015): 268, DOI: 10.1353/bhm.2015.0045.

⁵² Watson, 'War in the Wards'.

VOLUNTARY AID

Both these projects of professional reform, the military and medical, had important repercussions for the specific reforms around military medicine which culminated in the establishment of the Royal Army Medical Corps as a formally recognized unit in 1898. A further complicating factor which needs to be examined to understand the context of this process, however, was the simultaneous development of an active voluntary medical movement in this period. As Sally Frampton has pointed out, the establishment of first-aid organizations such as the St John Ambulance Association (1877) posed challenges to the fragile professional boundaries that medicine was putting in place. While such organizations ‘have always stressed the limits of the volunteer role in emergency medical situations . . . by virtue of existing, they highlight the limits of professional medicine’.⁵³ For military, as opposed to civil, medicine such challenges were particularly noteworthy on two counts. In the first place, the genesis of voluntary medical organizations lay in the provision of medical aid specifically in wartime. Secondly, the question of the boundaries between voluntary and military aid, and amateurism and professionalism in the provision of such aid, was at the heart of the tensions which marked the development of medical relief as a vocational field. The field as a whole, as Gill notes, ‘emerged in close and not always harmonious connection with the professionalization of nursing, as well as army reform’.⁵⁴

While the Crimean conflict had a profound influence on the negotiation of relationships between voluntary-aid bodies and the Army Medical Services,⁵⁵ the formal foundation of voluntary medical aid in Britain is generally dated to the foundation of the NAS on the outbreak of the Franco-Prussian War in 1870. Under the leadership of Robert Loyd-Lindsay, and with the input of members of the revivified Order of St John, including John Furley, Henry Brackenbury, and Thomas Longmore, the Society initially formed ‘part of a wider reformist agenda within modernising circles in the army and the War Office’. However, the protocols for voluntary aid in wartime being promulgated by the new International Committee of the Red Cross were, under Loyd-Lindsay, ‘adopted only so far as they coincided with existing attempts to rationalize

⁵³ Sally Frampton, ‘Amateur Surgeon or Dutiful Citizen? The First Aid Movement in the Nineteenth Century’, *Remedia*, 2 November 2015, <https://remedianetwork.net/2015/11/02/amateur-surgeon-or-dutiful-citizen-the-first-aid-movement-in-the-nineteenth-century/>, last accessed 27 April 2017.

⁵⁴ Gill, *Calculating Compassion*, p.18.

⁵⁵ Ibid., p.27.

the army medical services'.⁵⁶ The initial provision of aid by the Society during the Franco-Prussian War, a conflict in which the British armed services and their medical arms were not involved, meant that 'The priority of non-discriminatory emergency care was... established, but this arose on the ground, in response to (British) military priorities.... The collection of the wounded and administration of "first aid", their transportation and the creation of "overspill" capacity in hospitals adjacent to the front, became the special niche of the NAS and the Red Cross movement. Here they contributed to a transformation in military medicine'⁵⁷ through the involvement of army reformists such as Longmore, a professor of military surgery, in the organization of the NAS.

In spite of this connection with military medical reform, in the wake of the war the NAS sought to portray itself as independent from the official workings of the War Office. In the 1877 Report on its work during the war, it was noted that 'one of the great advantages of voluntary societies is that their agents can work untrammelled by military regulation'.⁵⁸ This was very much the position adopted by Loyd-Lindsay, who also believed that 'leftover cash donations [from the conflict] should simply be deposited in the bank and left to gather interest until wanted again in the next war. To follow any other course was, in his opinion, to violate the trust of the donors, who deserved assurance that their gifts would be used by the society solely for the purpose of aiding the sick and wounded in war'.⁵⁹ This position was very much in conflict with that of the Order of St John members, who argued both for a programme of peacetime preparation and training in first aid for volunteers and for the official incorporation of voluntary medical aid into the army medical services.⁶⁰ This dissention ultimately resulted in the resignation of the members of the Order of St John from the NAS in 1874 and the creation by the Order of an Ambulance Department to provide the officially sanctioned systematized training that they had been advocating for. This move was seen by the Order's critics as a professionalization and militarization of voluntary aid.

This schism within the medical voluntary-aid movement helped to shape British voluntary humanitarian efforts in both the Balkan conflicts of 1876–8 and the Egyptian campaigns of 1882 and 1884. The aid provided in both conflicts was, according to Rebecca Gill, marked by 'Loyd Lindsay's

⁵⁶ Ibid., p.33. ⁵⁷ Ibid., pp.58–9.

⁵⁸ National Aid Society, *Report of the operations of the British National Society for Aid to the Sick and Wounded in War during the Franco-German war, 1870–1871, together with a statement of receipts and expenditure and maps, reports, and correspondence* (London: Harrison and Sons, 1871), p.152.

⁵⁹ Hutchinson, *Champions of Charity*, p.239.

⁶⁰ Ibid., p.239; Gill, *Calculating Compassion*, p.69.

lack of foresight and maladroit interventions . . . compounded by the lack of government interest in the proper functioning of volunteer aid'.⁶¹ This was a source of personal frustration for John Furley who, on 25 June 1877, in his role as 'Chevalier of Justice of the Order of the Knights of St John of Jerusalem in England', gave a paper to the Order's General Assembly calling for the organization of 'a training school on a large and comprehensive scale, in which men and women can be taught ambulance work and the first rudiments of the art of nursing'.⁶² This would form the basis of a 'Red Cross Army', providing first-aid training in peace and supplying voluntary aid in war. He returned to the themes of this paper in a letter in *The Nineteenth Century* in 1885, calling for 'a "perfect understanding" to be fostered between "benevolent neutrals" and the official army medical services, and for voluntary medical preparations for war to be placed upon a permanent footing'.⁶³ This in turn led to 'An angry correspondence . . . with attacks on the society's inefficiency. There were accusations that the money raised from the public was handed over with no accountability . . . that all good suggestions were "pigeon-holed in some dark corner" and that while the volunteers were excellent, the [National Aid] society itself was stagnant'.⁶⁴

At the heart of the disagreement was the relationship between voluntary and military medical aid, principally whether the former should come under the supervision and authority of the latter or maintain a level of amateur independence, and with it claims to neutrality. These debates would continue to intensify, even as cooperation between the two voluntary institutions was formalized, first in the form of the Central British Red Cross Committee (CBRCC, 1899), and then the BRCS (1905). As late as 1910, however, the BRCS and the Order of St John were still arguing over the level of training necessary for the issuing of a Voluntary Aid Detachment certificate and 'by 1914 many people had come to view the BRCS and the St John Ambulance Association as two separate bodies, which not only did not make common cause with one another but which were open rivals'.⁶⁵ However, despite the best efforts of Loyd-Lindsay and later his nephew Archie Loyd, to counter their arguments, the St John Ambulance Brigade was, throughout this period, increasingly able to make the case for a trained, uniformed service working closely with the War Office, if not actually under War Office authority.

⁶¹ Gill, *Calculating Compassion*, p.114.

⁶² John Furley, *The Proper Sphere of Volunteer Societies for the Relief of Sick and Wounded Soldiers in War* (London: Harrison and Sons, 1877), p.10.

⁶³ Gill, *Calculating Compassion*, p.178.

⁶⁴ Moorehead, *Dunant's Dream*, p.138.

⁶⁵ Hutchinson, *Champions of Charity*, p.253.

This evolution in voluntary medical care provision had important implications for the development of the official military medical services. If, as Gill suggests, ‘independent voluntary organisation had become a necessary part of national war planning . . . [with t]he line between “comforts” and “necessities” that had been traversed by the Red Cross in the Sudan . . . rendered meaningless by the extent of the critical services that it provided’,⁶⁶ then the precise role of the AMS as a specific military branch was open to question. Given the continuing ‘failure of the Army to recognise the importance of an efficient and authoritative medical service’⁶⁷ across this period, it is unsurprising that the officers and ranks of the medical services perceived the work of both the NAS and the St John Ambulance as a challenge to their ability and identity.⁶⁸ This was to persist throughout the First World War, with Sir William Macpherson, author of the official history of the medical services in the war, noting:

It has been a popular tradition that the regular medical services of the army, either from inadequacy of personnel and equipment, or from lack of elasticity and sympathy in administration, are incapable of giving all the care to which sick and wounded are entitled. But whatever may have been the original causes of this popular tradition it is essential to recognise that it is through voluntary aid organizations more than through official channels that the sympathy of the people, of the women of the country, and of those who from various causes are unable to take a more active part in a nation’s struggle finds expression. It thus becomes that element in the medical services of an army during war which appeals most to the popular imagination and obtains the greatest support in the public press.⁶⁹

As Macpherson’s comments indicate, the challenge to the professional demarcation of military medical services had a particularly gendered dimension, with both first aid and voluntary medical aid gaining an increasingly feminized image by the turn of the century.⁷⁰ The idea articulated by Nightingale during the campaign for a military nursing service, that women were especially suited to the care of the sick and injured by virtue of their gender, continued to develop and be reinforced by changes such as the establishment of the Army Nursing Service in 1861 and the institution of the Queen Alexandra’s Imperial Military Nursing

⁶⁶ Gill, *Calculating Compassion*, p.190.

⁶⁷ Whitehead, *Doctors in the Great War*, p.2.

⁶⁸ Gill, *Calculating Compassion*, p.174.

⁶⁹ W. G. Macpherson, *History of the Great War Based on Official Documents: Medical Services General History*, Vol. 1 (London: His Majesty’s Stationery Office, 1921), p.208.

⁷⁰ Frampton, ‘Amateur Surgeon or Dutiful Citizen?’.

Service (QAIMNS) in 1902.⁷¹ While the women recruited to these new units were predominantly, but not exclusively, lower middle class,⁷² voluntary medical service organizations were increasingly providing upper- and middle-class women with opportunities to become directly involved in the practical provision of relief. While this involvement led to repeated critiques of the role of the 'lady amateur' in the failures of medical provision, especially in the wake of the Boer War,⁷³ it also proved a potent source of imagery for fundraising and recruitment, with the Red Cross styled 'as the feminine counterpoint to battle-scarred masculinity'.⁷⁴ Thus the challenge that the increased importance of voluntary-aid organizations to the provision of medical care posed to the military medical services was not only to their identities as caregivers in a military context but to their identities as men. If women of all classes were constructed as natural caregivers in war as well as peace, the men tasked with providing care were at risk of being perceived as not fully masculine.

MEDICO-MILITARY REFORM

This, then, was the context in which the Army Medical Services undertook a series of reforms which culminated, in 1898, in the establishment of the RAMC as a single Corps by Royal Warrant. The initial reforms set in train by Nightingale and Herbert in the wake of the Crimean War were designed both to raise the status of medicine as a service within the military and, drawing on gendered understanding of care, to do so by locating women as medical caregivers within the formal military systems. In reality, these two goals were often at odds, producing a series of medical organizations so complex that, even when rationalized and granted the status of a corps, the identity of male military medical caregivers, particularly those of lower ranks, remained open to question by both the military hierarchy and British society more broadly.

The level of confusion around military medical reform can be seen in the fact that 'No less than six different commissions were set in train' in the wake of Crimea.⁷⁵ These commissions addressed questions including who should be responsible for hospital administration and the dispensing of medicines, the provision of practical services such as cookery and

⁷¹ 'An Address By The Chairman, Surgeon-General W. Taylor, C.B., Director-General, A.M.S., on the History of the Army Nursing Service', April 1902, WO 243/20, TNA.

⁷² Light, 'The Military Nursing Services'.

⁷³ Gill, *Calculating Compassion*, p.180.

⁷⁴ Ibid., p.188. See also Ouditt, *Fighting Forces, Writing Women*, pp.17–23.

⁷⁵ Cantlie, *A History of the Army Medical Department*, p.196.

hygiene, and the status of the Medical Department as a military or civil branch. The conclusion of the last of these was that 'The Army surgeons (should) be not a more military body than at present',⁷⁶ an unpopular option that was to have significant repercussions for the professionalization of military medicine.

Practical reorganization of the Department was also undertaken in the period. The Medical Staff Corps, which had been formed in 1855 as a unit without its own officers and whose poorly educated recruits received little training, either military or medical, was replaced in 1857 by the Army Hospital Corps (AHC). This was made up of two branches, the Purveyor's Branch of stewards, cooks, and storekeepers, and the Medical Branch, which staffed the wards of both general and regimental military hospitals. The Corps never recruited sufficiently to staff both types of hospital fully and, in 1861:

it was laid down in a Royal Warrant . . . that duties were to be confined to general, station, and field hospitals. It was therefore agreed that the *regimental* hospital orderlies would be retained but regarded as supernumerary to establishment and should be unarmed except for a sword bayonet designed for self-defence; while continuing to wear the regimental uniform they also wore distinctive badges. The terms under which volunteers were accepted expressly laid down that in times of war the Corps would be liable for employment with the ambulance transport and the removal of wounded from the field.⁷⁷

The supernumerary status of these men would have its legacy in the regimental stretcher bearers who formed a key link in the evacuation chain during the First World War.

The regimental hospital system, whereby each regiment provided medical care on British soil to its own men, was, in this situation, unsustainable and was abolished in 1873 as part of the Cardwell Reforms. In its place an apparently more professional system of garrison and station hospitals was introduced, along, importantly, with military ranks for Corps members: 'chief stewards became sergeant majors, whilst orderlies 1st, 2nd and 3rd class were ranked as corporals and privates. All this made for a more corporate spirit.'⁷⁸ It did not, however, increase or improve the training of these men as providers of specifically medical care. They thus remained unarmed on the one hand and untrained on the other, leaving

⁷⁶ Quoted in Cantlie, *A History of the Army Medical Department*, p.199.

⁷⁷ Cantlie, *A History of the Army Medical Department*, p.233.

⁷⁸ Cantlie, *A History of the Army Medical Department*, p.234.

their professional identities as servicemen caught between the medical and the military.

It is important to note that throughout this period the Medical Services continued to consist of the AHC, made up entirely of men ‘possessed of a kindly disposition’,⁷⁹ and the Army Medical Department (AMD), made up entirely of officers. Reforms of both units were instituted, designed to attract a better class of recruit, with reforms to medical officers’ status initially aimed at improving their standing vis-à-vis the military officer corps, rather than recognizing their status as medical specialists through the acknowledgement of professional medical credentials. While the Royal Commission of 1857 did lead to the foundation of an Army Medical School which ‘allowed for the education and specialist training of Medical Officers, and became a centre for research into military medical hygiene’,⁸⁰ the plea by Dr Andrew Smith, Principal Medical Officer to the British Army in Crimea, that military commandants be removed from hospitals and replaced by medical officers, was dismissed by Herbert as ‘derogatory to the dignity of the medical profession and a waste of skilled labour to impose upon the medical officer duties of administration which he said were performed in a civil hospital by a matron, a nurse, and a house steward’.⁸¹

The Warrant of 1858 did, however, grant staff medical officers an increase in pay and equality of rank with regimental officers, placing them in theory on a level status with the rest of the Army. In reality, however, the Royal Warrant failed in its aim of raising the status of MOs with the military. According to Whitehead, ‘regimental medical officers, resenting the parity of status now enjoyed by [Staff] medical officers, successfully neutralized the effect of the new warrant’ through a policy of slights and blackballing.⁸² The result was, in the words of Lord Dalhousie, Secretary of State for War, ‘a system which gives a subaltern who is hardly free from his drill, precedence over his elder, who perhaps has served through every campaign for thirty years,—a system which treats a member of a learned profession, a man of ability, skill and experience as inferior to the cornet of cavalry’.⁸³ Both Staff and Regimental MOs, therefore, ended up with little respect either as military officers or medical professionals in the decade which immediately followed Crimea.

⁷⁹ McLaughlin, *The Royal Army Medical Corps*, p.16.

⁸⁰ Whitehead, *Doctors in the Great War*, p.9.

⁸¹ Cantlie, *A History of the Army Medical Department*, pp.204–5.

⁸² Whitehead, *Doctors in the Great War*, p.9.

⁸³ Quoted in Cantlie, *A History of the Army Medical Department*, p.269.

The regimental reforms of 1873 aimed to address MO dissatisfaction through the unification of the regimental and staff branches into a single department, with its own officers and distinctive uniform. The result was disastrous. Regimental Medical Officers lost military status through no longer being directly connected to their regiment but, because disciplinary control of the AHC continued to be withheld from them, failed to gain any commensurate recognition for their medical credentials. Indeed, the new Warrant was perceived as imposing non-professional administrative duties on men with a specialist medical skill set. The result was a department divided into six classes:

- (a) Medical officers, divided into executive staff and administrative staff.
- (b) Purveyors, or quartermasters as they were now called—controlling stores, equipment, rations, and clothing.
- (c) Apothecaries for medical stores and surgical appliances.
- (d) Dispensing department which included dispensers and compounders.
- (e) Army Hospital Corps for nursing duties and cooking, care of patients' kits and cleaning.
- (f) Female nurses, introduced into regulations for the first time.⁸⁴

Of these, only the medical officers could lay any claim at all to the status of doctor as defined by the professional demarcations laid down by the civil profession, and many of their responsibilities were administrative rather than medical. According to Whitehead, 'Medical Officers' lack of authority combined with the failure of the AMS to keep pace with the opportunities available to doctors in civil life to make it increasingly difficult for the Army to recruit a sufficient number of medical recruits. The number of candidates coming forward for commissions became so few that competitive examinations ceased',⁸⁵ throwing the status of MOs as professionals on the basis of credentialism into further question.

Criticism of the management of the AHC by military authorities during Wolseley's Egyptian campaign of 1882 led, in 1884, to further renamings. The AMD became the Army Medical Staff, and was given more authority over the renamed Medical Staff Corps. Members of the Medical Staff still did not, however, hold substantive military rank. Instead, they were awarded 'compound titles', in 'a victory for those in the combatant branch who refused to recognise the right of Medical

⁸⁴ Candie, *A History of the Army Medical Department*, p.277.

⁸⁵ Whitehead, *Doctors in the Great War*, p.10.

Officers to full military status'.⁸⁶ According to Whitehead, until 1898, when the RAMC was finally formed under the authority of Lord Lansdowne, who was sympathetic to the cause of MOs, 'The War Office ignored the growing importance of an efficient medical service in modern warfare. It failed to appreciate that the medical branch needed to be consulted in preparation for a campaign, or to see that doctors required a clear understanding of military tactics and procedures if they were to execute their duties properly'.⁸⁷ In other words, the reformatory moves of the military towards a more professional organization failed to incorporate the medical services until the very end of the nineteenth century. Even then, many within the military hierarchy continued to view medical officers as 'just doctors', placing them within a hierarchy of care and responsibility that failed to respect the credentials which accorded them their civilian expertise.

This failure of military medical services to reflect the civil status of medicine as a profession can also be seen in the reforms of the Army Nursing Service which legitimized women's roles as caregivers in a military context, often at the expense of the status of male military caregivers of all ranks. This attitude towards women's caring roles, as we have seen, dated from Crimea, where:

Nightingale's image as . . . simultaneously a strong leader and angelic healer successfully displaced widespread anxieties about the administration of the army and the inadequacies of transport, supply, and medical care that the war exposed. The voluntary nursing response attempted to alleviate the immediate problem of suffering, at the same time as the gendered ideology of women's unique ability to minister to the sick deflected attention from these structural problems, allowing the British public to feel better about the care for soldiers.⁸⁸

In the process, male orderlies and army surgeons were either denigrated by or excised from popular representations of the military medical services. The result was a powerful popular message of the gendered division of labour, which Nightingale would reinforce over the following decades in her campaign for an established female army nursing service. It continues to inform the historiography of medical nursing; as recently as 2012 Barton Hacker argued that the rise of military nursing as a respectable role for middle-class women in the second half of the nineteenth century enabled them to reassert 'women's claim to nurse sick and wounded

⁸⁶ Ibid., p.11. ⁸⁷ Ibid., p.11.

⁸⁸ Furneaux, *Military Men of Feeling*, pp.197–8.

soldiers, eventually bringing to an end, at least temporarily, the army's brief and troubled experiment with male orderlies'.⁸⁹

In fact, the process of female domination of army nursing as outlined by Hacker was perhaps rather slower and less comprehensive than he implies. While the Army Nursing Service was formed as early as 1861, it was marginalized by the British military to an even greater extent than the AMD. Formal acknowledgement of the service in the regulations only came about in the 1887 Warrant, while full establishment arguably only occurred in 1902 with the formation of the QAIMNS. What is significant about the development of the service in this period, however, is the extent to which it operated a system of dual closure similar to that of civil nurses, using a combination of regulated entry and the articulation of a prestige status, both socially and professionally, in relation to male orderlies, who were trained by female nurses,⁹⁰ to define their role as a profession. As Sue Light has noted:

The high standards imposed on new applicants meant that [the QAIMNS] was always under establishment, and relied on members of the Army Nursing Service Reserve to fill gaps in staffing throughout the pre-war period. Members of QAIMNS were all over the age of 25, single (or just possibly widowed), educated, of impeccable social standing, and had completed a three year course of nurse training in a hospital approved by the War Office. Difficulties in recruitment soon resulted in some slight relaxation in the number of 'approved' institutions, but insistence on the women being of a 'certain' social class was strongly adhered to.⁹¹

This successful formulation of a role for women of a certain class in the military medical services would have an important role to play in the final set of reforms to British military medical services prior to the First World War, namely the Haldane Reforms which occurred in the wake of the Second Anglo-Boer War (1899–1902). In combination with the increased professionalization of voluntary medical aid which was formalized through these reforms, the changes to military medical training and organization would provide the basis on which medical services of 1914–18 would be founded.

⁸⁹ Hacker, 'Reformers, Nurses, and Ladies in Uniform', p.142.

⁹⁰ Advisory Board for Army Medical Services and Nursing Board, 'Conjoint Report of the Advisory and Nursing Boards containing a Scheme to develop the Training of Orderlies of the Royal Army Medical Corps as attendants up on the sick and wounded', 1902, WO 243/20, TNA. I am grateful to the late Sue Light for drawing my attention to and helping me access this report.

⁹¹ Light, 'The Military Nursing Services'; Summers, *Angels and Citizens*, pp.227–8.

REFINING THE ARMY MEDICAL SERVICES

The Second Anglo-Boer War played a particularly significant role in the development of military medical services in Britain, primarily because of its timing as the first significant conflict involving the British armed forces following the establishment of the RAMC. John Blair has suggested that ‘in this South African . . . conflict, the Royal Army Medical Corps made its own transition from an irregularly organized, civilian-orientated service of the 19th century to the fully organized professional Corps of the Army of the 20th.⁹² Not all such assessments have been as positive, however. As Richard Gabriel and Karen Metz noted, the evacuation arrangements put in place by the young Corps, while ‘consistent with the doctrine of forward treatment adequately proven by the Germans in the Franco-Prussian War of 1870 and adopted as standard practice in the major armies’ of Europe, proved problematic in the context of the conflict in South Africa: ‘Although each brigade had a field hospital, there were no clearing points for triage and sorting casualties for evacuation to the rear. The gap between field and stationary hospitals proved as troublesome as it had to the Americans in the Civil War.’ It was only towards the end of the conflict that ‘British medical units began to establish clearing stations situated at rail heads for triage, stabilization, housing and eventual evacuation by trains. In 1907 these new units were officially incorporated into the British military medical service.⁹³ Field ambulances, meanwhile, proved difficult to move rapidly on the rough roads of the veldt, resulting in a large number of patient deaths in transport, while:

Transport of the wounded was made even more difficult in the early days of the war because of a lack of coordination between the litter bearer companies and the field hospitals. Although 2,400 men were assigned as stretcher bearers, the litter companies were assigned to brigades and were under military command of the division and not the hospital. After collecting the wounded and transporting them to the field hospitals, these companies returned to their line units, often marching off with the advancing brigade, leaving the field hospital deluged with casualties that needed evacuation to the rear but with no personnel or vehicles to accomplish their movement. As the war continued, eventually better coordination developed between the litter companies and the field hospitals, but it was not until 1905 that the British finally combined the two into a single unit [the Field Ambulance]

⁹² Blair, *In Arduis Fidelis*, p.6.

⁹³ Gabriel and Metz, *A History of Military Medicine*, p.218.

under the command of a medical officer belonging to the medical corps chain of command.⁹⁴

The war can thus be seen to be a steep learning curve for the Corps, the lessons of which only came to full fruition in the wake of the Royal Commission on the War in South Africa, whose findings were issued in 1903.⁹⁵

While transport and evacuation were key issues for the Royal Army Medical Corps and its ability to function effectively during the war, the most visible sources of criticism, which resulted in a separate enquiry in 1901, were the hospitals where men were nursed, which attracted much the same attention that Scutari Hospital had during the Crimean War. Epidemic levels of disease led William Burdett-Coutts, MP, acting as correspondent to *The Times*, to write of the

hundreds of men [who] to my knowledge were lying in the worst stages of typhoid, with only a blanket and a thin waterproof sheet (not even that for many of them) between their aching bodies and the hard ground, with no milk and hardly any medicines, without a single nurse amongst them, only 'orderlies' rough and utterly untrained in nursing. There were 3 doctors to 350 patients.⁹⁶

In later despatches he would write 'fiercely against men nursing: "A glaring blot on our present Army system . . . it is a violation of nature—for this is women's work, not men's."'⁹⁷ Such criticisms directly echoed those made by William Russell during the Crimean War, as did the representations made for a gender-based system of care.

The continuity in such representations demonstrates the limits of moves towards professionalism on the part of the military medical services in the second half of the nineteenth century, particularly in relation to the men of the ranks who served as the still-despised hospital orderlies. The 1901 Royal Commission on South African Hospitals had aimed much of its criticism at the officers of the RAMC. The 1903 commission, however, interviewed both military witnesses, who 'spoke well, and some very highly, of the zeal and energy of the Army Medical Services, though some of them pointed out that the service was often shorthanded, and that the orderlies, many of whom were mere untrained privates brought in

⁹⁴ Ibid., p.219.

⁹⁵ 'Report of the Royal Commission on the South African War', *British Medical Journal*, 2 (22 August 1903): 484–7.

⁹⁶ 'Our Special Correspondent' [William Burdett-Coutts, M.P.], 'Our Wars and Our Wounded IX', *The Times*, 27 June 1900.

⁹⁷ Blair, *In Arduis Fidelis*, p.50.

as makeshifts, were not always good', and civilian medical men, such as Professor Sir Alexander Ogston, who said:

with regard to the men employed as orderlies, that although there was no lack of zeal and devotion, many of them were quite untrained, and that most of them were 'absolutely ignorant of anything like what was required for attending on the sick. They were utterly unaware of how to deal with a sick man . . . and hence, in spite of all their good will, they failed from the want of this training'.⁹⁸

This concern over lack of training would be taken up that year by the Advisory Board for the Army Medical Services and the QAIMNS, which expressed concern that:

male nurses were constantly used for work which had no connection with nursing, such as ordinary hospital fatigues . . . [while] non-commissioned officers, presumably the best educated, and most trustworthy members of the Corps, cease to nurse individuals on attaining non-commissioned rank, and are utilised for clerical and store duties, &c., thereby relegating the care of the sick to less intelligent and often less trustworthy men.

This was exacerbated by the insistence upon training in nursing for all men of the ranks, which, the Board argued, 'is wasteful of energy, time and money, it lowers the status of the male nurse, it puts on the wards of the hospital men, who from conduct, education and temperament are unfitted to undergo such training'.⁹⁹

Lack of training for both officers and ranks of the Corps became, therefore, a key issue in the post-war reforms to the medical services which sought to remove 'those grievances and deficiencies which the formation of the RAMC had failed to solve'.¹⁰⁰ The Advisory Board's response to the anxieties over the training of orderlies was to recommend a specific training scheme for 'Orderlies of the Royal Army Medical Corps as Attendants on the Sick and Wounded'.¹⁰¹ This scheme divided the ranks of the Corps into four sections: a nursing section; a cooks section; a clerical section; and a general duty section, which included men employed as carpenters, gardeners, officers' servants, postmen, handymen, mortuary assistants, and sanitary orderlies.¹⁰² Three of the four sections were considered specialized, with specific training plans outlined for the

⁹⁸ 'Report of the Royal Commission on the South African War', 485.

⁹⁹ Advisory Board for Army Medical Services and Nursing Board, 'Cojoint Report of the Advisory and Nursing Boards', p.44.

¹⁰⁰ Whitehead, *Doctors in the Great War*, p.16.

¹⁰¹ Advisory Board for Army Medical Services and Nursing Board, 'Cojoint Report of the Advisory and Nursing Boards', pp.43–66.

¹⁰² *Ibid.*, p.45.

cooking section, for example, drawing on specialist training already provided by the Navy.¹⁰³ The nursing section, however, was to hold 'a more exalted position', and 'when an eligible man enlists in or is transferred to the Royal Army Medical Corps, his advancement in the Corps should depend mainly on efficiency in the Nursing section'.¹⁰⁴ To attain full advancement, and consequent higher pay, the men of the nursing section would, after they had 'passed through the course of instruction at Aldershot, in the Training School and in the Cambridge Hospital',¹⁰⁵ be sent to a military hospital to receive additional training under the supervision of a QAIMNS matron. A special syllabus was drawn up and the orderly was to be examined upon completion of his additional training. Successful completion would qualify him as a 'Queen Alexandra's orderly' on a daily rate of pay of 2s. 4d., or 6d. more than a first class orderly.

Nursing practice was thus identified as the core element of the professional identity of the RAMC ranker in this period, although later reforms to the Corps included changes to the structure and organization of the chain of evacuation. In 1906:

the litter bearer companies were combined with the field hospitals and placed under the command of a medical officer. In addition, three field ambulances were allotted to each division, with one held in reserve. To fill the gap between the field hospitals and the stationary hospitals, the clearing hospital—the forerunner of the casualty clearing station—was introduced. It served as the pivot around which the field medical services operated. It received casualties and sick from the field ambulance, conducted triage, stabilization, and sorting, and then oversaw transport of the wounded to the rear. The idea was to locate it as far forward as possible and lighten its load to increase its mobility.¹⁰⁶

This system 'was different from the more flexible system of old, in that definite zones were defined for the purposes of collection, evacuation, and distribution of casualties'.¹⁰⁷ That same year a school of sanitation was opened at Aldershot, to train officers and NCOs for service in sanitary squads.¹⁰⁸ The work of rankers serving as nurses, bearers, and in sanitary roles was thus reformed and refined in the years immediately preceding the First World War through increased provision of skills training and, for nursing orderlies, a level of professional demarcation via exclusion and examination.

The method of training nursing orderlies, however, was of particular significance to the status of the RAMC as a military medical unit from a

¹⁰³ Ibid., pp.47–8.

¹⁰⁴ Ibid., pp.50–1.

¹⁰⁵ Ibid. p.51.

¹⁰⁶ Gabriel and Metz, *A History of Military Medicine*, p.224.

¹⁰⁷ Harrison, *The Medical War*, p.8.

¹⁰⁸ Ibid., pp.7–8.

specifically gendered perspective. The particular method of training laid out by the Advisory Board involved the specialist training of these men being 'placed in the hands of Matrons', while a nursing sister should 'take part in the examination of such orderlies'.¹⁰⁹ Thus these men's professional identity as Queen Alexandra's Imperial Nursing Service nursing orderlies relied on both the formal exchange of expertise from women to men as regards training, and the policing of demarcationary boundaries by women with regard to examination.

The report reflects the extent to which the demarcationary practices used by women to define female nursing as a profession influenced male military medical caregiving in the era prior to the First World War, not simply through exclusion but through a process of dual closure which enhanced the narrative of nursing practice as both naturally female-dominated and professionally aspirational. 'The admission of men to Queen Alexandra's Imperial Nursing Services should be jealously guarded', the Advisory Board report stated, 'and only men of exemplary character and high qualifications should be permitted'.¹¹⁰ While on the one hand this served to identify male nursing practice as high-status, with nursing the primary pathway to promotion within the Corps, it also excluded men of the Corps deemed unsuitable for a role in which women were presumed to hold positions of authority. As Anne Summers has pointed out, 'after decades of official equivocation on the subject, female military nurses were now empowered to exact obedience, rather than hope for courtesy from male ward orderlies'.¹¹¹ Thus although the reforms of the Corps served in many ways to strengthen a distinctive identity for its ranks based on specialist training, the persistent official reinforcement of nursing practice as a feminine sphere where women could now expect deference from the men under their authority, even in the context of war and the military, placed the RAMC in an ambivalent gender position relative to both military and medical hierarchies.

BLURRING THE BOUNDARIES

If reforms of the training and practice of the RAMC served to complicate the status of the Corps, changes to the military medical reserves in relation to voluntary medical aid organizations in the aftermath of the Boer War had an even more profound effect on the status of medical care provision

¹⁰⁹ Advisory Board for Army Medical Services and Nursing Board, 'Cojoint Report of the Advisory and Nursing Boards', p.51.

¹¹⁰ Ibid, p.51.

¹¹¹ Summers, *Angels and Citizens*, p.226.

in the context of conflict. While the reorganization of military provision in the second half of the nineteenth century served to professionalize the Corps, it remained small in numbers.¹¹² The Boer War had exposed the reliance of the RAMC on 'impromptu recruitments of surgical, nursing and orderly staff in South Africa and Britain, and an influx of volunteers'.¹¹³ The sweeping Haldane Reforms to military reserves provided the opportunity for a more formal system of supplementation through the formation of a medical reserve force which drew upon the organization and expertise of voluntary medical aid organizations. The result was a blurring of boundaries between military medical services, military medical reserve unit, and voluntary medical aid units.

The Haldane Reforms of 1906–12 were the most significant military reforms to army structures since the Cardwell Reforms of the 1860s. While they encompassed the reforms to the Army Medical Services outlined above, they had the primary purpose of creating a 'self-contained second line army' of partially trained reserves.¹¹⁴ To this end, the fourteen divisions of the newly constituted Territorial Force (TF) '[e]ach . . . contained the necessary artillery, engineer and signals units together with transport and medical personnel'¹¹⁵ (my emphasis). While Spiers argues that the TF was 'more organised and more complete in its arms and equipment than the old Volunteers . . . [because i]t had field artillery, companies of engineers, medical, veterinary and supply services; it could have taken the field after the requisite training as a mobile force',¹¹⁶ its members consistently faced critiques over their perceived lack of dedication and professionalism.¹¹⁷ In particular, the lack of a foreign service obligation for TF volunteers, abandoned as politically too sensitive to achieve as part of the reform process, and the failure to recruit enough men to complete the establishment undermined the TF as a respected reserve.¹¹⁸

In addition to the divisional medical attachments, the RAMC had its own reserve force in the form of the RAMC(T), made up of units which had, before Haldane's reforms, formed the Volunteer medical services.

¹¹² Timothy Bowman and Mark Connelly, *The Edwardian Army: Recruiting, Training, and Deploying the British Army, 1902–1914* (Oxford: Oxford University Press, 2012), pp.2–3.

¹¹³ Gill, *Calculating Compassion*, p.181.

¹¹⁴ Peter Dennis, *The Territorial Army, 1906–1940* (Woodbridge: The Boydell Press, 1987), p.34; Spiers, *The Army and Society*, p.272.

¹¹⁵ Ray Westlake, *The Territorial Force 1914* (Newport, Gwent: Ray Westlake Military Books, 1988), p.5.

¹¹⁶ Spiers, *The Army and Society*, p.281.

¹¹⁷ Dennis, *The Territorial Army*, pp.25–7.

¹¹⁸ Ian F. W. Beckett, *The Amateur Military Tradition* (Manchester: Manchester University Press, 1991), pp.218–19.

Officially this comprised fourteen Mounted Brigade Field Ambulances of two sections each, forty-two Divisional Field Ambulances of three sections each which were allotted three to a division, twenty-three General Hospitals, two sanitary companies, and fourteen Clearing Hospitals.¹¹⁹ The RAMC(T), however, suffered from similar critiques and problems of recruitment as the ‘teeth units’ of the TF. As a result,

[t]he medical organisation of the Territorial Force was sufficiently complete to provide medical establishments and units which must accompany the troops. It also provided general hospitals, but it lacked such units as clearing hospitals, stationary hospitals, ambulance trains, and other formations. The regular army had these units; but it was easy to see that should occasion arise for the Territorial Force to be enormously increased, there would come the necessity for a great many extra medical units.¹²⁰

These extra units were the Voluntary Aid Detachments, which had been established in 1909 as part of the Haldane Reforms to fill ‘all sorts of odd niches which the regular medical services could not afford to do’ and for which the Territorial Force did not have the manpower.¹²¹ Importantly, the VADs recruited both men and women, although women dominated, with two-thirds of VAD members recruited between 1910 and 1914 being women.¹²² The climate of invasion fears in 1909, which spurred men’s enlistment in the TF,¹²³ similarly saw ‘The War Office . . . inundated by those offering courses in first aid, drill, signalling and stretcher bearing’.¹²⁴ However, the popularity of the VAD scheme was most successfully exploited by the newly established BRCS and the St John Ambulance Association, both of which registered with the War Office as accredited training providers.

The creation of the BRCS out of a merger between the CBRCC and the NAS by royal command in 1905 has been identified by Gill as a result of the wider processes of military reform in which

[Sir John] Furley saw his opportunity. Working closely with fellow Order of St John members Sir Alfred Keogh, Director-General of the Army Medical Service, and Lord Knutsford, Loyd Lindsay’s replacement as chair of the Red Cross Committee, he stamped his vision of a trained paramedical corps upon proceedings. . . . Despite objections from leading members of the NAS, who

¹¹⁹ Westlake, *The Territorial Force*, pp.76–83; Spiers, *The Army and Society*, p.280.

¹²⁰ Thekla Bowser, *Britain’s Civilian Volunteers: The Authorized Story of British Voluntary Aid Detachment Work in the Great War* (New York: Moffat, York, and Company, 1917), p.10.

¹²¹ Bowser, *Britain’s Civilian Volunteers*, p.11.

¹²² Gill, *Calculating Compassion*, p.188.

¹²³ Spiers, *The Army and Society*, p.279.

¹²⁴ Gill, *Calculating Compassion*, p.188.

justifiably felt that such a scheme jeopardized their independence and rendered them at the beck and call of the War Office, the reforms had the support of the king and queen. A merger of the CBRCC and a reluctant NAS was affected by royal command in July 1905 and a new BRCS inaugurated.¹²⁵

The key figure here was not Furley, however, but rather Sir Alfred Keogh, Director General of the Army Medical Services, who

was charged with meeting the needs of both the regular army and the Territorial force.... For the regular army, Keogh contracted the Order of St. John to supply bearer companies that would be formed into a Home Hospital Reserve. For the Territorial Force, Keogh, borrowing an idea from the Japanese and the Germans, . . . of having the BRCS organise voluntary aid detachments (VADs), which would be assigned the work of transporting the wounded from field ambulances to the railways and from the railways to the general hospitals. The original plan was that VADs would be organised and controlled at the county level by the local branch of the BRCS; they would be composed of men and women who had received preliminary instruction in first aid and nursing and had received certificates from the St. John Ambulance Association. There was one obvious difficulty with this scheme: The BRCS had not yet created active local branches in every county.¹²⁶

The result was that the War Office increasingly turned to the St John Ambulance to provide detachments to support the Territorial Force County Associations, giving the order a significant role in the provision of all elements of medical military reserve, whether Home Hospital or TF.¹²⁷ Thus, despite the disagreements between the Order of St John and the BRCS, both organizations were, by 1914, as deeply invested in their new-found status as organizers of uniformed, trained units answering to the War Office as the War Office was in taking advantage of such units as necessary adjuncts to the RAMC.¹²⁸

As we have already seen, the feminization of voluntary aid had implications for the gendered status of male military medical caregivers in relation to both the military hierarchy and wider society. The blurring of the boundaries that the institution of the VADs and the formalization of their role in relation to the RAMC(T) caused served to further reinforce the gendered ambiguities around male military caregiving. While the RAMC(T) was, like the TF as a whole, an entirely male service, the dominance of women among VAD volunteers reinforced the association

¹²⁵ Ibid., p.181.

¹²⁶ Hutchinson, *Champions of Charity*, p.250.

¹²⁷ Ibid., p.251.

¹²⁸ Gill, *Calculating Compassion*, p.190.

of medical care provision with the feminine in relation to the military services. Through the work of the BRCS and the St John Ambulance Association, the training programmes of both volunteer and military medical services were linked in the years before the First World War in ways which would influence the status of both units during the war itself.

CONCLUSION

Both the RAMC(T) and the VAD would go on to play a significant role in the provision of medical care during the First World War, particularly on the home front. That they were to do so demonstrates the extent to which the ethos of volunteer amateurism, whether military or medical, still shaped understandings of military medical provision, even as professional organization was increasingly shaping the structure of both military medical services and voluntary-aid organizations on the eve of the war. The great period of military and medical reform had seen the establishment of a specific military medical service with Royal Army Corps status. The refinement of training for the Corps introduced demarcationary practices that began to acknowledge the anxieties around professional identity which were of such significance to the medical profession in this period.¹²⁹ Both medical officers and nurses were deeply implicated in these shifts in definition and practice, but so too were the men of the ranks, whether regular, RAMC(T), or VAD.

The development of female military nursing and the increasing involvement of voluntary-aid organizations in both the provision of care and the training of medical reserves presented additional challenges to male medical rankers. The perceived feminization of care that these developments reinforced provided a direct gendered challenge to the roles and status of these men. This challenge, so far unaddressed by the historical literature in relation to men below the rank of commissioned officer, would have profound effects on the recruitment, training, deployment, and experiences of military medical service personnel when war broke out in 1914. Indeed, the blurred boundaries between regular, reserve, and voluntary caregiving, and the gendered messages about who was most suitable to deliver care in the context of industrial warfare, would have profound implications for the way in which the RAMC developed strategies for the delivery of care throughout the war, as will be examined in Chapter 2.

¹²⁹ Whitehead, *Doctors in the Great War*.

2

Eye Tests and Stretcher Drill

The recruitment and training of the RAMC ranks

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 prejudicial [*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) owing 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

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.

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 wartime⁴ 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

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.

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

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.

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

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.)

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,

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.scarletpost.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.

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 18s.6d. for a cleaner to 35s. for a head cook or head clerk and 30s. 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

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.

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 through 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

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 Stationery Office, 1911; repr. 1915), p.1.

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 Bandsman 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

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.

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 dépôts 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

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.

³⁹ Ibid., p.50.

³⁸ Ibid., p.49.

⁴⁰ Harrison, *The Medical War*, p.26.

⁴¹ Ibid., pp.124–42.

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 (Astigmatism), 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

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

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

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.

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

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).

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 ‘crock[s].’ [This was before the start of the Derby Scheme and, of course, considerably before the introduction of Universal Service.]⁵⁷

Congscription 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

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

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:

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.

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

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.

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

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 Royaumont, 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 Royaumont, 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.)

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 forces⁷⁵ 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

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.

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

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.

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

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.)

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

⁸⁴ War Office, *Royal Army Medical Corps Training*, p.13.

⁸⁵ Harrison, *The Medical War*, p.9.

⁸⁶ Ibid., p.126.

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

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?'

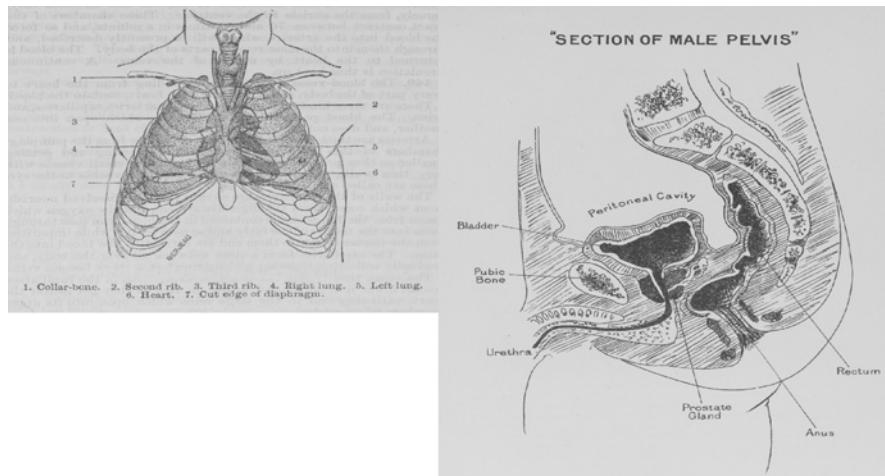


Fig. 2.1. 'The thorax or chest' and 'Section of male pelvis'; *Royal Army Medical Corps Training Manual*, pp.277, 300 (facing).

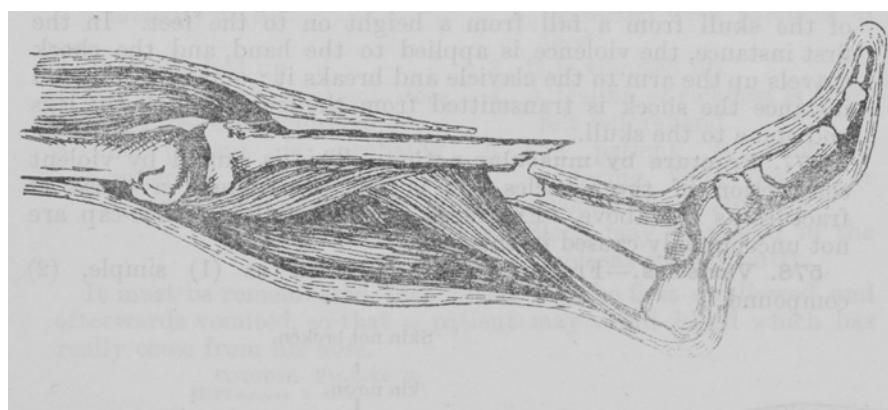


Fig. 2.2. 'Compound fracture of tibia'; *Royal Army Medical Corps Training Manual*, p.338.

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

⁹⁰ War Office, *Royal Army Medical Corps Training*, p.269.

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:

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

⁹¹ Whyte, 'Memoirs of the Great War, 1914–18', p.3.

⁹² Ibid., pp.3–4.

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 Dismiss⁹⁴

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

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.

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 grouching about

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.

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

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,

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 in 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

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.

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

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.

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

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

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.

THE SOLDIER'S FIRST AID



A. Patient on back of bearer. B. Patient on trench shovel.



A. Puttees fastened to feet of patient. B. Bearer's feet under armpits.

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.

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

¹²⁴ Ibid., pp.5–6.

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]

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.

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 masculinity¹³² 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.

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.

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.

3

Carrying, Cleaning, Caring

Other Ranks' roles along the line of evacuation

As we saw in Chapter 2, the training of RAMC servicemen attempted to prepare them for an ambiguous role, part medical caregiver, part resourceful campaigner, never fully practitioner or soldier. The ambiguity of their position within both the armed forces and the medical establishment, at once uniformed and subject to military discipline but forbidden from bearing arms, without formal medical training but laying claim to their own sense of semi-professional identity as carers, persisted as they moved from training into active service. This service drew on skills and knowledge designed in the training programme to be delivered as standard.¹ The nature of war service, however, inevitably varied among individuals in relation to a number of factors. These included not only the level of training provided and the individual interest and autodidacticism of the men themselves but also the size and mobility of the unit of service, the distance of that unit from the front line, and the theatre of service. These factors defined not only the types of work undertaken but also the challenges to be overcome and the patients and co-workers encountered in the course of service. The work of RAMC rankers can thus be seen to be defined in large part by the spaces in which they operated.

A number of historians have drawn on theories including historic geography and Foucault's concept of biopower to demonstrate how the spaces of caregiving in the First World War played a significant role in defining the cultures of caring for both caregivers and the cared-for in two important ways. On the one hand, sites of healing served as heterotopias, places 'outside of all places' where 'men arrive at a sort of absolute break with their traditional time'.² By taking wounded men out of their narrative trajectories as soldiers through exhaustion, wounds, and illness, rest huts and hospitals highlighted wartime anxieties over national efficiency

¹ War Office, *Royal Army Medical Corps Training*, p.2.

² Michel Foucault, 'Of Other Spaces', tr. Jay Miskowiec, *Diacritics* 16 (1986): 24.

and both civilian and military morale. The role of women in many of these spaces, meanwhile, helped to reinforce traditional values associated with domesticity and ideal masculinities. Patient encounters with female carers were represented in popular culture as a longed-for return to domesticity and a reinforcement of peacetime understandings of the gender order.³ On the other hand, hospital spaces were constructed around disciplinary power relationships of surveillance through the clinical gaze and bodily control.⁴ The work of female nurses and doctors in hospitals in close proximity to young men in states of increased physical and emotional vulnerability formed the locus of a range of anxieties over gender respectability, gendered divisions of labour, and the consequent effect on the social power dynamics between men and women in these spaces.⁵ As both spaces of retreat and spaces of control, therefore, wartime hospitals challenged and reinforced gendered constructs of care.

While such analyses of caring sites have, following Foucault, tended to focus on the architecturally defined hospital, not all spaces of medical care in war were so clearly demarcated by physical boundaries. Aid posts formed a small part of the non-medical space of the trench or merged into the landscape in which they were situated. Dressing stations and overseas hospitals co-opted and adopted other institutional settings in ways which challenged definitional boundaries.⁶ In Britain, meanwhile, in hospitals such as the First Eastern General, with its open-air wards, and the King George Hospital, Waterloo, which boasted a roof garden, the physical spatial boundaries of caregiving institutions were increasingly breached.⁷ Along the chain of evacuation, boundaries became even more blurred, with the work of caregiving undertaken not only within but also across spaces, with wounded men receiving care in a range of forms of transport, from stretcher through ambulance waggon or car to hospital barge, train, and ship. All these spaces of caregiving were, in turn, affected by factors such as distance, landscape, and weather conditions, which influenced the particular cultures of caring to be found within them.

³ Reznick, *Healing the Nation*, pp.137–9; Hallett, *Containing Trauma*, pp. 177–82; Alison S. Fell and Christine E. Hallett, 'Introduction: New Perspectives in First World War Nursing', in *First World War Nursing*, ed. Fell and Hallett, p.3; Carden-Coyne, *The Politics of Wounds*, p.251.

⁴ Carden-Coyne, *The Politics of Wounds*, pp.7–9.

⁵ Ibid., pp. 286–97.

⁶ The 1st/3rd Lowland Field Ambulance, for instance, turned a monastery in Gaza into a field hospital, complete with operating theatre for abdominal surgery. William Murray Lamb, Diary, TS transcript, 24 November 1917, Papers of William Murray Lamb, LIDDLE/WW1/GS/0912, LC.

⁷ Reznick, *Healing the Nation*, pp.46–54.

Unlike nurses, who were not allowed to serve further forward than the Casualty Clearing Station (CCS), and whose work was more clearly bounded by physically defined spaces such as wards, operating theatres, and hospital structures, whether buildings or tents, RAMC rankers worked in the full range of caring spaces. The diversity of these spaces shaped their labour, requiring them to undertake roles ranging from the construction of aid posts to carrying the wounded, from bandaging wounds to cleaning wards, from negotiating sand dunes to escorting convalescents through the English countryside. This variety of work in turn shaped their identities as carers and servicemen, particularly as it was defined in relation to the women alongside whom they served and with whom they increasingly shared spaces of care through official practices of dilution and substitution. Some labour allowed men to lay claim to a service identity by demanding they use physical strength and resourcefulness or demonstrate physical and emotional control on a par with that of front-line combatants.⁸ Such caregiving, which took place predominantly within the male-dominated spaces of the front lines and immediate reserve areas, had emotional significance as well, supporting as it did cultural narratives of male comradeship and bonding that developed in the physically and emotionally intimate spaces of the trenches.⁹ At the same time, service in other spaces, while no less intimate, served to challenge RAMC servicemen's masculine identities. In sites located in support areas, men found themselves serving under the authority of women while undertaking roles associated with female domesticity. In such spaces, the emotional labour of care also took on different meanings in light of the presence of female nurses, whose explicit femininity both offset and shaped the masculine identity of non-professional male carers.¹⁰

This chapter will examine different types of work undertaken by RAMC rankers in the range of spaces and landscapes that they served and acted in throughout the war, exploring the combination of physical and emotional labour which their work encompassed. This, it will be argued, enabled these men to lay claim to a form of wartime service which bridged the space between fighting line and home front, a space defined in wartime culture explicitly in gendered terms,¹¹ in ways no other category of wartime service could. Thus the work of the RAMC rankers reinforces the liminality not only of their own status as men and servicemen in wartime, but also that of caregiving as a gendered practice.

⁸ Meyer, *Men of War*, pp.49, 141–5.

⁹ Bourke, *Dismembering the Male*, pp.133–7.

¹⁰ Carden-Coyne, *The Politics of Wounds*, pp.242–9.

¹¹ Gullace, 'The Blood of Our Sons', p.43; Ugolini, *Civvies*, pp.4–7.

MEDICAL EVACUATION ALONG THE LINE OF COMMUNICATION

To understand the particular spaces within which RAMC rankers worked, it is necessary to outline the chain of evacuation that linked the regimental stretcher bearers collecting the wounded in no man's land to the hospital orderlies feeding, bathing, and entertaining patients in military hospitals in Alexandria, on the French coast, and in Britain. The system of evacuation which developed over the course of the war adapted spatially and temporally to the shifting demands of modern, industrialized warfare, and the varying priorities of different theatres of war.¹² At its heart, however, were three zones, defined by the military authorities as the collecting zone, occupied by combatants and medical field units; the evacuation zone, corresponding with the busy lines of communication, where dressing stations and CCSs were located; and the distribution zone, comprising the base area, home hospitals, convalescence units, and the transport between them (Figure 3.1).

Before looking at specific temporal developments, it is important to understand how the chain of evacuation formed the spatial basis for medical care provision by the RAMC. This system, which was developed in response to the investigations which followed the Second Anglo-Boer War,¹³ was visualized in the official *Medical Services General History* of the war in a number of diagrams, ranging from the schematic (Figure 3.2) to the specific (Figure 3.3). While the relative elaboration of such diagrams depended on the individual creating them, the fundamental structure was well established and consistent throughout the war.

The first zone, the collecting zone was, as shown most clearly in Figure 3.3, triangular in shape and,

nominally... contains only the regimental aid posts, the field ambulances and a 'casualty clearing station', or railhead hospital, which stands at the apex, and serves to house the sick and wounded sent on from the field ambulances until they can be passed down through the evacuating zone to the distributing zone. In practice, however, it contains certain other units of a medical character.¹⁴

¹² Harrison, *The Medical War*, pp.293–9.

¹³ Macpherson, *History of the Great War*, Vol. 1, pp.8–10.

¹⁴ 'The Royal Army Medical Corps and its Work', *British Medical Journal* 2 (18 August 1917): 217, DOI: 10.1136/bmj.2.2955.217.

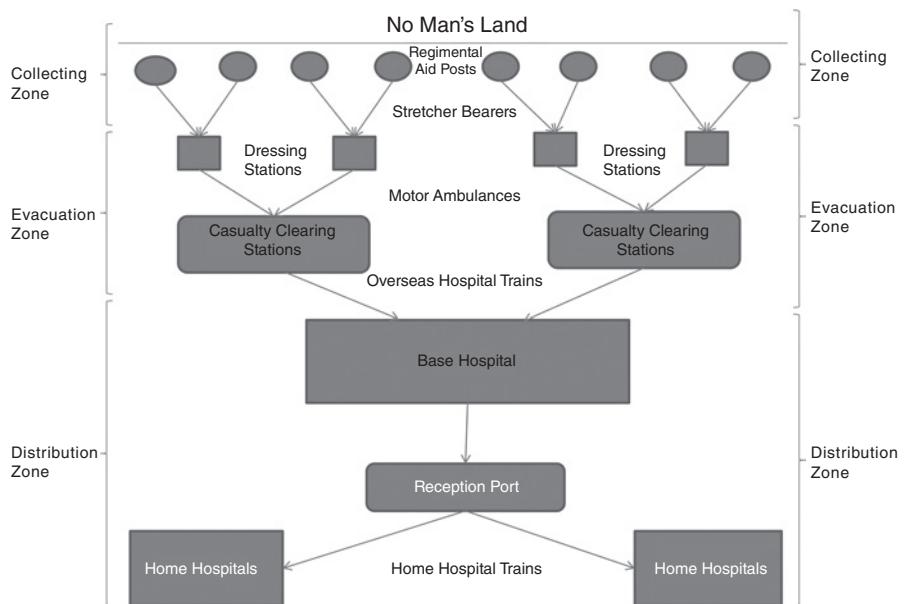


Fig. 3.1. Diagram of medical evacuations.

These other units included bearer relay and motor ambulance car posts, and the corps rest stations. Other relevant units might include advance medical store depots, divisional baths, and sanitary squads.

The evacuating zone, by contrast, was long and narrow, ‘containing, from a medical point of view, nothing but the various means of transport, and perhaps a medical store or two and a few “stationary” hospitals for the reception of patients who should not be taken any further towards the distributing zone’. This final zone was

an area of indefinite size, corresponding roughly to that in which munitions of war are gathered and reinforcements collected, and which, from a purely military point of view, is known as the base. In this war it lies partly in Great Britain, partly overseas, and consequently it is common to speak of it as if it contained institutions of two different orders—‘home hospitals’ and ‘overseas or base hospitals’.¹⁵

These three zones formed the broad spaces within which the military medical services functioned. RAMC rankers had, in theory, the least work to do in the collecting zone, the space comprising no man’s land and the

¹⁵ *Ibid.*

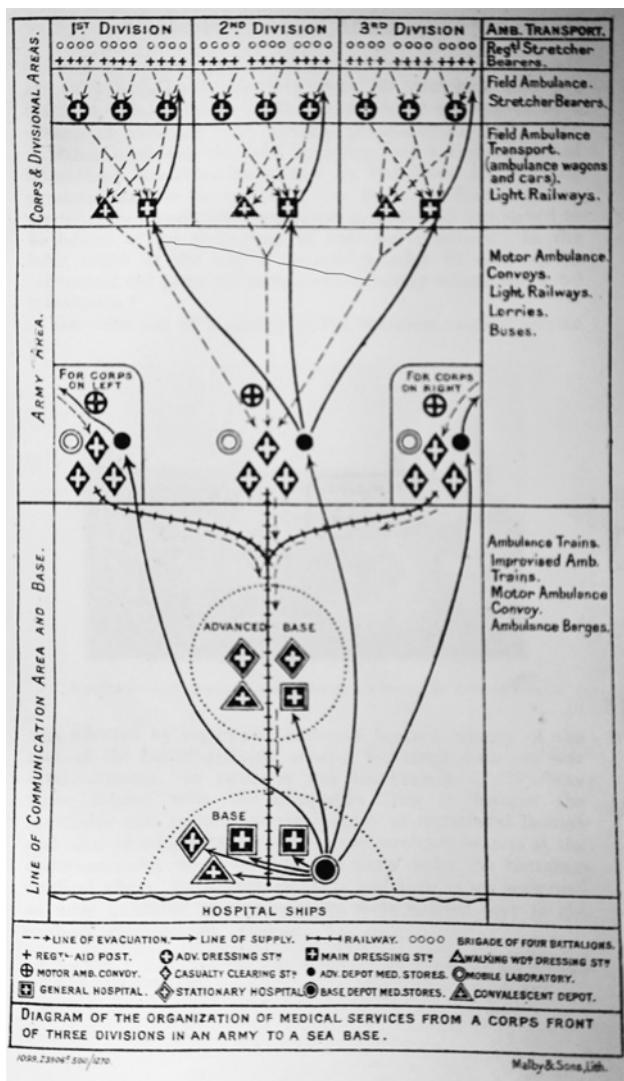


Fig. 3.2. Diagram of medical services; Macpherson, *History of the Great War*, Vol. 2, p.17.

front line of trenches, the site of the RAPs. Medically speaking, this area was within the purview of the RMO, an RAMC officer attached to a regiment who, assisted by a single orderly servant, organized and trained regimental stretcher bearers, the men who undertook the function of

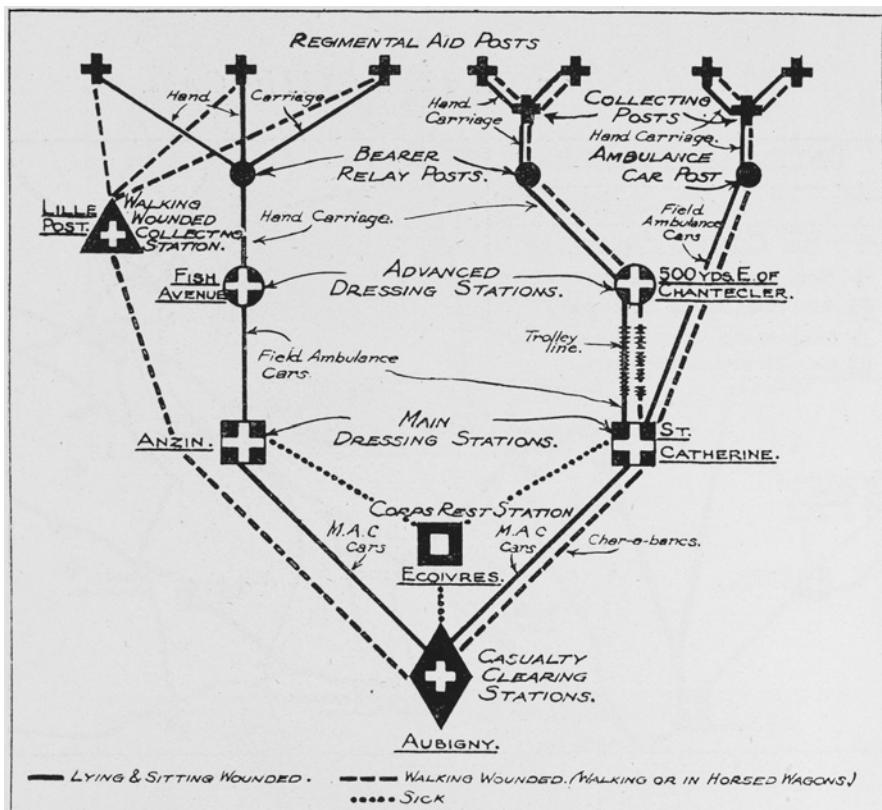


Fig. 3.3. Diagram of XIII Corps evacuation organization, April 1917; MacPherson, *History of the Great War*, Vol. 2, p.102.

actually collecting the wounded and transporting or directing them to RAPs. The RMO and his orderly were also responsible for the day-to-day health of the unit, in conjunction with the sanitary companies.¹⁶

While RAPs were thus under the authority of RMOs, they nonetheless served as the boundary between the collecting and evacuation zones, as well as between the areas of responsibility of the RMO and RAMC Field Ambulances (FAs). As such they formed spaces within which FA Other Ranks found themselves functioning. It was from RAPs that FA stretcher bearers collected wounded men and transported them, via one or more advanced dressing stations run by FA tent orderlies, to the main dressing

¹⁶ Harrison, *The Medical War*, pp.125–6.

station, again manned by the tent orderlies of the Field Ambulance. From the dressing station the wounded man would be evacuated, by horse-drawn or, increasingly, motor ambulance, to a CCS, from where, depending on the severity of his injury, he might be discharged to his unit or sent further down the line, by road, rail, or hospital barge, to a Base hospital at a French port city such as Boulogne, Le Havre, or Rouen. Men serving in the Middle East would be transported by hospital ship or rail to Alexandria.

Base hospitals formed a similar boundary point between the evacuation and distribution zones, although here the overlap was between voluntary and military units of medical care provision, rather than between combatant units and the RAMC. Men might be, and increasingly were, treated in hospitals staffed entirely by BRCS and St John Ambulance Association volunteers, although they did so as enlisted servicemen under military discipline.¹⁷ This overlap penetrated deeply into the evacuation zone, with non-military volunteers provided by the BRCS serving on medical transports between CCSs and the Base as the staff of ambulance trains and ambulance convoys.¹⁸ From Base hospitals, the wounded man might again be discharged, this time to a convalescent hospital or depot, or sent, via hospital ship, to Britain. Here he would be transported via rail to a military and then auxiliary hospital for treatment and convalescence, before being discharged either to civilian life, for the most seriously injured,¹⁹ or to a convalescent camp where he would be recycled, via training depots, into the armed forces again.

Within these broad zones of collection, evacuation and distribution, RAMC servicemen occupied a range of spaces which shaped the precise nature of their labour and consequent experience. These spaces varied from the ad hoc RAP (Figure 3.4) through the temporary dressing station (Figure 3.5) and more stable CCS (Figure 3.6) to the comparatively luxurious Base hospital (Figure 3.7) and the large, and often specialist, home hospital. They also included more mobile spaces, with RAMC servicemen travelling as caregivers in transportation ranging from

¹⁷ *Reports by the Joint Committees*, pp.214, 277.

¹⁸ Ibid., pp.341–2.

¹⁹ While discharge from the armed forces was the ultimate end of service for seriously injured men, this could take a number of years, particularly for men suffering from facial injuries or amputation. For example, No. 2 Northern General Military Hospital at Beckett's Park in Leeds remained open until 1926, continuing to treat men for orthopaedic and facial injuries. In 1927, the remaining 200 patients were transferred to the newly opened Chapel Allerton Hospital, which was run under the authority of the Ministry of Pensions rather than the War Office. (Richard Wilcox, *Stories from the War Hospital* (Meerkat Publications, 2014); Julie Anderson, *War, Disability and Rehabilitation in Britain: 'Soul of a Nation'* (Manchester: Manchester University Press, 2011), p.57; Anderson, "Jumpy Stump").



Fig. 3.4. Regimental aid post; L0009419, WL.

horse-drawn and motor ambulances through hospital trains and barges to hospital ships. Indeed, as we shall see, it was the mobility of the RAMC ranker, as much as the sites of healing within which he worked,²⁰ which defined his wartime labour and service. Given the importance of mobility, therefore, it is worth travelling along the path of evacuation which the sick or wounded man would have followed to explore in more detail the different types of labour, both physical and emotional, undertaken by RAMC servicemen at each stage.

REGIMENTAL AID POSTS

The first staging post on this journey would be the RAP, where a wounded man would either walk from walking-wounded collecting points or be

²⁰ Reznick, *Healing the Nation*, p.6.



Fig. 3.5. Stretcher cases awaiting transport to a casualty clearing station lie on the ground outside a dressing station at Blangy near Arras, April 1917; Q 6195, IWM.

carried by regimental stretcher bearers or comrades. This would be the injured man's first encounter with a trained medical professional in the form of the RMO. The man might have been bandaged either by himself, a comrade, or one of the bearers, using the first field dressing with which all men were issued and for which he would have received basic instructions on use. The regimental stretcher bearers might have received some additional training, principally in the various forms of carry used to transport men manually when a stretcher was not available,²¹ but this depended on the diligence of individual RMOs. Charles McKerrow, a particularly dedicated RMO with the 10th Battalion, Northumberland Fusiliers, trained his bearers through regular weekly lectures.²² J. C. Dunn, RMO with the 2nd Battalion, Royal Welch Fusiliers, was,

²¹ War Office, *Royal Army Medical Corps Training*, pp.136–43.

²² Mayhew, *Wounded*, p.49.



Fig. 3.6. A ward of the 2nd Australian Casualty Clearing Station at Steenwerke, November 1917; E (AUS) 4623, IWM.

perhaps, less thorough, recording in his diary for 30 September 1916 that 'my afternoon lecture [on hygiene] did not disturb the nap that many of the audience were used to take when in billets'.²³ However, at a minimum the bearers would, like all members of the regiment, have received instruction on how to apply the first field dressing. Comprising a wool pad, a square piece of gauze, and a piece of waterproof cloth, the dressing also came with instructions for application.²⁴ The only additional medical equipment carried by the regimental bearer were the stretchers that they were issued with in place of rifles.

At the RAP, the first field dressing might be changed and the man's wound inspected and cleaned. RAPs were, however, inconvenient spaces in which to carry out significant examinations due to their location in or very near the front line. Many were simply dugouts in trenches,

²³ J. C. Dunn, *The War the Infantry Knew 1914–1919: A Chronicle of Service in France and Belgium* (London: Abacus, 1994; first published P. S. King Ltd, 1938), p.262.

²⁴ See Chapter 4, pp.142–8.



Fig. 3.7. Patients and nursing staff on a hutted ward of one of the British base hospitals at Basra, 1917; Q 25698, IWM.

meaning that they were small, stuffy, badly lit, and, on occasion, prone to flooding.²⁵ During active engagement not only were they shelled, leading to experiences such as that of Frank Ridsdale, who was gassed out of an RAP at Wormhoudt,²⁶ but, more commonly, simply overwhelmed with casualties.

The role of the medical orderly attached to the RMO, and serving as his batman as well as medical assistant, was, on these occasions, less medical than clerical. Although he assisted with the cleaning and redressing of wounds, his most important work consisted of ensuring that all wounded men were appropriately tagged with an indication of the nature and severity of the wound as diagnosed by the RMO. An NCO of the RAMC, his work in less busy times involved assisting with the RMO's regular sick parades and sanitary duties, as well as maintaining the contents of the medical panniers which carried the RMO's supplies.²⁷ (Figure 3.8) The role as a

²⁵ Dunn, *The War the Infantry Knew*, p.298.

²⁶ Frank Ridsdale, Diary, 18 July 1917, Papers of Frank Ridsdale.

²⁷ Beggs, *Guide to Promotion* p.242.

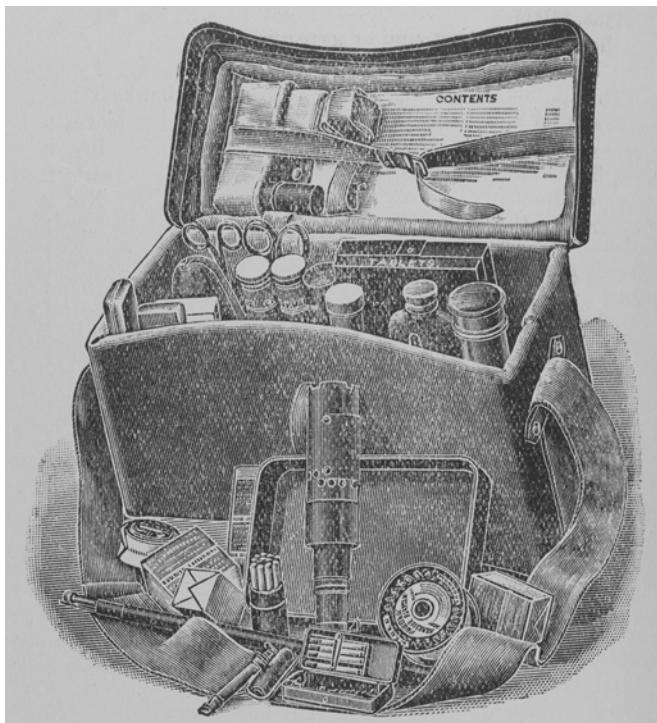


Fig. 3.8. Contents of a Medical Companion (1905 pattern); Beggs, *Guide to Promotion*, p.242.

whole thus combined medical and clerical skills, as well as the domestic duties associated with the work of an officer's servant.²⁸

It was from the RAP that the RAMC took over responsibility for the wounded man. From this point, if he was not classified as 'walking wounded' and directed to make his own way to the dressing station, possibly under the guidance of an RAMC bearer, he would be collected by bearers from one of the Field Ambulances attached to the Division. Like the RMO's orderly, these men undertook a dual role; unlike the orderly, however, this role was not medical and clerical but rather physical and emotional. The movement of men down the lines of communication to the Aid Posts further towards the rear almost always required the physical effort of a manual carry over ground disrupted by shellfire and

²⁸ John Lewis-Stempel, *Six Weeks: The Short and Gallant Life of the British Officer in the First World War* (London: Orion Books, 2010), p.135.

prey to adverse weather conditions, from the foot-dragging heaviness of mud or sand to the ankle-breaking ruts of frozen or parched ground. As one untitled account of the work of the 6th London Field Ambulance on the Somme recalled, 'During the next few weeks the weather conditions became extremely bad and wounded had to be man handled [*sic*] from High Alley to Flat Iron Copse and often as far as Bottom Wood—a carry sometimes necessitating five or six hours—as motor and horse transport could frequently only reach the Main Dressing Station at Bottom Wood.'²⁹ In a later anecdote the same author recalled, 'A party of Bearers struggle back to the ADS [advanced dressing station] with wounded, no word spoken, all attention being concentrated on the negotiation of the slimy ocean of mud and endeavouring to follow the right track.'³⁰ George Swindell's memory was of a different landscape, but one no less difficult to negotiate: 'The earth, from the continual explosions, was like bread crumbs and when it got wet, there being no tracks, except what we made ourselves, it made carrying wounded a rotten job.'³¹

While the negotiation of war- and weather-damaged landscapes required a noticeable physical effort, it was the basic act of lifting and carrying wounded men that had the greatest physical effect on bearers. Stretchers themselves, made of wood and canvas, weighed 30 pounds.³² This was then combined with the weight of the wounded man and all his clothing, although his kit would, if not lost, be carried by the number 2 bearer in the squad.³³ In addition, to prevent the onset of shock, 'a condition produced by any severe injury or emotional disturbance... usual[ly] as the result of pain, or of injuries such as extensive burns or serious mutilations of the body',³⁴ wounded men were wrapped in up to three army blankets to enable them to retain their core temperature at an appropriate level.³⁵ As Julie Anderson has noted, these woollen blankets had astonishing capacities for retaining dirt, germs, and, above all, water.³⁶ They became extremely heavy when wet. In combination with the weight of woollen clothing, also often sodden, the amount of weight stretcher bearers were expected to carry could well exceed the 12 stone per stretcher they were trained for.³⁷ Additionally, to ensure a suitable supply of

²⁹ Untitled account, *6th London Field Ambulance History*, p.2.

³⁰ Ibid., p.6.

³¹ Swindell, 'In Arduis Fidelus', p. 215.

³² War Office, *Royal Army Medical Corps Training*, p.146.

³³ Beggs, *Guide to Promotion*, p.60.

³⁴ War Office, *Royal Army Medical Corps Training*, p.352.

³⁵ See Chapter 4, pp.134–5.

³⁶ Julie Anderson, 'Disinfecting the Front: Dirt and Disease 1914–1918', War and Trauma Conference, In Flanders Fields Museum, Ypres, 7 November 2013.

³⁷ War Office, *Royal Army Medical Corps Training*, p.227.

blankets was available at the points where patients would require them, both regimental and RAMC bearers had to carry fresh supplies of blankets on their return journeys to dressing stations and RAPs. While increasing medical understanding of the physiological dangers of shock and its appropriate treatment undoubtedly saved lives, it also added to bearers' responsibilities, as well as their labours.

The physical demands presented by such weight could be further exacerbated by the number of bearers allotted to each stretcher. Bearers were trained in squads of four, who might either carry a pole apiece or work as rotating pairs, with one man carrying either end with the aid of slings. The level of work required during an engagement, however, meant that this was often impossible. Richard Capell of the 6th London Field Ambulance recalled clearing the last wounded out of an Aid Post nicknamed the Cough Drop during the Battle of the Somme: 'We were four to a stretcher and my squad had three cases—on the stretcher, one carried pickaback, and third who limped along leaning on the fourth bearer's shoulder.'³⁸ Here the stretcher must have been carried by two men only, one at either end, using slings, with little relief available from the rest of the similarly burdened team. The physical difficulties such work entailed is reflected in Herbert Empson's diary entry, where he urges his reader to 'Imagine the tortuous and twisting trenches and then think of a party of four bearers manipulating a stretcher containing a heavy patient and carrying a patient's kit too! Think of them stumbling through mud and water and tripping over broken trench boards.'³⁹

The ability to make such carries successfully could be a matter of some pride to Field Ambulance stretcher bearers. Serving at Ypres, Swindell wrote of calling on 'Infantry, Engineers and anybody that could be spared to help clear 200 of the Eighth Division wounded. These men were given a stretcher between six, we only had four as, we were used to it.'⁴⁰ On another occasion he recalled an instance where 'It was impossible for us to clear all the wounded, and as it was cold weather, and the wounded lying about, the M.O. had to get help and a lot of the pioneer battalion, 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.'⁴¹ The physical labour of carrying was a role that bearers shared with combatant Other Ranks, who regularly carried supplies,

³⁸ Richard Capell, 'Stretcher-Bearers on the Somme', *6th London Field Ambulance History*, p.1.

³⁹ Herbert Empson, Diary, MS, 19 September 1916, RAMC 1217, WL, quoted in Harrison, *The Medical War*, p.75.

⁴⁰ Swindell, 'In Arduis Fidelus', p.294.

⁴¹ Ibid., p.224.

munitions, and rations up the line. Yet in the carrying of wounded men the expertise developed through both training and practice reinforced the particular physical labour bearers undertook when in the line. In undertaking labour which combatant colleagues did not have the experience or knowledge to do as effectively, bearers proved themselves to be not merely as physically capable as combatants, but indeed as more capable within the scope of their specialist role.

The extent to which such expertise was understood as specialized can be seen in the routine detailed descriptions of the ability to negotiate various challenges posed by the differing landscapes of the different theatres in which men served in their retrospective memoirs. C. Midwinter, for example, noted that 'The rocky ground [at Gallipoli] made the going very rough.'⁴² Bearers 'were hard at it, collecting and transferring the wounded and retiring at the same time'.⁴³ These particular skills were very different from those noted in H. L. Chase's description of the work of bearers on the Somme:

Throughout the battle rain fell frequently and the ground rapidly became indescribably bad. Roads ceased to exist, or at best degenerated into mere tracks, pitted with shell holes at every few yards and churned up and re-churned by the constant stream of gun limbers, pack mules, and other transport supplying the lines. The lot of the bearers who had to carry their loads of wounded for long distances under these conditions was not a happy one, and more than one infantryman, slogging along und the weight of [a] vast amount of impedimenta..., was heard to remark that he would not change jobs with the ambulance stretcher bearers for any consideration.⁴⁴

Charles Ammons, meanwhile, developed more specialist skills when his unit was 'issued with riding camels, mules and donkeys.... Since I was among the few actually liking the animals I was often given the job of leading, camel-mounted, the pack-camels with their loads of disabled troopers carried in the cacolets... to the casualty clearing station many miles to the rear'.⁴⁵ As William Lamb noted, 'camel convoys consist of beds, stretchers and seats fixed on camels. It is not too good a transport for wounded men but transporting wounded across miles of desert is a serious

⁴² C. Midwinter, *1914–1919 Memoirs of the 32nd Field Ambulance 10th (Irish) Division* (Bexleyheath: G. E. Foulger, 1933), p.22.

⁴³ Midwinter, *1914–1919 Memoirs*, p.45.

⁴⁴ H. L. Chase, *The 2/1st London Field Ambulance: An Outline of the 4½ Year Service of a Unit of the 56th Division at Home and Abroad During the Great War* (London: Morton, Burt & Sons, Limited, 1924), pp.37–8.

⁴⁵ Charles Cyril Ammons, 'Service in the First World War', TS memoir, n.d., RAMC 1599, WL.

problem and that seems the best way, so far.⁴⁶ Qualified as they were, such comments indicate the interest and even pride that former bearers took in their work.

Given the difficulty of the landscapes to be negotiated, the distances to be travelled, and the weight bearers were required to carry, it is unsurprising that the stretcher bearer's labour became imprinted on his body. As Emily Mayhew has noted:

Everyone at the front could spot a bearer by his hands. The wooden handles of the stretchers quickly started to deteriorate. They got shot at, or had bits broken off, and the splinters were the very devil. In the wet the wood rotted, splitting the handle ends. All the bearers could do was wind a length of wire round the handles to keep them together, but the wire would cut their hands to pieces. Gloves weren't much help. They made it difficult to get a grip on the wood, and no one ever kept a pair of gloves for very long at the front. . . . [B]earer's hands [were] a mix of blisters and calluses, first rubbed raw and then scar-cracked and worn.⁴⁷

David Rorie, working as an MO with the 1st/2nd Highland Field Ambulance at Beaumont Hamel, recalled the necessity 'at all cost to ease off the strain on the now thoroughly exhausted bearers, many of whom had their shoulders absolutely rubbed raw with the constant friction and pressure of the slings'.⁴⁸ While Swindell tried to see a silver lining in his labour, arguing that stretcher bearing 'so strengthened our necks and shoulder muscles, we could manage the unequal strain' of carrying full marching kit, for Midwinter the experience of carrying wounded at Gallipoli was 'body-racking': 'Stretchers had to be lowered over ledges, steered through narrow paths and thorn bushes . . . in the intense heat, with the smells of the dead constantly in our nostrils'.⁴⁹ The visceral physicality of the labour these men undertook was summed up by an anonymous poet of the 6th London Field Ambulance:

'A breather!—Lower!'—We halted with a groan,
Half to the knees in mud, tongues dry as bone.
The Burden spoke in a mild wandering tone: —
'You're doing grandly, boys! A night you've had!
Rough luck for you the going's been so bad.'
And hundreds more to come!—Poor lad! Poor lad!⁵⁰

⁴⁶ Lamb, Diary, 9 August 1916.

⁴⁷ Mayhew, *Wounded*, p.21.

⁴⁸ David Rorie, *A Medico's Luck in the War* (Eastbourne: Anthony Rowe, Ltd, 1929), p.111.

⁴⁹ Swindell, 'In Arduis Fidelus', p.169; Midwinter, *1914–1919 Memoirs*, p.22.

⁵⁰ Anon, 'Stretcher-Bearers on the Somme', *6th London Field Ambulance (47th London Division) History*, p.6.

As the final words of the poem indicate, if stretcher bearing was in the first instance a form of physical labour, it could also be a form of emotional labour. Bearers could become deeply invested in the fate of the men they carried. Having carried a patient with abdominal wounds for two hours, Swindell went out of his way to remonstrate with a group of infantrymen who gave the wounded man water to drink, an action which probably led to his death.⁵¹ Such emotional attachments were reinforced by interactions which served to develop relationships of reassurance and comfort. Swindell recalled encounters ranging from conflicts over the priority given (or not given) to officers by bearer parties to jokes over the weight of a particularly large patient with leg wounds.⁵² Swindell, a working-class merchant mariner prior to the war, wrote his memoir in a predominantly unreflective narrative style, with little space given to the discussion of the emotional impact of the stories told. Yet the very fact of the inclusion of a record of these interactions in a memoir apparently written many years after the end of the war reflects the level of impression they made on his emotions and his memory of them.⁵³ Certainly at least one case—that of a tall, heavy officer—had a clear psychological impact on Swindell:

At last after a night mare [sic] of a carry we got him down, he was in a bad way, but he asked for us all, and when we came, in his pocket he had cigarettes, take them he said, you have earned them, and asked us all to shake hands with him and said, if I live, I have you all to thank. we were upset, as he seemed so bad when we left him, he was gone when next we came down, so we hoped he would live, he was a brave man.⁵⁴

The upset felt by Swindell is one of the few explicit articulations of the emotional investment that he and his fellow bearers made in the men they carried and cared for.

Swindell's anecdotal, repetitive, and often fractured narrative in part reflects his educational background, but also places his memories firmly with a tradition of narratives of care identified by Margaret Higonnet, and Carol Acton and Jane Potter.⁵⁵ The memoirs of American nurses Ellen la

⁵¹ Swindell, 'In Arduis Fidelus', p.151. Food and drink could be fatal to a man with abdominal wounds due to the risk of increased blood loss, a fact that Swindell learned as part of his training as a bearer.

⁵² Ibid., pp.270, 142.

⁵³ Although Swindell's memoirs are undated, internal evidence suggests that he wrote and attempted to get them published sometime after 1933. For discussion of reading the subjective implications of personal testimony, see Michael Roper, 'The Unconscious Work of History', *Cultural & Social History* 11 (June 2014): 177–80 and Acton and Potter, *Working in a World of Hurt*, p.16.

⁵⁴ Swindell, 'In Arduis Fidelus', p.142.

⁵⁵ Higonnet, 'Introduction'; Acton and Potter, *Working in a World of Hurt*, p.33.

Motte and Mary Borden are notable, Higonnet argues, for their ‘driven pace, hyper-intense images, repetitions, and fragmentations of the landscape of war into individual sketches’.⁵⁶ Acton and Potter identify a similar fracturing of narrative in the vagueness evident in the post-war commentaries of medical officers such as George Gask, although these are less formally experimental in style.⁵⁷ It is not only stylistically, however, that Swindell’s memoirs can be read as part of a wider literature of wartime caregiving. His emotional investment places his wartime work within a broader narrative of the emotional labour of caring that, in wartime, was often to be found in the silences and the spaces between.⁵⁸

Individual engagement was not, however, the only form of emotional labour undertaken by bearers. Like other medical personnel, they also had a role as witnesses to the horrors of the wounds of modern war.⁵⁹ Frank Ridsdale regularly recorded the horrors he had observed in his diary, in entries such as ‘1 Officer + Gunner with heads blown clean off, a ghastly sight, stretchers saturated in blood’,⁶⁰ and, describing a body at a destroyed gun emplacement, ‘both legs off below the knee + the body all burned + charred’.⁶¹ As with other caregivers, witnessing and interacting with such wounded bodies could have as profound a traumatic effect as the death and mutilation witnessed by combatant units.⁶² Certainly Ridsdale’s anguished record of 1 July 1916 as a ‘never to be forgotten night’ filled with ‘terrible wounds’ and ‘men moaning + in agony with pain’⁶³ indicates some of the emotional labour involved with the provision of care in the front line for rankers as much as medical officers. Ridsdale’s diaries were clearly a much-needed outlet where he could express, however briefly, his emotional reaction to the trauma he witnessed.⁶⁴

As in the case of MOs and nurses, in their efforts to maintain resilience in the face of traumatic encounters stretcher bearers tended to divert the focus in their accounts from their own emotional labour to the fortitude of the wounded.⁶⁵ Yet both physical and emotional labour on the part of bearers was observed and praised by others. Field Ambulance MOs wrote regularly in praise of their bearer units, often using the language of high

⁵⁶ Higonnet, ‘Introduction’, p. xxxiv.

⁵⁷ Acton and Potter, *Working in a World of Hurt*, pp.38–9.

⁵⁸ Ibid., p.12.

⁵⁹ The bearing of witness to the destruction of war through the horror of wounds has tended to be discussed as the role primarily of nurses and combatants in wartime. See Fell and Hallett ‘Introduction’, p.8; Das, *Touch and Intimacy*, pp.188–94; Hynes, *The Soldiers’ Tale*, pp.1–31.

⁶⁰ Ridsdale, 6 May 1917, Papers of Frank Ridsdale.

⁶¹ Ridsdale, 21 May 1917, Papers of Frank Ridsdale.

⁶² Acton and Potter, *Working in a World of Hurt*, pp.1–4.

⁶³ Ridsdale, 1 July 1916, Papers of Frank Ridsdale.

⁶⁴ Meyer, *Men of War*, p.49.

⁶⁵ Acton and Potter, *Working in a World of Hurt*, pp.33–4.

diction and traditional heroics, as in the case of Norman Tattersall, who wrote in his 'Gallipoli Diary': 'The stretcher bearers are magnificent... Many of them have been doing it for nearly 70 hours now without a break and still go on—exhausted—and bleeding feet—Sniped at and cannot snipe back—they are heroes to a man.'⁶⁶ Patients also acknowledged the work of the bearers—in the case of W. H. Atkins, in poetic form:

We are the men who carry them back,
The wounded, the dying and dead.
It's 'Halt' 'Dressing here'—'Come, buck-up, old dear,
You're all right for "Blighty", so be of good cheer—
Turn him gently, now bandage his head.'
The 'stretcher-bearers' doing their bit,
Of V.C.'s not many they score,
Yet are earned every day in a quiet sort of way
By the Royal Army Medical Corps.⁶⁷

While traditional constructions of wartime masculinity were being challenged by the nature of combat in industrialized warfare,⁶⁸ non-combatants could still be valorized in traditional terms, even if the actions praised were not those of the traditional warrior. As we will see in Chapter 5, as the war continued the labour of stretcher bearers, both physical and emotional, would increasingly be perceived by others as comprising, at least in part, a particular form of wartime heroism, reflecting these shifting understandings of what wartime masculinity entailed.

DRESSING STATIONS

Bearer units were not, of course, the only medical rankers who undertook the physical and emotional labour of caregiving within Field Ambulances. The nursing or 'tent' orderlies who manned the Dressing Stations, both Main and Advanced, along the lines of evacuation performed similar duties. This is unsurprising given that tent sections and bearer sections both formed the subunits of each of the three companies which made up a Field Ambulance. This structure gave the whole Ambulance greater flexibility in deployment, which often extended to the actual roles within

⁶⁶ Norman Tattersall, 'Gallipoli Diary', quoted in Acton and Potter, *Working in a World of Hurt*, p.43.

⁶⁷ W. H. Atkins, 'The R.A.M.C.', *The 'Southern' Cross* 2 (June 1917): lines 9–17. Other poems celebrating the work of the stretcher bearer include the work of Geoffrey Studdert Kennedy ('Woodbine Willie') and Robert Service, discussed in Chapter 5, pp.180–2.

⁶⁸ Meyer, *Men of War*; Roper, *The Secret Battle*.

the Ambulance. Thus stretcher bearers found themselves staffing dressing stations and aid posts, as Ridsdale did in October 1915, while tent orderlies were often seconded as stretcher bearers in moments of crisis,⁶⁹ or, in quieter periods, volunteered for the role. David Randle McMaster, for example, worked as a bearer bringing men from RAPs to an ADS three kilometres behind the trenches in November 1914, writing proudly to his parents, ‘Now perhaps you will be able to picture me collecting wounded’.⁷⁰ As J. B. Bennett recalled in his memoirs, ‘With others I experienced the full range of duties, bearer, medical and nursing, in the field.’⁷¹

Despite this overlap, the actual work that manning a dressing station or aid post entailed was often quite different to that of a bearer. Tent orderlies spent a considerable portion of their time manipulating the landscape and shelter to provide sites of care. John Upton, a private with the 137th Field Ambulance, was on one occasion detailed ‘up to the Regimental Aid Post which was practically in the line’, not to help care for the wounded there but to ‘dig a place in a bank, to enable a Ford Ambulance car to take shelter whilst waiting for “cases”’.⁷² Norman Fermor, serving near Albert, found himself undertaking ‘a different job for a time helping the Engineers dig a large Dugout with two Entrances. They dug and we carried it all out’.⁷³ A tent subsection of the 2/1st London Field Ambulance similarly helped to build the dugout which served as ‘B’ section’s advanced dressing station at Hébuterne in May 1916.⁷⁴ In undertaking such work, tent orderlies were labouring in ways which could be equated with the manual work that dominated the lives of many combatants in wartime. Where bearers could claim technical expertise in relation to their carrying duties, the ditching and building work of tent orderlies could be almost the exact equivalent of that of non-caring units, as Fermor’s temporary secondment to the Engineers demonstrates.

It was not only general roads and dugouts that RAMC servicemen were called upon to construct, however. Sites of care along the lines of evacuation needed to both move and expand to meet the growing demands placed upon them. As a result, men such as Walter Bentham often found

⁶⁹ Lamb, Diary, 6–10 December 1915, Papers of William Murray Lamb; J.W. Upton, Account, MS, 1974, Papers of J. W. Upton, RAMC/1750, WL, p.19.

⁷⁰ Randle, Letter to Father and Mother, 27 November 1914, Letters of David Randle McMaster.

⁷¹ Bennett, ‘Memories of Gallipoli’, p. 34, Papers of J. B. Bennett.

⁷² Upton, Diary, MS, Papers of J. W. Upton, p. 8.

⁷³ Norman Fermor, ‘Personal experience of an N.C.O. in charge of Stretcher Squads R.A.M.C. Field Ambulance on the Western Front During World War One Including 12 Miracle Escapes’, MS, RAMC 1781, WL, p.5.

⁷⁴ Chase, *The 2/1st London Field Ambulance*, pp.24–5.

themselves undertaking fatigues such as ‘clearing all the wreckage and making a good entrance’ to an abandoned building which was to be the winter headquarters of No. 8 Field Ambulance at Hoograf in 1915.⁷⁵ Later that year, while constructing a hospital in the stables of the Mazin-garbe brewery, ‘Parties of men [of the 6th London Field Ambulance], provided with waders and scythes, were sent to a stream in the neighbourhood to cut rushes for thatching parts of a hut in the hospital yard.’⁷⁶ On the Western Front this sort of repurposing of abandoned or damaged structures, which offered some sort of protection against shellfire, was not only common but often creative. Bearers at the headquarters of the 2/1st London Field Ambulance, for instance, found themselves, during the Arras offensive, ‘located in a deep chalk cave at Wancourt, which certainly provided better shelter than the usually very temporary and unprotected bivouac, but the atmosphere of the cave was—well, to put it mildly—not particularly healthy.’⁷⁷ Not all locations for dressing stations already existed, however. The comparatively sparse populations outside the major conurbations in Egypt and Palestine meant that tented units were extremely common. As William Lamb wrote of his time in Palestine, ‘Tent pitch and hard work [was often] the order of the day’, as was ‘plenty of digging’ in order to construct hospital facilities.⁷⁸

Thus, as with bearers’ abilities to negotiate landscapes, the knowledge that tent orderlies brought to their work often reflected the specific demands of the theatre of war in which men served. Where possible the landscape was utilized to shelter static encampments. Thus the dressing station that Lamb built on 14 April was ‘in a gully, or whadi as it is called here’.⁷⁹ Like Bentham and the 2/1st London Field Ambulance, Lamb and his unit utilized as much as they manipulated the landscape in which they found themselves. The work of RAMC servicemen in static sites of care was defined by the need of the units to adapt to the landscape as well as by the labour of shaping the landscape to suit the unit.

While such labour may not have required specialist skills, it often called upon specialist knowledge, particularly in relation to sanitation. In Egypt, for instance, drainage was a medical as well as a logistical necessity in the effort to combat the mosquitoes which carried a variety of diseases.⁸⁰ While specialist sanitary units could be attached to Field Ambulances, as with combatant units ‘the responsibility for maintaining hygienic

⁷⁵ Walter Bentham, Diary, TS, 16 September 1915, RAMC 2010, WL.

⁷⁶ 6th London Field Ambulance History, 22 December 1915, p.12.

⁷⁷ Chase, *The 2/1st London Field Ambulance*, p.46.

⁷⁸ Lamb, Diary, 14 April 1917, 5–7 August 1917, Papers of William Murray Lamb.

⁷⁹ Lamb, Diary, 16 April 1917, Papers of William Murray Lamb.

⁸⁰ Harrison, *The Medical War*, pp.254–5.

discipline lay clearly with the line officers and NCOs.⁸¹ Given that the prevention of disease was a primary objective for the RAMC in all theatres, the creation and maintenance of sanitary conditions within spaces of care such as dressing stations relied on the labour and knowledge of the tent orderlies, who thus had an important role in ensuring the cleanliness of sites of care. Every move a Field Ambulance made appears to have involved cleaning work for these men. Upton recorded that, on taking over a rest camp, 'Our first job was to clear up the rubbish.'⁸² Bentham similarly 'took over a hospital from No.9 F.A., in a school attached to a convent. It was very dirty, and as we had 60 patients in that day it took us all the time to get cleaned out and set right.'⁸³

Nor did orderlies' responsibilities for cleanliness only relate to buildings. They also extended to bodies. While in reserve over Christmas of 1915, Bentham, along with a sergeant and seventeen men, ran a divisional baths at Boeschepe. This involved not only the supervision of the actual bathing process, but also 'Giving out and taking in washing from women who wash the same at their own houses'⁸⁴ and preparing, serving, and clearing up meals for 150 men on Christmas Day. Bentham's role in running the baths clearly reflects both increasing medical knowledge around infection and its prevention throughout the British medical services,⁸⁵ and the growing military importance of the relationship between cleanliness and morale.⁸⁶ The labour he undertook in this role was also very much an extension of orderlies' work at dressing stations, where medical intervention was kept to a minimum and the work of the orderly was focused on cleaning and feeding. In dressing stations, wounded men were assessed, had their wound cleaned and redressed, and were given a cup of tea. Even in these cramped and hurried spaces sanitation and the orderly's role in providing it remained. J. B. Bennett recalled that, 'while serving as an orderly in the dressing tent at the advanced station [near Khan Yunis] in May [1917] part of my duty specifically included sterilising instruments in boiling water generated by methylated spirit, (commercial alcohol—which smelt like and was a good substitute for whiskey), in a nickel container'.⁸⁷

⁸¹ Ibid., pp.131–2. ⁸² Upton, Diary, p.7.

⁸³ Bentham, Diary, 5 January 1915.

⁸⁴ Ibid., 24–25 November 1916. '[Bathing] arrangements always include the provision of fresh underclothing for every man who has taken a bath.' ('The Royal Army Medical Corps, And Its Work', *British Medical Journal*, p.223.)

⁸⁵ Harrison, *The Medical War*, pp.124–42; Hallett, *Containing Trauma*, pp.85–92.

⁸⁶ Meyer, *Men of War*, p. 65; Ugolini, 'War-stained'.

⁸⁷ Bennett, 'Personal Memories: Egypt and Palestine 1915–1918', TS memoir, p. 76., Papers of J. B. Bennett.

However, as dressing stations were often not far behind the line and thus within range of shellfire, the focus of those serving in them was above all on evacuation to the CCS. As Ammons noted, 'Patients were rarely detained in the ambulance; the practice was to give necessary attention or first aid and to despatch them quickly away from the line to leave room for emergencies.'⁸⁸ The role of the tent orderly in facilitating this process, particularly at moments of intense pressure, was crucial. While triage was nominally the purview of the medically qualified MO, tent orderlies, like bearers, built on their training through practice as well as further instruction. Over time many developed great skill in medically assessing patients. Bennett, while serving at Gallipoli, boasted of his ability to clinically record cases 'for pulse, respiration, temperature and bowels, at a tempo of 2 minutes each. On one occasion alone I had a count of 55 within 120 minutes.' When later stationed at Sidi Bishr, he claimed, 'It was routine to record on a clinical chart for each case, temperature, pulse, respiration, and bowels before being seen by the Medical Officer, and when pressure was on most orderlies were competent in recording the first three items simultaneously and within two minutes.'⁸⁹

Nor were tent orderlies' skills only those of efficient medical recording. Bentham spent the Second Battle of Ypres at an ADS alongside his medical officer, 'dressing the poor chaps as quick as ever we could go.... They had to be dressed and hurried along to the rear dressing station.'⁹⁰ At Hébuterne, at the height of the Battle of the Somme, 'a little band of officers and men worked incessantly hour after hour dressing the worst of the stretcher cases, which were then sent on... to Couin, where the M.D.S. (Main Dressing Station) was established. Here... in 24 hours more than 2,000 wounded were dealt with and evacuated to the C.C.S.'⁹¹ Nearly two years later, Frank Ridsdale, serving as a dressing-station orderly during the Hundred Days campaign of 1918, similarly helped to dress and evacuate 400 wounded men in twenty-four hours without rest and with little food. The physical effects on Ridsdale were both emotional and visible. The following day he wrote, 'feeling the want of food badly, only had cup of tea + a few biscuits in 24 hours, hands saturated with blood'.⁹² As Santanu Das has noted in relation to nurses serving in Casualty Clearing Stations, moments of physical contact between wounded and their carers helped to define the subjective experiences of caregivers,

⁸⁸ Ammons, 'Service in the First World War', p.20.

⁸⁹ Bennett, 'Memories of Gallipoli', pp.15, 34, Papers of J. B. Bennett.

⁹⁰ Bentham, Diary, 25th September, 1915.

⁹¹ Chase, *The 2/1st London Field Ambulance*, pp.27–8.

⁹² Ridsdale, Diary, 3 and 4 September 1918, Papers of Frank Ridsdale.

particularly in situations of intense physical strain.⁹³ In Ridsdale's case, the blood of the wounded on his hands, in conjunction with his own hunger and exhaustion, becomes a symbol of shared bodily trauma, a point of contact between the carer and cared-for, where the wounds of the latter become visible physical markers of the labour of the former.

As Ridsdale's brief but agonized diary entries for this period demonstrate, the work of dressing and evacuating wounded men in large numbers and at great speed was not only intensely physical labour but deeply emotional as well. While tent orderlies, whose encounters with individual wounded men might only be momentary, did not have the opportunities to develop relationships with patients afforded to stretcher bearers by long carries, or to the nurses and orderlies at hospitals further down the line where wounded patients were held for longer periods, their encounter with the wounded could still be intensely emotional. Archie Whyte wrote to his brother Jack of there being 'worse things in some ways than being under fire, although they may not actually affect us directly', going on to relate the case of

an officer with both his legs smashed up most horribly. The poor chap was in a very bad way and he knew it, but his only question was 'Will I live long enough to see my wife + two kiddies again?' Of course we told him he would do so, though we knew only too well that it was only a matter of hours for him—barring miracles—and as a matter of fact the poor chap died before he reached the clearing-station. It's things like that that seem to strike home far more than anything else: anything that brings with it the personal side of it all and thoughts of those at home.⁹⁴

So profound was the emotional impact of this case on Whyte that, in his 1971 memoir of the war, he noted in relation to this particular incident, 'It is strange how just one case remains in one's mind when so many others are forgotten, but that's how it is.'⁹⁵ In providing comfort to a dying man, however mendaciously, Whyte and his comrades were performing the emotional labour of care, labour which marked their psyches as profoundly as the physical labour of bearing and bandaging marked their bodies.

As Whyte's comments make clear, it is less the act of deceit perpetrated on the dying man that emphasized the emotional labour of care undertaken here than the connection between the home and the work of caring that created the sense of burden, because it 'brings with it the personal side

⁹³ Das, *Touch and Intimacy*, p.178.

⁹⁴ Archie, MS letter to Jack, 12 January 1918, Papers of A. L. G. Whyte.

⁹⁵ Whyte, 'Memoirs of the Great War, 1914–18', Papers of A. L. G. Whyte.

and thoughts of those at home'. Care of the sick and dying as a facet of the domestic sphere, and labour that came specifically within the scope of women's work,⁹⁶ reinforced the emotional impact of such work on these men. By transgressing traditional gender categories in relation to handling the dying and the dead, tent orderlies found themselves facing emotional traumas as profound and challenging to their understanding of their own masculinity as any combatant encountering the rotting or dismembered corpse of a comrade.⁹⁷

CASUALTY CLEARING STATIONS

The emotional labour of Field Ambulance tent orderlies was, as Whyte's story indicates, profound but, due to the unit's role in clearing casualties away from the field of battle, often provided hurriedly and *in extremis*. Where RAMC orderlies were in a position to develop more profound relationships with their patients over time was at the next stage along the lines of evacuation, the CCS. As in the Field Ambulances, however, the emotional labour undertaken by rankers was shaped by the particular forms of physical labour that these establishments required.

CCSs were units which developed from clearing hospitals, originally formed in 1906 '[t]o fill the gap between the field hospitals and the stationary hospitals'.⁹⁸ Over the course of the war they became ever larger and more complex, enabling increasingly sophisticated surgery to be carried out at sites deliberately built adjacent to railheads to facilitate their role in *clearing* the wounded down the line.⁹⁹ In addition, from 1915, the nursing staff of these units were drawn from the personnel of the trained military nursing services, the closest to the front line that female military nurses were officially allowed to serve.¹⁰⁰ As a result, the work of rankers attached to CCSs shifted from the dressing of wounds and other nursing duties undertaken by the Field Ambulance orderly, to clerical duties, such as running store rooms and dispensaries, and the 'rough work' of running the hospital, including moving patients to and from operations

⁹⁶ Robert Dingwall, Anne Marie Rafferty, and Charles Webster, *An Introduction to the Social History of Nursing* (London: Routledge, 2002), p.1; Claudia Siebrecht, *The Aesthetics of Loss: German Women's Art of the First World War* (Oxford: Oxford University Press, 2013), p.14.

⁹⁷ Denis Winter, *Death's Men: Soldiers of the Great War* (London: Penguin Books, 1979), pp.132–3.

⁹⁸ Gabriel and Metz, *A History of Military Medicine*, p.224.

⁹⁹ 'The Royal Army Medical Corps, And Its Work', *British Medical Journal*, p.254.

¹⁰⁰ Hallett, *Veiled Warriors*, pp.48–9; Harrison, *The Medical War*, p.33. See Chapter 4, pp.143–8.

and transport, incinerating amputated limbs, and grave-digging. They also undertook building work to establish or expand the units, which could develop into large complexes of tents and hutments, and, in the event of a move, they were responsible for packing up the hospital in its entirety, a role which required a certain amount of skill. By 1918 an entire CCS could be closed, packed, repitched, and reopened in between thirty-six and forty-eight hours.¹⁰¹ Given that these establishments required the installation of amenities including pathways, incinerators, and cook-houses, this could involve significant amounts of labour (Figure 3.9).

While the building and deconstruction involved with establishing and moving CCSs reflect the role of the orderly in manipulating the landscape already seen in the work of FA orderlies, the necessity for such labour decreased as the war went on and units became more static.¹⁰² There was still plenty of physical labour to be undertaken, however. Like Field Ambulance orderlies, who were often seconded to CCSs for periods of service, CCS orderlies were required to transport the wounded into, out of, and within the camp, maintain cleanliness and sanitation through cleaning wards and ensuring that sources of possible infection were appropriately dealt with, and help with non-specialist elements of medical caregiving.

Such labour was never, however, solely physical. CCSs, as the first semi-static sites of care on the line of evacuation, contained, as Figure 3.9 shows, increasingly sophisticated surgical tents, as well as reception tents for triage and isolation tents for infectious diseases.¹⁰³ Transport between bed wards and preoperative and operative wards was provided by the RAMC orderlies who made up the establishment of the unit. Men being taken for surgery were often terrified by the prospect both of the anaesthetic and the possibility of losing a limb.¹⁰⁴ The orderlies who transported them were called upon to offer reassurance and comfort, 'To hold the hot hand of the man who talks wild / And blabs of his wife or his kids, / Who dreams he is back in the old home again, / Till the morphia bites, and he loses his pain / As sleep settles down on his lids.'¹⁰⁵ Such emotional labour was more commonly associated in the popular mind with the work of female nurses.¹⁰⁶ Yet, in reality, the work undertaken by the trained military nurses and the men of the RAMC in these sites

¹⁰¹ 'The Royal Army Medical Corps and Its Work', *British Medical Journal*, p.254.

¹⁰² Harrison, *The Medical War*, p.32. ¹⁰³ Ibid., p.36.

¹⁰⁴ Carden-Coyne, *The Politics of Wounds*, pp.162–7.

¹⁰⁵ W. H. Atkins, 'The R.A.M.C.', *The "Southern" Cross* 18 (June 1917): ll. 26–30.

¹⁰⁶ Harrison, *The Medical War*, pp.33–4. For cultural representations of the wartime nurse, and nursing VADs in particular, see Ouditt, *Fighting Forces, Fighting Women*, pp.7–46.

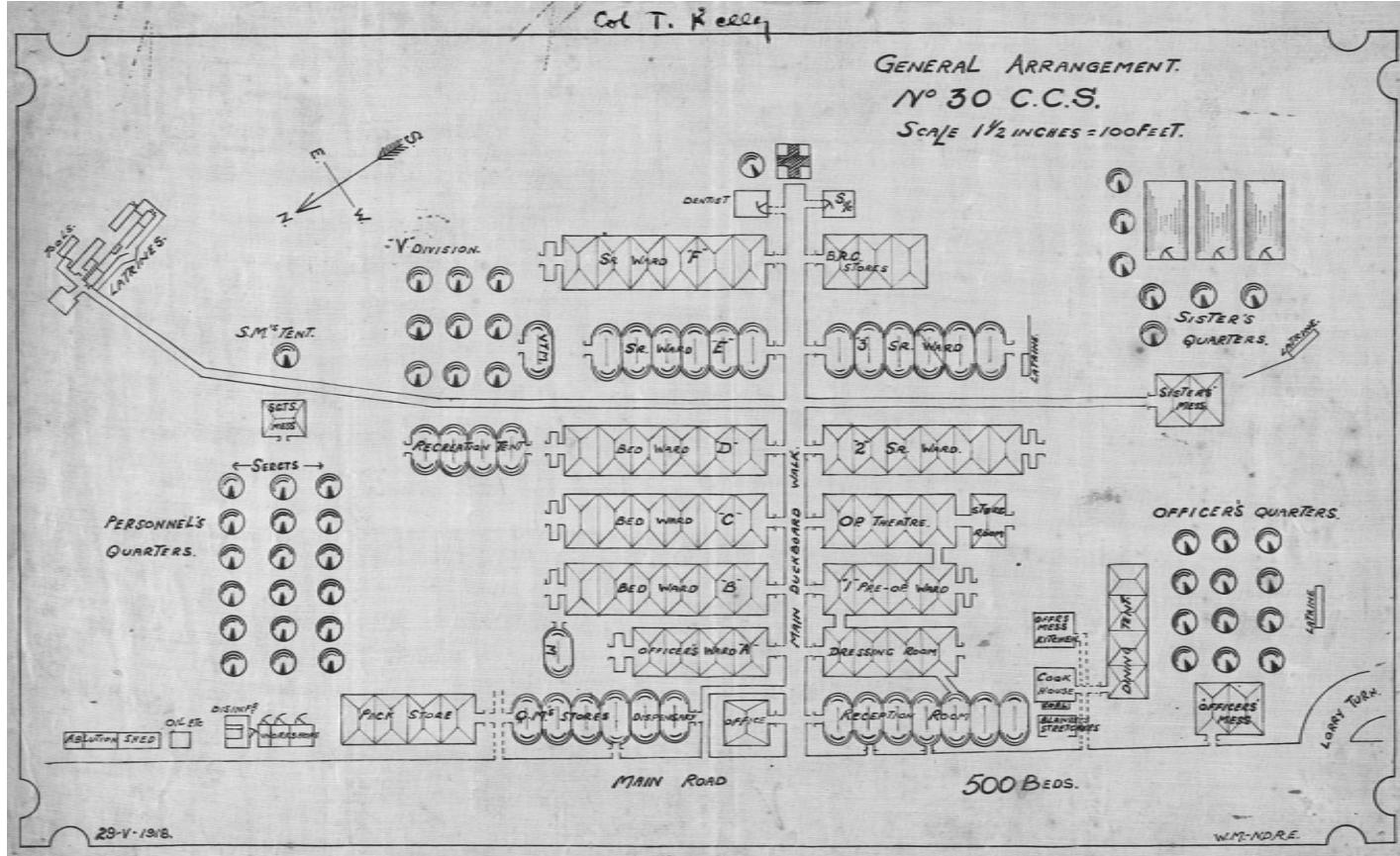


Fig. 3.9. Plan of general arrangement of No. 30 Casualty Clearing Station, May 1918; L0044173, RAMC Muniment Collection in the care of the Wellcome Library.

of care inverted the perceived gender order of caregiving. While rankers took on roles of reassurance and comfort, ‘Casualty Clearing Station nurses...often functioned with a high level of independence and used their discretion with pain medication and stimulant orders for their patients.... This autonomy reflected the increased respect that both patients and other medical staff had for nurses.’¹⁰⁷ The training of nurses to act as anaesthetists from 1917 meant that these women became, for some, agents of fear rather than comfort.¹⁰⁸

Despite this, the fact of female nursing in CCSs defined these sites, at least in part, as spaces of feminine care for both patients and RAMC rankers.¹⁰⁹ Ridsdale, when assisting with the transport of cases from his Field Ambulance to the nearest CCS, often commented on the welcome given to him by the nursing Sisters. Later, when clearing out the ruins of a former CCS, he reflected, ‘we are using for a Dressing Station a dugout which was once used by the Sisters during bombing raids, it would be nice to see them now instead of these half-buried corpses which are lying about’.¹¹⁰ Yet while CCSs might offer feminine encounter for patient and RAMC ranker alike, they contained spaces that remained male preserves. These included, most notably, the secure wards for men suffering from psychological disorders, and the moribund wards, those set aside for men too ill or badly wounded to warrant further medical attention when time and resources were limited.¹¹¹ On these wards, deemed too dangerous or distressing for female nursing staff, RAMC rankers, sometimes working alongside a chaplain, provided all the nursing care.¹¹²

Working on such wards could be physically dangerous, with psychologically wounded men sometimes requiring restraint. It was also

¹⁰⁷ Kirsty Harris, “All for the Boys”: The Nurse-Patient Relationship of Australian Army Nurses in the First World War, in *First World War Nursing*, ed. Fell and Hallett, p.72. See also Hallett, *Containing Trauma*, p.94.

¹⁰⁸ Carden-Coyne, *The Politics of Wounds*, p.161.

¹⁰⁹ Harris, “All for the Boys”, pp.74–5.

¹¹⁰ Ridsdale, Diary, 28 December 1916, 30 November 1917, 31 August 1918, Papers of Frank Ridsdale.

¹¹¹ Moribund wards continued to exist throughout the war, in spite of the increased development of resuscitation wards, where blood transfusions and increasingly sophisticated wound drainage ensured the survival of men who would previously have died. (Carden-Coyne, *The Politics of Wounds*, p.339.)

¹¹² Carden-Coyne, *The Politics of Wounds*, pp. 65, 154; Mayhew, *Wounded*, p.144; Simon Harold Walker, ‘Saving Bodies and Souls: Army Chaplains and Medical Care in the First World War’, *Postgraduate Journal of Medical Humanities* 3 (2016): 29–30, http://humanities.exeter.ac.uk/media/universityofexeter/collegeofhumanities/history/researchcentres/centreformedicalhistory/pdfsanddocs/2_-_Army_Chaplains_and_Medical_Care_in_the_First_World_War.pdf. Walker supports Edward Madigan’s argument that the work of chaplains as care providers under fire played an important role in shaping perceptions of their wartime service. (Madigan, *Faith Under Fire*, pp.138–40, 152.)

emotionally taxing. Swindell, who was seconded to a CCS in early 1916, recalled the emotional toll that his work on the moribund ward, known familiarly as the 'Death and Glory' ward, took on him:

Sixteen hours a day, in that ward, was enough to break the spirit of war in any man and we had days of it, the one thing that stays in my memory was the passing of these men, never a cry against their fate, taking it with the rest of their wounds, as one of the prices paid for war... over three weeks we were there, and only two men who entered the Portals of that tragic ward left it alive, the dead, why sometimes hourly, I feel that I cannot give a realistic account of that ward, and one thing I learned, and that was the way to die.¹¹³

Swindell might have claimed that 'they live better in the CCS than we did in the Ambulance',¹¹⁴ but, as his own account indicates, the work undertaken by men serving in these units was no less arduous or important to the physical and emotional care that patients received. Nor was the emotional labour of bearing witness to the deaths of men by RAMC rankers limited to the acceptable hidden confines of the moribund ward. A man serving with the 5th Canadian Field Ambulance was required to attend the execution of a man by firing squad: 'The officer in charge of the shooting party forced him, under threat of severe punishment, to remain and watch the poor victim's frightful death. The padre who was with the infantryman during his final few hours was hysterical for many hours afterwards.'¹¹⁵ Even in the context of the all-encompassing disruption of total war, such a death was emotionally disruptive for those in caring roles who witnessed it. Bearing witness to such death allowed men of the RAMC to articulate a range of suffering, both their own and others', acts which ultimately formed an important part of the work that these men undertook.

The emotional labour of bearing witness to the deaths of men did not end for RAMC rankers with the death itself, as a key role of these men was to act as gravediggers. This role, like that of cleaning operating theatres and burning refuse, including amputated limbs, had important sanitary implications, making up a central part of the cleaning work that CCS orderlies undertook.¹¹⁶ It also, however, involved a significant emotional responsibility, as these men bore witness to an important rite of mourning, one which increased in significance as the war disrupted traditional

¹¹³ Swindell, 'In Arduis Fidelus', pp. 118–19.

¹¹⁴ Ibid., p.89.

¹¹⁵ Frederick Walter Noyes, *Stretcher bearers...at the double!: History of the Fifth Canadian Field Ambulance which Served Overseas during the Great War of 1914–1918* (Toronto: The Hunter-Rose Company, Limited, 1937), p.113.

¹¹⁶ War Office, *Royal Army Medical Corps Training*, p.93.

interments of the dead.¹¹⁷ In acting as gravediggers, orderlies encompassed all facets of the male caregiver role in wartime, carrying the dead body, ensuring the sanitation of the unit, and caring for the dead man and his family by bearing witness to the man's Christian burial and so acting as repositories of his memory.

Orderlies at all sites along the line of evacuation took the last of these duties, as witnesses to the appropriate interment of the dead, seriously, with Frank Ridsdale recording in his diary for 11 December 1916: 'buried 2 men at dawn, no Padre available so read few sentences of Burial Service + Lords Prayer graveside, put 2 crosses up, L. Cpl. Hardacre, Borders Regt + unknown British soldiers'.¹¹⁸ In bearing witness in this way, men like Ridsdale formed one of a number of conduits of information to families seeking news of their loved ones and information about where they were buried and how they were commemorated. Ridsdale himself kept a detailed record of where men known to him were buried, and spent time caring for their graves.¹¹⁹ Through such acts, as through their letters to grieving families, these men, like chaplains and nurses who also wrote letters of condolence, formed a primary link in the network of fictive kinship which shaped commemorative practice during and after the war.¹²⁰

BASE AND HOME HOSPITALS

The dual role of physical and emotional labour continued to shape the work of RAMC orderlies serving in the distribution zone of the medical evacuation chain, the Base hospitals on the French coast and at Alexandria, and, for the most seriously wounded, the military hospitals and Territorial Forces General hospitals which mobilized across Britain. The type of men serving in these units changed over the course of the war, as

¹¹⁷ Artillery had the power, on the one hand, to bury men even as it killed them, thereby denying them ritual rites of interment (Smith, *The Embattled Self*, p.69), and, on the other, to disinter the dead, thereby pre-empting Christian resurrection (Bart Ziino, *A Distant Grief: Australians, War Graves and the Great War* (Crawley, WA: University of Western Australia Press, 2007), p.31.) For British servicemen, the government's decision not to repatriate the dead added an additional layer of significance to the work of those who witnessed and aided the burial of the dead. (See J. M. Winter, *Sites of Memory, Sites of Mourning: The Great War in European Cultural History* (Cambridge: Cambridge University Press, 1995), pp.23–44 and David Crane, *Empires of the Dead: How One Man's Vision Led to the Creation of WWI's War Graves* (London: William Collins, 2013)).

¹¹⁸ Ridsdale, Diary, 11 December 1916, Papers of Frank Ridsdale.

¹¹⁹ Ridsdale, Diary, 26 November 1916, 25 April 1917, 9 May 1917, Papers of Frank Ridsdale.

¹²⁰ Winter, *Sites of Memory*, pp.35–53.

military demands for manpower increased the recruitment of women to serve in non-combatant roles. At Base and Home hospitals, female VAD units,¹²¹ both nursing and general-service, progressively took on the work previously undertaken by male orderlies, a situation which could give rise to acute anxiety on the part of RAMC rankers. More and more specialist administrative and medical roles, previously the preserve of RAMC NCOs, such as dispensing and X-ray attendance, were given to female nurses who received special training. Even the relatively unskilled labour of transporting men between trains, hospitals, and hospital ships was increasingly assigned to convalescent soldiers or civilian volunteers such as the 'Bluebottles' of the London Ambulance Corps,¹²² to free up formal medical units for work further up the line.

Yet sections of the RAMC continued to serve in these hospitals, although the men who did so were increasingly those who were either too old or unfit for overseas or front-line service, or who were temporarily attached as part of their training or convalescence. Despite these men's physical frailties, both perceived and actual,¹²³ the work they undertook often required considerable physical effort. Like their counterparts serving in the evacuation zone, orderlies in the distribution zone had an important role to play in maintaining the cleanliness and hygiene of the units in which they served, although, particularly on the home front, this work tended to take on aspects of domestic service. As an article in the *Gazette of the 3rd London General Hospital* noted, the work of the ward orderly in the hospital was that of a 'parlour-maid and waitress, ... charwoman and messenger boy, bath-chairman, barber, bootblack, window cleaner, bath attendant, gardener, valet, washer-up and odd man all rolled into one'.¹²⁴ Ward Muir, a lance corporal in the hospital and author of two collections of essays on hospital life, *Observations of an Orderly* (1917) and *The Happy Hospital* (1918), was equally deprecating about the labour of the home hospital orderly. 'Work on the wards', he wrote, 'has its compensations: here there is the human element. But only a portion of a unit such as ours can be detailed forward work: the rest are either hewers of wood and drawers of water or else have their noses to a

¹²¹ For discussion of the distinction between the work of the VADs and trained military nurses, see Hallett, *Containing Trauma*, pp.6–9.

¹²² Muir, *Observations of an Orderly*, pp.207–10. Civilian volunteer ambulance corps formed in most cities where there was a military hospital. They transported wounded men from the train station to the hospital using adapted private vehicles.

¹²³ See Chapter 5, pp.156–62.

¹²⁴ 'A Nursing Orderly's Day', *Gazette of the 3rd London General Hospital* (November 1915): 45.

grindstone of clerical monotonousness beside which the ledger-keeping of a bank employee is a heaven of blissful excitements.¹²⁵

In his attempt to counteract the popular image of the home hospital orderly as what he termed a ‘Slacker in Khaki’—an able-bodied man who had wangled a role that kept him safely out of harm’s way, involved little actual work, but provided the status associated with military service in wartime—Muir focused on the physical labour the role involved. He pointed out that the work was onerous and dull, involving everything from shovelling coke and shifting bedding to typing documents and cleaning windows, as well as the inevitable carrying of stretchers several times a day as new patients arrived. Whatever their perceived or actual physical frailties, orderlies had to be strong enough to unload and carry up to 600 stretcher patients within a 48-hour period.¹²⁶ This involved four orderlies pulling the stretcher from the ambulance and two carrying it indoors. As with bearers in the field, this had to be done ‘swiftly but gently’, and the stretcher needed to remain stable. While the patient might no longer carry the weight of mud or sodden clothing, he could be encumbered with splints and bandages. The regularity and repetition of this work added to the profound physical exertion required of men who could be over 60, suffering from chronic illnesses, or who had already acquired a wound during overseas service.

Yet Muir’s reference to ‘the human element’ of ward work also points to the emotional labour of the home hospital orderly. In one of the most moving articles in *Observations of an Orderly*, he describes his role as an escort to a blinded ex-serviceman travelling home from hospital following his formal discharge from military service. During the journey Muir serves first as tour guide, then as audience. He arranges a detour past Buckingham Palace, so that the Yorkshireman can tell his wife that he has ‘seen’, however sightlessly, the famous landmark, and is later guided through the patient’s unnamed home city through the man’s recollection of a familiar landscape. In both roles Muir provides his patient with a sense of normalcy, even importance, thus helping to counteract the emotional impairment that disability has the power to inflict.¹²⁷ In his final act as caregiver, Muir serves as the bridge between his patient’s old identity as a wounded soldier and his new one as disabled civilian, and as witness to this transition:

I unhooked my arm from Briggs’s and made as though to push him forward into the family group.

¹²⁵ Muir, *Observations of an Orderly*, p.154.

¹²⁷ Anderson, “Jumpy Stump”, p.10.

¹²⁶ Ibid., pp.148–9.

'Nay!' said Briggs. 'I mun take my top-coat off first.'

I helped him off with his coat. Not one of the three members of his family had either moved or spoken—beyond one faint murmur, not an actual word, in response to my 'Here we are.' But Briggs seemed to know that his folk were in the room with him, and he neither accosted them, expressed any curiosity about them, nor betrayed any astonishment at their silence.

When he had got his coat off I expected him to move forward into the room. A mistake.... Briggs put out his hand, felt for the cottage door, half closed it, felt for a nail on the inner side of it, and carefully hung his coat thereon.

Now I could usher him into the waiting family circle.

No. I was wrong.

Briggs calmly divested himself of his jacket. He then felt for another door, a door which opened on to a stair leading to the upper storey. On a nail in this door he hung his jacket. And then, in his shirt-sleeves, he was ready. Shirt-sleeves were symbolical. He was home at last, and prepared to sit down with his people.¹²⁸

Such acts of emotional caregiving were, in Muir's view, distinctive to the role of the ward orderly. After the institution of VAD dilution, which prompted the introduction of the figure of the female 'orderlette' to the *Gazette's* gallery of caricatures, he argued that, 'genuine though the resulting friendships may be, I doubt whether the orderlette ever knows her patients quite as well as the orderly. There is a bond of sex as well as of khaki.'¹²⁹ In this opinion he anticipated the views of the Navy and Army Male Nursing Co-operation (NAMNC), which argued in the 1920s that a specific organization for the employment of male nurses was needed because men who were 'seriously disabled [in the war]... would prefer as nurses a male comrade who had served in the great war to a civilian who had been in England the whole of the past four years'.¹³⁰ While overseas service was foregrounded by the NAMNC, it was the sex of the caregiver as much as the specific nature of his service which defined his acceptability for the role. Thus despite the pressures brought to bear by the manpower crisis during the war years, and the consequent expansion of female caregiving in military medical settings, the idea that male caregivers had a unique role to play in nursing the sick, wounded, and disabled serviceman persisted throughout the war and beyond.

¹²⁸ Muir, *Observations of an Orderly*, pp.246–8.

¹²⁹ Muir, *The Happy Hospital*, pp.30–1.

¹³⁰ 'Nurses in War and Peace Times: Importance of Male Nurses', *Streatham News*, (8 November 1920), RAMC 1922, WL.

TRANSPORTATION

Muir's role as cicerone for Briggs points to a final key space in which RAMC rankers provided care along the line of evacuation, namely the spaces between sites of care, encompassing the range of transport by which men were evacuated, including horse-drawn and motor ambulances, ambulance trains and barges, and hospital ships. These were in some ways the most complex sites within which rankers' labour as caregivers was defined. Not only did continuous technological development over the course of the war mean that they were constantly shifting as spaces themselves, they were also shared spaces of caregiving. Even more than in CCSs and Base and home hospitals, RAMC rankers serving with medical transport vehicles were forced to work alongside, and in often uneasy relationships with, a range of other caregivers.

While orderlies working in CCSs and Base and home hospitals worked with and occasionally under the authority of military nurses and VADs,¹³¹ servicemen attached to transport worked additionally with members of the RASC and volunteers from a range of units such as the FAU and the American Field Service Ambulance Unit (AFSU). While there is relatively little evidence of conflict between these groups, beyond a certain amount of friendly rivalry between the RAMC and RASC in sporting arenas during rest periods,¹³² these relationships could create tensions. As Corder Catchpool of the FAU noted in his statement of pacifist principles, by 1916, 'Voluntary units were either dispensed with, or practically absorbed into the regular armies... and the R.A.M.C. was often closed to applicants. Men displaced from the service taken over by the Unit... were often drafted into the firing line and complained bitterly that I and my comrades had sent them there.'¹³³ While the BRCS, which organized the voluntary units providing care on ambulance trains and hospital ships, might celebrate the fact that the organization's 'assistance in certain spheres of work, such as transport of wounded... had become recognised as our normal function, [and] the Army knew by experience... that our help could always be counted on', the exclusion of RAMC rankers from

¹³¹ Military nurses officially had the status of officers in relation to RAMC rankers, whatever their rank within the nursing service. VADs had no such official rank, but the cultural capital provided by the association between caregiving and femininity could give them a level of authority in relation to RAMC orderlies.

¹³² Such rivalry reflects wider inter-unit rivalries throughout the British armed forces which were encouraged as part of the development of *esprit de corps*. (French, *Military Identities*.)

¹³³ Corder Catchpool quoted in Greenwood, *Friends and Relief*, p.183.

the work of orderlies on mechanical transport was not unproblematic for the men themselves.

When RAMC orderlies did serve in these spaces, as some did in the early years of the war, the labour was subtly different to that of Field Ambulance, CCS, and hospital bearers and orderlies. Carrying was still a key element of the role, with a particular emphasis on loading and unloading vehicles, a particular skill with its own set of training drills.¹³⁴ The domestic work of cleaning was also important, supplemented by the role of waiter, with the work of BRCS orderlies specifically defined as being 'to serve the meals for their patients and wait on them'.¹³⁵ Caring, however, appears to have been a lower priority for these men. Walter Bray, serving on a hospital ship during the Dardanelles campaign, may have recorded regularly assisting with operations on board ship.¹³⁶ On both ships and trains, however, it was the female nurses who undertook the bulk of medical caregiving under the command of an RAMC medical officer.¹³⁷ And, while fewer demands for caring may have been made on these men, they did require additional skills, particularly if serving on hospital trains. According to the BRCS, which supplied a mechanic to all hospital trains which it outfitted, 'It would frequently have been necessary to send the train into dock and thus stop its work had it not been for this handyman, who was always on the spot, and who, assisted by orderlies, was able to keep the train running whilst the necessary repairs were made either in machinery, painting, plumbing or otherwise'¹³⁸ (my emphasis). The mechanical skills associated with caring for machinery, rather than the medical skills necessary for caring for humans, were those which define the particular work of orderlies on hospital trains. The work of the RAMC ranker was thus squeezed out of these mobile spaces of care by voluntary medical carers on the one hand and technical specialists in mechanics on the other.

By the end of the war, care provision in mobile spaces had become almost the exclusive responsibility of voluntary care providers under the authority of RAMC officers. In this they echoed and, indeed, extended the process of 'feminization' seen in home hospitals. The act of transportation, so central to the service identity of the Field Ambulance stretcher bearer, became increasingly dissociated from the work of the unit further along the chain of evacuation. Yet the link between RAMC rankers and the

¹³⁴ War Office, *Royal Army Medical Corps Training*, pp.232–44.

¹³⁵ *Reports by the Joint Committees*, p.331.

¹³⁶ Walter Percy Bray, MS diary, 17–19 August, 1915, 4 September 1915, RAMC 1673, WL.

¹³⁷ *Reports by the Joint War Committees*, pp.330–1.

¹³⁸ *Ibid.*, p.184.

process of moving men down the line of evacuation was never completely broken, any more than the increasing number of women serving in clearing stations and hospitals eradicated their caring role. The specific spaces within which the work of carrying, cleaning, and caring was carried out shifted as the war continued, but nonetheless persisted as the identifying forms of labour undertaken by the rankers of the RAMC.

CONCLUSION

Along the chain of evacuation, from the stretcher bearers collecting from Regimental Aid Posts to hospital orderlies chaperoning disabled men into new, complex civilian lives, the work of the RAMC ranker was defined by both the physical and emotional labour that he undertook. The precise nature of the physical labour was shaped by the space in which it was undertaken, moving from road building to floor scrubbing, from negotiating ditches to manoeuvring up stairs. Nonetheless, all such labour required bodily effort from men who were often assigned to non-combatant service due to perceived physical frailty. It had the power to inscribe itself upon their bodies through increased strength as well as roughened hands and strained shoulders, something experienced by men in home hospitals as well as on the fighting front. While men serving in Field Ambulances and Casualty Clearing Stations faced threats to their physical integrity through the dangers of shell and rifle fire, this was less integral to their role than the work of building, cleaning, and carrying which they shared with home hospital orderlies.

Continuities along the lines of evacuation can also be seen in the emotional labour undertaken by these men. The centrality of cleaning to the work of all orderlies, whatever their unit of service, gave them an important role in the maintenance of morale, both in rest and hospitals. The comfort and reassurance they offered to wounded men, whether being carried along a trench, rebandaged in a dressing station, accompanied to surgery, or returned to civilian life, was a vital aspect of the process of medical care and recovery, one which was perceived as having social usefulness after the war's end. For the RAMC rankers themselves, the emotional labour of care undoubtedly had a profound and long-lasting effect, with the memories of trauma witnessed continuing to haunt them for days, months, and even years. The record of witness that they kept, in letters, diaries, and memoirs, stands as evidence of the centrality of their role as witness-bearer and the impact that bearing witness had on their subjective identities.

The work of RAMC rankers was not wholly continuous, however. In spaces such as ambulance trains and hospital ships, their work was squeezed out, appropriated by volunteers on the one hand and technical mechanical specialists on the other. Yet the fact that the work these men did was so firmly underpinned by the three categories of carrying, cleaning, and caring enabled the Corps as a whole to demonstrate flexibility to match the improvisation inculcated during training, with men able to serve at multiple points along the line of evacuation. As we have seen in the case of George Swindell, men could serve in a wide variety of sites of healing, whether as volunteer bearers or seconded orderlies. Even when ill or wounded themselves, they could find themselves undertaking caregiving work while convalescing in hospital, as Archie Whyte did while recuperating from rheumatism in Cairo in 1918.¹³⁹

Through the work they undertook, RAMC servicemen would develop a sense of a unique wartime masculinity, a masculinity defined by the acts of bearing both bodies and witness rather than by any sense of lack, either of professional medical identity or of military identity associated with arms-bearing. In not bearing arms, in digging and building, in comforting the dying, RAMC rankers variously undermined, reinforced, and transgressed the gendered divisions of wartime labour which underpinned the hierarchies of both military and medical systems. In doing so, they used their work to define an alternative definition of appropriate wartime masculinity. How this occurred across time, in response to both changing military practice and developing medical innovations, forms the subject of Chapter 4.

¹³⁹ Whyte, Diary, 21–23 September 1918, Papers of A. L. G. Whyte.

4

From No Man's Land to Auxiliary Hospital

The development of medical evacuation, 1914–1918

In 1917 the *British Medical Journal (BMJ)* published a two-part article entitled 'The Royal Army Medical Corps and its Works'. Replete with numerous illustrations depicting the three sections of the front in which medical work was undertaken, as well as images of trenches, aid posts, and evacuation vehicles of various types, the article used the structure of the chain of evacuation to describe the particular work of the RAMC on the Western Front in detail. In doing so, it described not only the roles of those who served in the Corps, but also the various spaces in which care was undertaken.

As we saw in Chapter 3, the spaces in which the men of the RAMC worked, both static and mobile, played an important role in defining the nature of that work. Different types of healing spaces were not, however, the only variable which shaped these men's practice and experience of war service, as the publication of the *BMJ* article three years into the war indicates. In its concluding sentence, the article points to another, equally important factor: 'after the war, when details become known to those capable of assessing its more scientific aspects, it will be acknowledged that the corps has taken full advantage of opportunity offered for advancing precise knowledge of medicine and surgery as well as means of handling vast numbers of sick and wounded men'.¹ Here the significant variable is that of time, with the development of medical knowledge and skill presented as advancing in a linear fashion in all the areas described in detail by the article.

Such a narrative of medical progress in wartime is typical of official histories of the war which, underpinned by wartime propaganda, sought

¹ 'The Royal Army Medical Corps and its Work', *British Medical Journal*: 260.

to justify the war effort to the wider British public.² While this interpretation of the relationship between war and medicine has been challenged by more recent scholarship,³ the very question of the relationship between medicine and war has tended, as Roger Cooter suggests, to 'not only reify[...] both war and medicine, privileging them from the societies and cultures in which they were set, but [also] locks them within a simple-minded mechanical causal relationship which only furthers an ahistorical transcendence'.⁴ In the work of medical officers, this narrative has been explored and challenged in studies of both the close engagement and even integration with civilian medical structures and expertise in wartime,⁵ and the opportunities for specialization and even experimentation that war created.⁶ Examining the work of the ranks of the RAMC across time as well as space, however, serves to further complicate our understanding of this relationship by exposing how war-induced technological and social developments shaped the labours of this particular category of medical care providers in ambiguous and paradoxical ways. This in turn influenced their agency in constructing themselves as servicemen in relation to the dominant masculine ideal of the soldier, just as the development of destructive technologies of war shaped wider understandings of dominant masculine ideals.⁷

This chapter, therefore, will examine a number of specific medical and transport technologies which were developed and elaborated upon over the course of the war to interrogate the extent to which such developments might be perceived as progressive in relation to the work of the ranks of the RAMC. It will also look at social developments in the practice and administration of medicine. In exploring the changing importance of first field dressings, mechanized forms of transportation, and the increasing range and scope of women's roles in hospital settings, this chapter will demonstrate the qualified nature of medical progress as practised by RAMC rankers between 1914 and 1918, qualifications which call into question the assertion that medicine, and its practice during the war, 'was one of the key means of bringing... modernity into being'.⁸

The extent to which Weberian modernist principles of technological rationalization and differentiation depersonalized and made redundant the

² Carden-Coyne *The Politics of Wounds*, pp.44–52.

³ Cooter, 'Medicine and the Goodness of War': 150.

⁴ Ibid.: 151.

⁵ Carden-Coyne, *The Politics of Wounds*; Whitehead, *Doctors in the Great War*.

⁶ Howell, "‘Soldier’s heart’"; Cooter, *Surgery and Society*; Hallett, *Veiled Warriors*, pp.91–3; Pelis, 'Taking Credit'; Carden-Coyne, *The Politics of Wounds*, pp.88–139; van Bergen, *Before My Helpless Sight*, pp.340–50.

⁷ Horne, 'Masculinity in politics and war', pp.32–3.

⁸ Cooter and Sturdy, 'Of War, Medicine and Modernity', p.17.

work of men involved in the functioning of such systems forms the subject of this chapter.⁹ In exploring how military medicine and its practice changed over the course of the war in relation to the British Army Medical Services, it will ask to what extent RAMC rankers were silenced and excluded from the practice of care by such developments, and the extent to which this forced a redefinition of their roles and status over the course of the war. It will do this through the exploration of four areas of change: the evolution of first-aid practices in no man's land and at RAPs; the increased mechanization of systems of transportation along the line of evacuation; the employment of trained nurses at CCSs; and the development of the auxiliary hospital system of convalescent homes and rehabilitative care within civilian communities. All four changes would have a profound influence on the work of RAMC rankers, which would, in turn, respond and adapt to this pressure over the course of the war.

As in Chapter 3, these areas will be explored along the chain of evacuation as travelled by men wounded on the front line. The topics examined cover the three key zones of medical evacuation which underpinned military medical operational planning. First aid took place predominantly in the collecting zone; transport formed the backbone of the evacuating zone; and women's work in both the evacuating and distribution zones was central to the changing nature of nurses' wartime roles. Yet it is not in relation to space that these themes can best be understood. While the shape of the three zones of medical evacuation, and the medical spaces of care within them, influenced the work of RAMC rankers, both stretcher bearers and orderlies, forcing them to engage flexibly and improvisationally in their provision of care, the spaces themselves were never static. Across the war they altered in response to changing military strategy and tactics,¹⁰ as well as to the introduction of new medical technologies. This chapter will explore how such developments affected both the work and status of RAMC rankers in relation to both wounded men and the women they worked alongside. Focusing on the spaces between sites of care, it will look at the promulgation of first aid technologies, developments in trench design, the employment of motorized transport, policies around the deployment of women in a range of medical roles, and the growth in the social significance of the auxiliary and convalescent hospital. In doing so, it will argue that RAMC rankers' work, viewed through the paradigm

⁹ See Max Weber, 'Bureaucracy', in *From Max Weber: Essays in Sociology*, ed. and tr. H. H. Gerth and C. Wright Mills (London: Routledge & Kegan Paul, 1948), pp.196–244. For a discussion of Weberian interpretations of war and medicine, see Cooter and Sturdy, 'Of War, Medicine and Modernity', pp.1–6.

¹⁰ Gary Sheffield, *Forgotten Victory: The First World War: Myths and Realities* (London: Headline Books, 2001); Boff, *Winning and Losing on the Western Front*, pp.246–51.

of space, can be seen to be continuous, with a consistent focus on core themes of carrying, cleaning, and caring, and the men themselves providing continuity from front line to home front. When viewed through the prism of time, however, these men's wartime roles were discontinuous, with technological developments disrupting the scope of their work and, with it, their status as servicemen.

NO MAN'S LAND

While as a whole the medical technologies to be examined will be shown to create discontinuities in care provision by RAMC servicemen, the first set of such technologies, those related to first aid, may be said to represent a form of continuity with pre-war care provision. The development of the first-aid movement as both an element of the international humanitarian movement and as a national voluntary endeavour in the years before the war had, as discussed in Chapter 1, profound implications for the organization and status of military medicine before 1914.¹¹ The continuities with this trajectory were most clearly reflected in possibly the most ubiquitous wartime medical technology—the first field dressing. This packet of supplies, including wool pad, square of gauze, and waterproof jacenet, was the first item of medical technology that a serviceman would encounter. It was first introduced in the British armed services during the Crimean War, although it was not until 1884 that it formally appeared on the *List of Changes in War Material*.¹² Designed to enable individual combat troops to undertake initial medical treatment of wounds, 'any British soldier was considered qualified, to administer the first field dressing'.¹³ Indeed, not only any but all soldiers were deemed qualified and would encounter this technology as they were issued as a standard element of service kit throughout the war.¹⁴

The content of the field dressing changed somewhat between its 19th-century issue and 1914. Most notably, the advice on using the waterproof jacenet, which lacked breathability, to cover the dressing once in place was reversed during the Second Anglo-Boer War. In the hot, arid conditions of South Africa, the practice of covering the wound with the jacenet was

¹¹ Gill, *Calculating Compassion*, p.193; Chapter 1, pp.22–6.

¹² P. H. Starling, 'First Field Dressing', *Journal of the Royal Army Medical Corps* 147 (October 2001): 371, PMID: 11766226.

¹³ Edward H. Benton, 'British Surgery in the South African War: The Work of Major Frederick Porter', *Medical History* 21 (1977): 281.

¹⁴ Peter Doyle and Chris Foster, *What Tommy Took To War 1914–1918* (Oxford: Shire Publications, 2014), p.107.

found to keep ‘wounds moist and liable to infection, whereas uncovered wounds would dry out and scab over’.¹⁵ By 1911, while the packets still consisted of ‘Two dressings in waterproof covers, each consisting of a gauze pad stitched to a bandage, and a safety pin’,¹⁶ the waterproof element was provided as a protective shield for the dressing prior to use, rather than as part of the process of wound care. Additionally, by this date the gauze was impregnated with the solvent sal alembroth and tinted with aniline blue to aid the identification of leakage once the bandage was in place. It appears that earlier practices of impregnating all dressing materials with a solution of 1 in 1,000 solution of corrosive sublimate for the purposes of antisepsis had been discontinued. Instead, the instructions printed on the dressings included an emphasized warning not to touch the gauze padding or the wound itself. Men were also briefly issued with a phial of iodine for cleaning wounds prior to the application of the dressing, although this was discontinued for combatant servicemen by the middle of the war.¹⁷

As this narrative indicates, throughout the war several small changes were made to the first field dressing. A separate wool pad took the place of the stitched-on gauze pad and the waterproof cover was reintroduced, reflecting the greater wetness of conditions on the Western Front in comparison to the South African veldt. In 1916 a larger ‘shell dressing’ began to be issued, in response to wounds arising from increasingly industrialized weaponry and the dominance of artillery on the field of battle, although, like iodine, this dressing were predominantly issued to medical servicemen. Increased demand for dressings, which accompanied the rapid expansion of military service under Lord Kitchener, also meant that producers of medical supplies, such as Thackray’s Pharmaceutical Shop in Leeds, invested in specialist technologies, enabling increased and improved production of branded ‘Aseptic’ field dressings under Home Office contracts.¹⁸

However, the technology of the field dressing itself, as issued in 1918, would have been easily recognized by servicemen of previous conflicts, just as the field dressings issued during the Second World War were little different from those issued between 1914 and 1918. A similar continuity can be seen in the triangular bandages which formed part of the standard

¹⁵ Benton, ‘British Surgery in the South African War’, 280.

¹⁶ War Office, *Royal Army Medical Corps Training*, p.321.

¹⁷ RAMC bearers continued to be issued with iodine throughout the war, and it formed part of the RMO’s medical pack for use at RAPs.

¹⁸ Penny Wainright, ‘Chas. F. Thackray Ltd: suppliers to the surgeons’, in *Leeds City Business 1893–1993: Essays Marking the Centenary of the Incorporation*, ed. John Chartres and Katrina Honeyman (Leeds: Leeds University Press, 1993), pp.244–69.

kit of the surgical haversack, medical companion, and fracture kit which accompanied medical officers and which it was the responsibility of the medical orderly to pack and maintain.¹⁹ Introduced in the first half of the nineteenth century, these highly flexible objects were central to the first-aid training offered by the St John Ambulance Association, which viewed them as 'a universal tool for the treatment of a variety of wounds and fractures', as well as to military medical practice.²⁰ Their use would thus have been familiar to men of the RAMC(T) and pre-war VAD volunteers, as well as to men of the Regular RAMC.

This material link between the practice of the St John Ambulance training and that of the RAMC is a further demonstration of the extent to which the work of civilian voluntary first aid overlapped and, indeed, integrated with military medical practice.²¹ The tools of primary care provision were the same for both groups. The promulgation and increased ubiquity of first-aid materials throughout the war via the issue of first field dressings to an army of mass mobilization had, however, a significant accelerating effect on understandings of *who* was qualified to undertake medical care provision on the battlefield. The issuing of all soldiers with basic medical supplies, whether volunteer or conscript, ranker or officer, combatant or non-combatant, democratized medical caregiving in line with Sir John Furley's ambitions for first aid training in the nineteenth century, but further and faster than he could have anticipated in peacetime.²² Meanwhile, the triangular bandage, an aid to improvisation, could itself be improvised out of a range of materials, putting the means of carrying out basic first aid in the hands of the ordinary soldier rather than the trained or part-trained medical serviceman.

Yet the democratization of medical caring over the course of the war ultimately remained limited. Information about the ways in which a puttee might substitute for a triangular bandage, whether as a bandage or to strap a splint, was never part of formal military first aid training in the way in which the application of the first field dressing was decreed to be.²³ It appears to have remained confined to training manuals, both formal publications for use of more specialized medical service personnel and unofficial ones which had to be purchased privately. Similarly, the more sophisticated wound and shell dressings, where the gauze was

¹⁹ Beggs, *Guide to Promotions*, pp.240, 242, 245.

²⁰ Vincent Little, 'The Fabric of First Aid: A History of the Triangular Bandage', *Pharmacy History Australia* 9 (November 1999): 10–12; 'Historical Happenings: The Triangular Bandage', *The Newsletter of St John Ambulance South Australia* (August 2012): 9.

²¹ Chapter 2, pp.54–5. ²² Furley, *The Proper Sphere of Volunteer Societies*.

²³ Wood, *The Soldier's First Aid*, pp.11, 54–5.

impregnated with 2 per cent iodine solution or, in the case of ‘extensive or foul wounds . . . [either] 1-60 carbolic lotion to which has been added 5 percent of sodium chloride; Lysol 1 drachm to 1 pint; or 1-2000 mercuric chloride or biniodide’,²⁴ were primarily supplied to the staff of Field Ambulances and other medical establishments, rather than to combatant servicemen.

While a form of specialized wound dressing could thus occur at multiple points along the lines of evacuation provided by the men of the RAMC, the CCS increasingly became a particular site for complex wound drainage and care, due to the presence of ‘trained nurses . . . [who] were competent and confident wound dressers’.²⁵ This spatial focus for complex wound care reflected the increasing levels of technical and specialist knowledge attained by trained female nurses in the late nineteenth and early twentieth century, but it also progressed over the course of the war, not least through the development of the Carrel-Dakin method of wound treatment between 1915 and 1917.²⁶ Onerous, labour-intensive, and requiring both painstaking aseptic medical practice and meticulous record-keeping, this method was increasingly used in the second half of the war and created a specific sphere of practice in which those who provided such care could point to their development of a specialized skill set.²⁷ As surgeons Richard Charles and Arthur Sladden noted in 1919, ‘the successful management of . . . a ward [of a CCS] is very greatly dependent on the skill and untiring patience and energy of the sisters and orderlies’.²⁸

Part of this skill was knowledge and practice of asepsis in the treatment of wounds by both nurses and orderlies, including, where possible, orderlies serving in dressing stations as well as CCSs and Base hospitals. The War Office’s 1915 *Memorandum on the Treatment of Injuries in War* (hereafter *Memorandum*) instructed that ‘Both medical officers and orderlies should wear clean aprons or gowns, and sterile rubber gloves should be worn if wounds are explored with the finger, or opened up for drainage, or

²⁴ *Memorandum on the Treatment of Injuries in War Based on Experience of the Present Campaign* (London: HMSO, 1915), pp.5–6.

²⁵ Hallett, *Containing Trauma*, p.41.

²⁶ The process of this development can be traced from the original formulation of the method in 1915, through the publication of scientific papers in medical journals, to its official adoption as the preferred method of wound treatment in British CCSs in 1917. See Carden-Coyne, *The Politics of Wounds*, pp.127–9 and Hallett, *Containing Trauma*, pp.56–9.

²⁷ Ibid., pp.41–2.

²⁸ Richard Charles and Arthur Sladden, ‘Resuscitation Work in a Casualty Clearing Station’, *British Medical Journal* 1 (5 April 1919): 403.

other manipulation.²⁹ Instructions were given on the winding of gauze around splints to prevent the tightening of bandages as blood dried, as well as on the necessity to fill in tallies to include 'An accurate description of the injury, for example—"Compound fracture of skull", not "G.S.W. head." "Compound fracture of femur," not "Shrapnel wound of leg."³⁰ While the practicality of such instructions being put into practice in the actual battlefield conditions which field-ambulance medical officers and nursing orderlies found themselves providing care in must be open to question, the inclusion of orderlies in such instructions identifies them as part of the development of medical expertise around wound care over the course of the war.³¹ Like trained female nurses, they formed part of a larger process of developing and communicating particular technical expertise which could, over time, be constructed as semi-professional.³²

This narrative of increasing professionalism was not fully inclusive, however, with the RAMC stretcher bearer positioned uncomfortably in relation to narratives of developing knowledge of asepsis and appropriate wound care, which increasingly foregrounded the role of women. Although, at least in theory, in receipt of more first-aid training than combatant troops, stretcher bearers' work tended to place them outside of the CCS and other physically defined spaces of care, the context in which expertise in drainage and asepsis was increasingly being developed. Instead, these men assisted with the provision of unskilled wound care through their work on the battlefield, something which placed them in an ambiguous position in relation to developing medical standards. The *Memorandum*, for example, asserted that those who applied the first field dressings in the front line could be viewed as dangerously unskilled:

It is of the utmost importance that the *first field dressing should always be removed as soon as possible*. It has in many cases been applied by the soldier himself or by his comrades, it has been soiled by contact with dirty clothes and dirty hands, and it is often applied to a dirty skin. It has almost always been put on too tightly if applied by unskilled persons, and even if not put on too tightly, the swelling of an injured limb may soon make the bandage too tight.³³ (Original emphasis.)

H. W. M. Gray, in his monograph *The Early Treatment of War Wounds* (1919), gave a contrasting view, arguing that dressings should not

²⁹ *Memorandum*, p.2. ³⁰ Ibid., p.7.

³¹ In doing so, it also implicates these men in ongoing debates about the best and most appropriate methods of treating wounds and wound infection which were played out in the pages of medical journals throughout the war. See Harrison, *The Medical War*, pp.28–9; Carden-Coyne, *The Politics of Wounds*, pp.122–9.

³² Hallett, *Containing Trauma*, p.68. ³³ *Memorandum*, p.2.

automatically be changed at dressing stations unless one of six definite indicators was present. These included the application of a first field dressing over dirty or imperfectly cleaned skin, bandages that were either too loose or too tight, and imperfectly applied splints.³⁴ While offering contrasting advice to MOs, both the *Memorandum* and Gray built their cases on the assumption that the first field dressing was likely to be poorly applied by combatant troops and that stretcher bearers, whatever training they might have received, would still lack the skill necessary to remedy poor application prior to arrival at either the RAP or dressing station. The lack of standardized training provided to regimental stretcher bearers would seem to support this understanding of bearer skills in stabilizing wounds for initial transport; however, the generalized circulation of the *Memorandum*, in particular to all MOs, whether attached to a regiment or other military medical establishment, would appear to also implicate RAMC bearers attached to Field Ambulances in this critique.

At the same time, while stretcher bearers, both regimental and RAMC, were issued with additional dressings, the application was not necessarily seen as the prerogative of bearers as medical care providers. Arthur Mills, a captain in the Duke of Cornwall's Light Infantry Special Reserve, for instance, did not associate the first field dressing with bearers, describing the dressings as 'two pads of gauze and cotton-wool and a bandage, [which] can be ripped out of its case and clapped on to the wound, and so save the injured man, who may have to lie out hours before he can be taken back to a dressing station, many risks from loss of blood or outside infection'.³⁵ Mills associated the bearers who carried him back under enemy fire after he was wounded not with the initial dressing of his wound but rather with the speed of their collection and transportation. While Mills did not have long to wait for such transport,³⁶ the delay for others was noted and often blamed by doctors and nurses for infections setting in due to lack of prompt treatment.³⁷ With the overall speed of the evacuation process a source of public criticism and political contention from the early days of the war,³⁸ stretcher bearers found themselves from the start the subject of scrutiny and criticism similar to that levelled at hospital orderlies during the Crimean War, with their labour criticized as more damaging than healing, whatever their intentions.³⁹

³⁴ Gray, *The Early Treatment of War Wounds*, p.41.

³⁵ Platoon Commander [Arthur Mills], *Hospital Days* (London: T. Fisher Unwin, 1916), p.14.

³⁶ Ibid., pp.14–15.

³⁷ Carden-Coyne, *The Politics of Wounds*, p.102.

³⁸ Ibid., p.44.

³⁹ Furneaux, *Military Men of Feeling*, p.196.

While the use of first field dressings had the potential to lay stretcher bearers open to scrutiny and criticisms, the development of other medical technologies had the opposite effect. The Thomas splint, introduced as part of orthopaedic practice from 1915,⁴⁰ for example, was credited with reducing fatalities due to bone haemorrhage in cases of femoral fracture from 80 per cent to 15.5 per cent.⁴¹ While the splints themselves were primarily used by medical officers who applied them at RAPs, their increasing use was part of a wider trend in the promulgation of practices aimed at improving the stabilization of broken limbs through appropriate splinting throughout front-line medical services. *The Soldier's First Aid*, published in 1917, for instance, included a description of how to manufacture a Thomas splint out of a rifle, a bayonet, a bayonet scabbard, and some puttees for use on the battlefield.⁴² Building on the emphasis placed on improvisation in RAMC rankers' training, such knowledge and skills made the work of both manual and mechanically assisted carriage by bearers easier, safer, and more effective.

Similarly, and related to this, improved knowledge of the impact of shock on wound survival shaped bearer practice, as well as that of nurses and nursing orderlies.⁴³ Shock was defined by the RAMC manual as 'a condition produced by severe injury or emotional disturbance', whereby 'The sufferer becomes pale and cold, he lies in a semi-conscious and helpless state, the face pinched, the lips ashy, the temperature sub-normal, the pulse feeble or absent. He often breaks out into a cold sweat, and may have fits of shivering, or be restless.'⁴⁴ According to Christine Hallett, it was 'conceptualised as a form of disintegration caused by injury, haemorrhage, pain and exposure to cold[,] . . . part of a process by which the body systems seemed to "shut down", threatening physiological coherence'.⁴⁵ Although 'The diagnosis and conceptualisation of "shock" or "collapse" was problematic in the second decade of the twentieth century',⁴⁶ the condition was already understood to require rapid 'containment' of the patient, both physiologically and psychologically. While nurses undertook much of this labour in CCSs, it was the responsibility of the bearers during the periods of transport that got them there.

⁴⁰ Harrison, *The Medical War*, p.101.

⁴¹ P. M. Robinson and M. J. O'Meara, 'The Thomas Splint: Its origins and use in trauma', *The Journal of Bone and Joint Surgery* 91 (April 2009): 540–4, DOI: 10.1302/0301-620X.91B4.21962.

⁴² Wood, *The Soldier's First Aid*, p.20–1. Mayhew, *Wounded*, pp.240–1.

⁴³ Hallett, *Containing Trauma*, pp.28–35.

⁴⁴ Royal Army Medical Corps Training, p.352.

⁴⁵ Hallett, *Containing Trauma*, p.28. ⁴⁶ Ibid., p.30.

According to H. M. W. Gray and K. M. Walker's pamphlet on *The Treatment of Wounded Men in Regimental Aid Posts and Field Ambulances* (1918), therefore, 'Regimental Stretcher Bearers should . . . be instructed in the gentle handling of patients and in the application of splints. Rough or unnecessary movement must be avoided as one of the most potent factors in precipitating shock.'⁴⁷ They were also to be made aware of 'the necessity for mobilizing every means of warmth in the forward area',⁴⁸ to be instructed in

the danger of wound shock and taught the urgency of preventing unnecessary loss of body heat during the carry back to the Aid Post. To obviate this loss, R.S.B.s should be supplied with a certain number of waterproof sheet-blanket packets, each packet consisting of one blanket wrapped in a ground sheet. These are strapped to the stretcher ready for use, and returned with the R.S.B.s as soon as they have delivered the wounded man at the Aid Post. . . . The occasional loss of a blanket will be amply compensated for by the saving of wounded men who would otherwise die from the effects of a carry on bare stretchers.⁴⁹

According to Gray and Walker:

The chief protection of the wounded man against cold during the first part of his journey lies in the liberal use of blankets. At no time is the loss of heat more rapid during the first two hours after wounding, and every effort must be made to prevent exposure to cold at this period. Nothing is more striking than the deterioration in condition that takes place when a stretcher case has been started on his journey without a blanket beneath him as well as one on top. . . . In cold weather and with shocked cases a third must be added.⁵⁰

In *The Early Treatment of Wounds*, Gray included three pages of instructions on how to wrap patients in blankets, including detailed illustrations (Figure 4.1), as well as a further nine pages of instructions on keeping the patient warm and dry once he had arrived at the RAP or dressing station. Again, the emphasis was placed on the capacity of medical servicemen for innovation, with sterilizing and heating devices being variously constructed from biscuit tins and the exhausts of motor ambulance cars (Figure 4.2). Indeed, so successful was this last improvisation that it was

⁴⁷ H. M. W. Gray and K. M. Walker, *The Treatment of Wounded Men in Regimental Aid Posts and Field Ambulances* (Third Field Survey Company, 1916), p.3 in Papers of R. A. Bryden, RAMC/PE/1/BRYD/63, AMS.

⁴⁸ Gray, *Early Treatment of War Wounds*, p.12.

⁴⁹ Gray and Walker, *The Treatment of Wounded Men*, p.3.

⁵⁰ Ibid., pp.2–3.

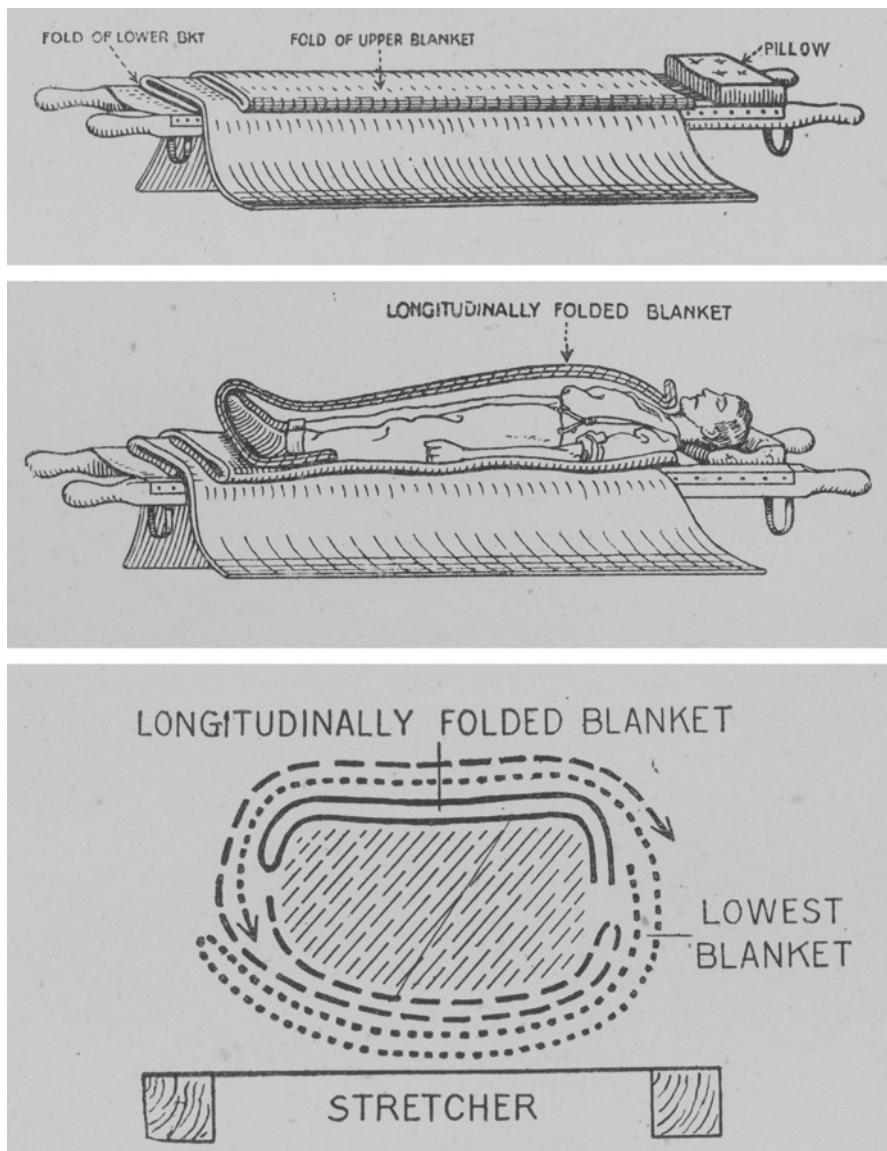


Fig. 4.1. Wrapping a patient; Gray, *Early Treatment of War Wounds*, pp.13–15.

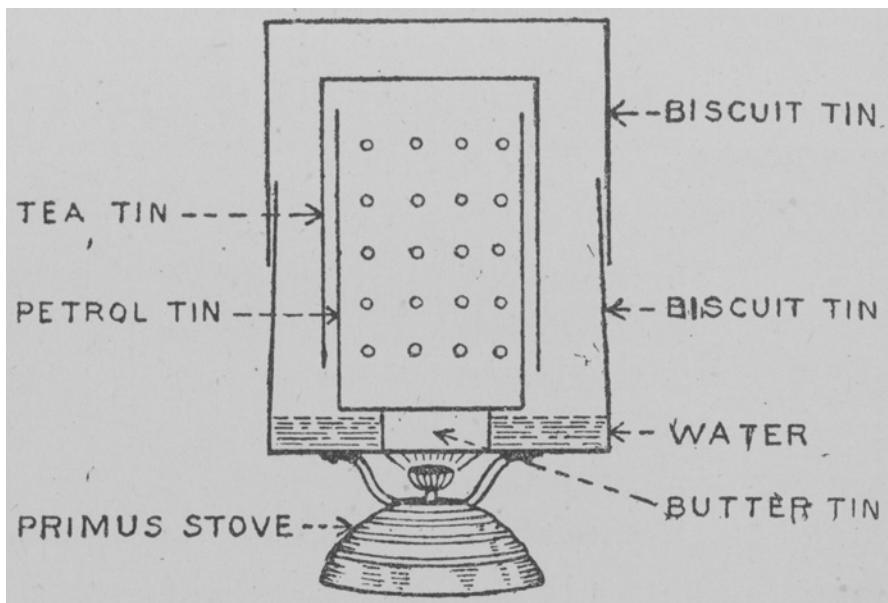


Fig. 4.2. Improvised sterilizer; Gray, *Early Treatment of War Wounds*, p.25.

developed into a formal technical innovation in motor ambulance design, with exhausts being routed to provide heating to vehicle interiors.⁵¹

THE TRENCHES

While the development of medical knowledge and consequent instruction of bearers around the treatment of shock were undoubtedly effective in saving lives as the war progressed, the logistics of providing more detailed and sophisticated treatment continued to present problems. David Rorie, serving as a medical officer with a Field Ambulance attached to the 51st (Highland) Division, recalled:

[I]t was a common experience that no proper attempt was made at the C.C.S. to return promptly the Field Ambulance's supply of hot-water bottles, Thomas' splints and other special appliances—things always of the utmost value to us—sent down with patients, nor see that proper drying arrangements existed for dealing with blankets and stretchers soaked by the

⁵¹ John S. Haller, Jr, *Farmcarts to Fords: A History of the Military Ambulance 1790–1925* (Carbondale and Edwardsville: Southern Illinois University Press, 1992), p.172.

rain and mud of the long carry from the front line. As the war went on there was a great improvement effected; for each motor transport driver was ultimately given a chit at the Main Dressing Station by the despatching N.C.O., detailing what special appliances went with the patients on his car; and this chit had to be signed by the C.C.S.'s receiving N.C.O., so that a check was available. And when the Casualty Clearing Stations were at last awake to the fact that blanket-drying was not a troublesome side-show but an important factor in combating shock up the line, we had taken a step forward by which everyone benefited.⁵²

Such developments had the potential to make the life of an MO such as Rorie easier, but they created additional labour, both bureaucratic and domestic, for RAMC rankers.

Other developments which had less than positive implications for the delivery of care by RAMC rankers, particularly bearers, were some of those relating to 'trench work'. This was a subject to which the *BMJ* devoted two pages and nine illustrations in its 1917 article, and it appears to have been an area which presented particular logistical problems for medical personnel. While for the medical services the trenches were the first point of contact for wounded men with a trained medical professional and were spaces to be negotiated in the process of evacuating men rapidly out of danger to a site where they could receive appropriate care, for the military they were strategic tools of offence and defence.⁵³ Unsurprisingly, the development of trench design over the course of the war owed more to their role in changing military strategy than considerations for the convenience of medical services. Thus the introduction of the zigzag formation of trenches, designed to make it more difficult for an enemy to control them in the event of a successful attack, made the negotiation of corners so difficult as to render the design of stretcher then in use all but unusable (Figure 4.3). According to the *BMJ*, 'it is common for the problem [of negotiating corners] to be solved by lifting the patient on a blanket or on a stretcher over the parados or back wall of the trench, and carrying him to the regimental aid post over the intervening ground'. This was a risky manoeuvre: 'Should the trenches happen to lie at the top of an ascent this is a relatively easy process, but otherwise it can only be carried out after nightfall unless the need for removal is so urgent that the risk must be taken of the patient and his bearers all being killed.'⁵⁴

The width of trenches was also a problem. As the *BMJ* noted, the twin trench, new in 1917, 'may be nowhere wider than 24 in., while the

⁵² Rorie, *A Medico's Luck in the War*, pp.6–7.

⁵³ Sheffield, *Forgotten Victory*, pp.118–19.

⁵⁴ 'The Royal Army Medical Corps and its Work', *British Medical Journal*: 219.

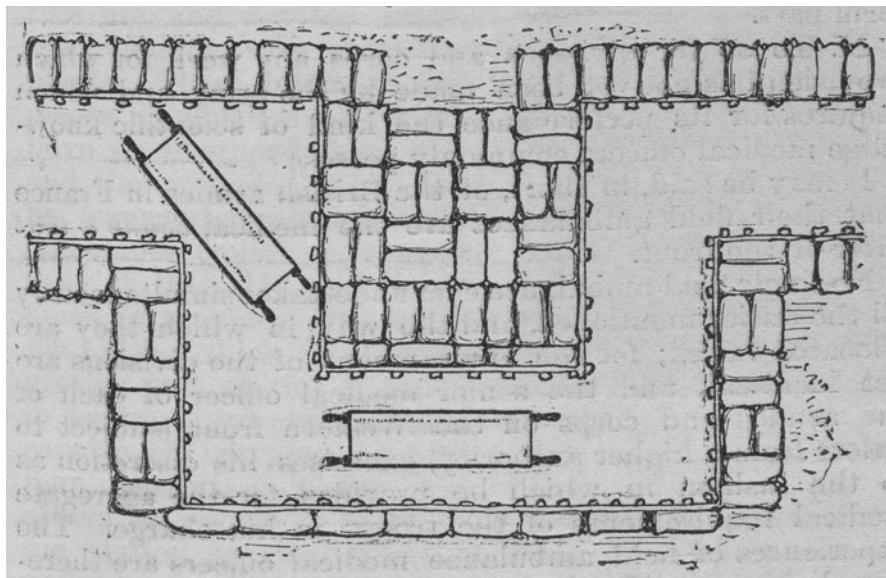


Fig. 4.3. Diagram to illustrate the difficulty of getting a stretcher round the angle of a trench; 'The Royal Army Medical Corps and Its Work', *BMJ*: 219.

average width of a fully-developed trench is not more than 4 ft. at the level of the shoulders'. Again, 'its course is invariably interrupted by angles round which an ordinary stretcher cannot be carried except by tilting'.⁵⁵ Trenches located where the ground water was low enough to allow a trench depth of over 6 feet, meanwhile, may have provided excellent protection for the men in them at the expense of only three layers of sandbags, but were designed to be dug at an angle whereby the bottom was 2 feet wide and the ground-level width was 4 feet. With Army pattern stretchers measuring 1 foot 11 inches in width, and 7 feet 9 inches in length including the poles, stretchers could not physically be carried along such trenches, again forcing bearers and their patients to leave the comparative protection they offered for open ground.

These developments in trench design thus posed not merely challenges but actual risks to the evacuation process undertaken by RAMC bearers. The design of stretchers failed to develop in an integrated manner with that of trenches, with direct implications for the way in which bearers were required to work, forcing them to face greater danger than they would

⁵⁵ *Ibid.*

have otherwise. It also affected bearers' ability to improvise, particularly in relation to piggyback lifts, which were problematic in narrow spaces. Manual carries remained useful, as Sir George Beatson noted in his pamphlet on *How the Wounded are Cared for in War*. 'In the trenches it is difficult to use the ordinary Army stretcher, especially in the zig-zag communication trenches, and it has been found that the wounded are best conveyed on a blanket. Modified stretchers have been devised to meet the difficulties, but it cannot be said that they have been very successful. Use has, however, been made of wheeled stretchers after the wounded have left the communication trenches.'⁵⁶

THE MOTOR AMBULANCE CORPS

Wheeled stretchers were not the only form of wheeled transportation that saw increased use over the course of the war. As Beatson went on to note, 'It is the Motor Ambulances that have done the chief part of the transportation in the present campaign.'⁵⁷ This was in spite of the fact that this form of mobile medical unit had not been 'contemplated in the original scheme of mobilization',⁵⁸ reflecting wider weaknesses in the 'rather vague' arrangements for medical provision in the event of a European war drawn up by the then Director of Military Operations, Sir Henry Wilson, in 1911.⁵⁹ Plans were in place for the mobilization of horse-drawn transport, although difficulties in acquiring suitable animals presented problems. Walter Bentham, recalled to service having previously served with the Royal Garrison Artillery, remembered that 'all the harness for the horses had to be got ready, as well as the horses and a good many of the horses had to be broken in for the work, for they were quite fresh and never used in the Army before'.⁶⁰

It was, however, the lack of specifically *motorized* ambulance cars in the early days of the war that became a focus for political and public criticisms of the work of the RAMC.⁶¹ The deficiency was initially made up by donated ambulance cars coordinated by the BRCS, but by the end of 1914, 'the formation of motor ambulance convoys, in proportion to the number of divisions in the field, had become definitely authorized, and the War Office... had prepared and despatched as many as 324 motor

⁵⁶ George Thomas Beatson, *How the Wounded Are Cared for in War* (Glasgow: Scottish Branch, British Red Cross Society, n.d.), p.20.

⁵⁷ Ibid. ⁵⁸ Macpherson, *History of the Great War*, Vol. 1, p.52.

⁵⁹ Harrison *The Medical War*, p.17. ⁶⁰ Bentham, Diary, 9 August 1914.

⁶¹ Carden-Coyne, *The Politics of Wounds*, pp.28–37.

ambulance cars to France'.⁶² These added to the eighty Wolseley chassis cars sent in September, which already formed No. 1 Motor Ambulance Convoy. 'Subsequent convoys were made up of motor ambulance cars presented by various generous donors, local committees, and the British Red Cross Society and Order of St. John, as well as of cars purchased by the War Office. . . . By the end of 1915 eighteen motor ambulance convoys had been sent overseas. . . . [The] total number of convoys mobilized before the termination of the war was 48.'⁶³ Each convoy was made up of fifty vehicles, with a convoy allocated to each army corps. Their establishment was, according to the *BMJ*, 'an outcome of the circumstances of the war in France, and an example of the ingenuity of the Royal Army Medical Corps in promptly adapting its arrangements to the needs from time to time arising'.⁶⁴ Here medical improvisation in the face of circumstances may be said to have occurred at unit rather than individual level.

The development of this new medical unit was not, however, as smooth as this summary implies. In theatres other than the Western Front, particular landscapes often made motorized vehicles unsuitable as forms of transport,⁶⁵ while even on the Western Front conditions created by industrialized warfare produced problems for the deployment of a technology that was still lacking in robustness as well as comfort.⁶⁶ Horse-drawn ambulance waggons, with their RASC drivers, remained in service throughout the war, clearing the wounded at Pozières who had been brought down by trolley from the fighting at Courcelette in 1916.⁶⁷ At the Second Battle of Ypres, a combination of heavy shelling and the disruption to RAMC pre-battle planning by orders from the General Officer Commanding (GOC) of the Vth Corps for all units to fall back on Ypres made the distance to be covered in the evacuation from front line to aid post much longer than planned. As a result, motor ambulance cars were all but unusable. Instead, field-ambulance bearer units were mobilized for extended manual carries, and wheeled stretchers were deployed.⁶⁸ Despite the fact that the following year, at St. Eloi, motor ambulance cars 'continued running both night and day under frequent and heavy shell-fire',⁶⁹ the problem of the destruction of roads by shelling for the deployment of motorized medical transport would never be fully resolved. On the Somme in 1916 and at Passchendaele in 1917, levels of destruction to the landscape, particularly when combined with poor

⁶² Macpherson, *History of the Great War*, Vol. 1, p.53.

⁶³ Ibid., pp.53–4.

⁶⁴ 'The Royal Army Medical Corps and its Work', *British Medical Journal*: 223–4.

⁶⁵ Carden-Coyne, *The Politics of Wounds*, p.36.

⁶⁶ Carden-Coyne, *The Politics of Wounds*, pp.55–6.

⁶⁷ Macpherson, *History of the Great War*, Vol. 3, p.25.

⁶⁸ Ibid., Vol. 2, p.399.

⁶⁹ Ibid., Vol. 3, p.2.

weather, would continue to make manual carries a necessary part of medical evacuations.

In Palestine, lack of any roads forced the officers and men of the Field Ambulances to rely on their own initiative and improvisation of road surfaces for effective transport, as well as on the Camel Corps. W. D. Fothergill recalled, 'During our trek across the Sinae [sic] Desert . . . [w]e also had sledges drawn by mules to carry the sick and wounded but eventually got Model T Ford ambulances which ran on "roads" made by laying down ordinary rabbit netting on top of the sand—it worked.'⁷⁰ Charles Ammons also recalled the invention of the 'wire road' '[t]o ease the movement of vehicles, animals and men in the loose sands . . . This consisted of mesh chicken wire pegged down at the edges and it fulfilled its purpose admirably of keeping wheels and feet on the surface.'⁷¹ Even so, officers such as W. Brown and R. C. Evans spent a great deal of time experimenting with alternative forms of transport. These included a variety of sleighs and wheeled stretchers which were designed to enable greater ease of evacuating the wounded, partly due to the shortage of suitable motorized transport but mainly to replace the camel cacolets, detested for their lack of comfort or convenience and their tendency, like the pavé roads of France, to cause further pain and injury to patients transported in them.⁷²

While increased use of motor ambulance cars could never fully replace the labour of the men of the RAMC, as a technological innovation they posed a significant challenge to the Medical Corp's control of casualties. The men who made up the motor ambulance convoys were drawn from the RASC, recruited for their engineering skills, rather than the RAMC—at a ratio of three to one. The *BMJ* noted that the small section of RAMC men attached to any given convoy

is commonly employed solely for train embarkation, and is then attached to one of the group of casualty clearing stations, and works under its commanding officer. The other two sections are each under the control of a motor convoy medical officer, who is personally responsible for the safe delivery of all patients loaded on the ambulance cars in his charge. Whenever possible he accompanies his section personally, not only because his attendance may be required for a patient, but also in order to regulate the travelling pace.⁷³

⁷⁰ W. D. Fothergill, Memoir, TS, p.4, Papers of W. D. Fothergill, LIDDLE/WWI/GS/0575, LC.

⁷¹ Ammons, 'Service in the First World War', p.18.

⁷² W. Brown, Diary, TS, 23 February 1917, 28 February 1917, Papers of W. Brown, LIDDLE/WWI/GS/0211, LC; Midwinter, 1914–1919 *Memoirs*, p.48.

⁷³ 'The Royal Army Medical Corps and its Work', 223.

Medical authority over the MAC sections was thus limited: ‘vehicles conveying seriously wounded cases requiring special medical equipment will be accompanied by R.A.M.C. personnel. . . . However, it may frequently happen that this duty will devolve on the driver, as the number of medical personnel in the M.A.C. is not sufficient to provide one nursing orderly for each vehicle.’⁷⁴

Nor was the substitution of RASC personnel and expertise the only way in which the RAMC relinquished authority in these mobile spaces of medical evacuation. The medical services’ increasing reliance on voluntary-aid organizations to run transportation links, with the Red Cross staffing 1,484 motor ambulances and three ambulance trains by the end of the war, provides another example. Thus a hospital train would be supervised by a single RAMC medical officer but, in the case of those staffed by the voluntary services, the forty-one male orderlies who formed the bulk of the train’s staff were drawn from the BRCS male VAD units and volunteers attached to associated voluntary units such as the FAU. This latter, after 1916, drew an increasing amount of its personnel from the ranks of non-absolutist conscientious objectors.⁷⁵

While the men of the FAU ultimately provided 600 personnel serving overseas and ran four ambulance trains,⁷⁶ the substitution of voluntary for military medical provision also entailed the increased use of women as motor ambulance drivers, whether as part of the BRCS’s Women’s Ambulance Corps or the First Aid Nursing Yeomanry (FANY). On the one hand, this development served to reinforce women’s claims to the role of care provider based on gendered divisions of labour, even in the context of the battlefield, with one wounded soldier writing that ‘I would a thousand times prefer to be driven by a woman’ as ‘they bump less’.⁷⁷ On the other hand, just as the recruitment of conscientious objectors to the Corps from 1916 helped create an association between male military medical service and men commonly viewed as ‘despised and rejected’,⁷⁸ so

⁷⁴ ‘Organization and Operation of a Motor Ambulance Convoy’, *Journal of the Royal Army Medical Corps*, repr. from the *Royal Army Service Corps Quarterly* (November 1934): 105.

⁷⁵ Rebecca Wynter, ‘Conscription, Conscience and Controversy: The Friends’ Ambulance Unit and the “Middle Course” in the First World War’, *Quaker Studies* 21 (December 2016): 213–33, DOI: 10.3828/quaker.2016.21.2.6; Meyer, ‘Neutral Caregivers or Military Support?’, 116–17; Chapter 2, p.71.

⁷⁶ Greenwood, *Friends and Relief*, p.193.

⁷⁷ Quoted in Laura Doan, ‘Primum Mobile: Women and Auto/mobility in the Era of the Great War’, *Women: A Cultural Review* 17 (August 2006): 34–5, DOI: 10.1080/09574040600628468.

⁷⁸ This phrase was first used in relation to conscientious objectors as the title of Rose Alatini’s 1917 novel, now viewed as a landmark in gay and lesbian fiction. (A. T. Fitzroy [Rose Alatini], *Despised and Rejected* (C. W. Daniel, Ltd, 1917)). For further discussion of the novel and its significance, see Lois Bibbings, ‘Images of Manliness: The Portrayal of

the increasing use of women in roles previously occupied by men served to undermine the claims to masculine status of men who still occupied those roles.

While the work of women in the dangerous masculine space of a theatre of war overseas was the subject of much press discussion,⁷⁹ the men of the RAMC did continue to serve in these roles throughout the war. Sixty-three ambulance trains were mobilized over the course of the war, only three of which were run by the BRCS. The Corps thus continued to play an important role in providing both the medical officers and the male orderlies who staffed trains, just as it provided the two officers and twenty-eight orderlies of the medical wing of an MAC. Yet the prominence given by the British press to female and voluntary staffing of these mobile medical units, as well as the outnumbering of RAMC staff by RASC staff in each MAC, resulted to a large extent in the cultural effacement of RAMC rankers as transport operatives beyond the Casualty Clearing Station, both in terms of physical presence and masculine status. The introduction of a range of non-military medical care providers into the evacuation process would prove to be one of the most significant developments for the gendered status of the RAMC as the unit where men provided medical care within the military.

CASUALTY CLEARING STATIONS

The increased use of voluntary medical care units as staff for transport units, alongside the increasing importance of non-medical transport servicemen in these mobile spaces of care, was one element of a wider change in military practice, whereby dilution and substitution were used to address the ongoing manpower crisis.⁸⁰ For the medical services this meant not only the dilution of staff at Base and home hospitals through the employment of women at the uneven ratio of two or three women to one man,⁸¹ but also the more direct substitution of enlisted men by both male conscientious objectors and trained medical women to free up combatant manpower. The latter included both female doctors and trained military nurses. The work of women doctors remained, as Whitehead has

Soldiers and Conscientious Objectors in the Great War', *Social & Legal Studies* 12 (September 2003): 355–8, DOI: 10.1177/09646639030123003.

⁷⁹ Robert, "All that is Best of the Modern Woman"?; Lucy Noakes, "Playing at Being Soldiers": British women and military uniform in the First World War', in *British Popular Culture and the First World War*, ed. Jessica Meyer (Leiden: Brill, 2009), pp.123–45.

⁸⁰ Thom, *Nice Girls and Rude Girls*, pp.53–77.

⁸¹ Macpherson, *History of the Great War*, Vol. 1, p.142.

shown, contested throughout the war. This meant that while their work might be welcomed by Allied military services, including France and Serbia, and the Scottish Women's Hospital was asked to establish a hospital at Wimereaux and allowed to run a military hospital at Endell Street, London, their service overseas as part of the British Army Medical Services was limited.⁸² By contrast, the British military authorities' embrace of the work of trained military nurses as substitutes for male orderlies overseas, particularly at CCSs, would have significant implications for the changing role and status of the men of the RAMC over the course of the war.

The idea of placing nurses in CCSs was suggested as early as 1914, when Colonel Arthur Lee, serving as Kitchener's personal commissioner on the state of the medical service, recommended in his reports the use of trained nurses 'on account of their superior training by comparison with most RAMC orderlies and their powerful effect on morale'.⁸³ While his opinion echoes the assessment of the work of female military nurses advanced after the Crimean War,⁸⁴ Lee's proposal was initially viewed by the senior ranks of the Corps 'as highly experimental and very dangerous. Male military medical officers had serious doubts over the wisdom of posting women so close to the front line, believing that they would be unable to cope with the privations and stresses of life in the "zone of armies".'⁸⁵ However, Sir Anthony Bowlby's suggestion, as Consulting Surgeon to the Forces, in advance of the Somme Offensive, that 'most CCSs became general hospitals in all but name' meant that it became 'possible to contemplate the employment of female nurses' in these units, in spite of their location relatively close to the front line.⁸⁶ As the *BMJ* noted in 1917, CCSs were

no longer mere stations but real hospitals, despite the fact that some are only about six miles from the fighting line, and few lie further off than double that distance. The patients are nursed by trained women nurses; ordinary hospital beds are provided for the more serious cases; the operating theatres have usually four operating tables, are equipped with electric light and the appliances familiar in the hospitals of large towns; and while some have x-ray annexes of their own, all have at their command the services of travelling x-ray outfits and clinical laboratory work is done for them by the mobile laboratories which are commonly to be found in the neighbourhood.⁸⁷

Stasis and complexity appear to have helped to overcome anxieties about relative proximity to the front line.

⁸² Whitehead, *Doctors in the Great War*, pp.107–12.

⁸³ Harrison, *The Medical War*, p.32. ⁸⁴ Chapter 1, pp.28–9.

⁸⁵ Hallett, *Veiled Warriors*, p.48.

⁸⁶ Harrison, *The Medical War*, pp. 32, 38.

⁸⁷ 'The Royal Army Medical Corps and its Work', 254.

The increasing capacity for CCSs to undertake surgery close to the front line was central to their status as what David Rorie called the 'spoiled children' of the army medical services,⁸⁸ although 'the chief differences between it and a base hospital are attributable to the diversity of duties that the casualty clearing station has to fulfil'.⁸⁹ As the *BMJ* noted,

the general practice is to provide sufficient accommodation and personnel for the performance of at least four operations simultaneously and continuously for an unlimited number of hours or days. Even when a battle is in progress, of the wounded men who arrive at the casualty clearing station at least 10 per cent must visit the operating theatre before they can be sent to the base hospital.⁹⁰

This meant that, within these spaces of care, 'The surgical team was the important unit of practice, and the [nursing] sister was the lynch-pin of this team, setting up the operating theatre, preparing dressings and sterilizing equipment; assisting in the surgical procedure; and finally, dressing the wounds and caring for the patient as he began to recover consciousness.'⁹¹

Nurses also played a significant role in the process of triage as it developed at CCSs,⁹² as well as increasingly providing specialized medical support as anaesthetists and X-ray operators.⁹³ The multiple roles that women occupied within the CCS, along with the fact that this was the first site where a wounded soldier would encounter a woman as part of the process of medical evacuation, meant that they were a recurrent theme in wounded men's memories of their medical evacuation. W. J. Handy, for instance, recalled that, on arrival at the CCS, 'the nurse packed me up with hot water bottles and I soon found myself in the operating theatre. A white figure made a rapid survey and I heard a voice a long way off say "Bring me the transfusion apparatus" before once more I slipped off into unconsciousness'.⁹⁴ The nurse was clearly a more solid individual to Handy than the dehumanized white figure of the anaesthetist.

While Handy had vivid recollections of the nursing care he received at the base and convalescent hospitals he spent time in, as well as the CCS, his memoir is also notable for the number of references he makes to the orderlies he encountered as part of his experience of medical care. In addition to the orderly who dressed his first wound at a CCS before he

⁸⁸ Rorie, *A Medico's Luck in War*, p.6.

⁸⁹ 'The Royal Army Medical Corps and its Work', 254.

⁹⁰ Ibid.

⁹¹ Hallett, *Containing Trauma*, p.94.

⁹² Hallett, *Veiled Warriors*, p.74.

⁹³ Carden-Coyne, *The Politics of Wounds*, p.161.

⁹⁴ W. J. Handy, 'The Adventures of a Civilian in Khaki', TS memoir, 1935, unpaginated, privately held, used with permission of Handy's family.

returned to service, it was an orderly, rather than a nurse, who provided emotional support when he came round from the anaesthetic after his leg was amputated later in the conflict:

I wakened to find myself in a real bed with sheets, a luxury that I had almost forgotten still existed in the world. It seemed like heaven except that my left foot was aching. I moved the other one over to rub it. 'That's funny' I thought and was settling down to sleep again when the orderly dashed over, thinking perhaps that I might have had a shock at my discovery, but I was past that. They could have taken my head off for all I should have cared.⁹⁵

Thus despite the cultural dominance of female nurses, the male rankers of the RAMC continued to play a role in these spaces of care, just as they made up the bulk of ambulance-train staff throughout the war. Men needed to be transported from ambulance to distribution room, from triage to preparation room to surgery, from surgery to recovery ward and, because CCSs still predominantly acted as evacuation units, from ward to train for transport to the base. Such labour required physical strength, which it was presumed women could not supply.

In the process, as Handy bore witness, medical orderlies also provided emotional comfort and reassurance to the wounded. More prosaically, David Rorie wrote that 'Constant demands were made by Corps to detail officers and nursing orderlies from the Ambulances for the purposes of assisting the C.C.S.s; . . . when sent to the C.C.S., they were looked on as "nobody's bairns", and too often given all the dirty work to do: in one such a case a medical officer and twenty nursing orderlies were set to dig drains!'⁹⁶ While this labour may not have differed in essence from the physical labour Field Ambulance tent orderlies and stretcher bearers were expected to undertake further up the line, Rorie's comments indicate the extent to which the Corps viewed itself, and the work of the men who served in it, as more than a labour corps. Such views find a parallel in the anxieties expressed by female VADs about the work expected of them by trained military nurses. Having enlisted to nurse, many felt the drudgery of cleaning, bed-making, and bandage-rolling that they were assigned to do did not make full use of their enthusiasm and skills.⁹⁷

As the war continued, VAD nurses increasingly developed the specialist skills that allowed them to position themselves as appropriate medical care providers in relation to the trained nurses who supervised them.⁹⁸

⁹⁵ Handy, 'The Adventures of a Civilian in Khaki'.

⁹⁶ Rorie, *A Medico's Luck in War*, p.6. ⁹⁷ Watson, 'War in the Wards', 500.

⁹⁸ Hallett, *Containing Trauma*, p.41.

Similarly, the men of the RAMC in CCSs were, over time, able to carve out new roles for themselves. Even as women were increasingly being recruited and trained to fill technical roles as anaesthetists and X-ray technicians, growing surgical specialism and expertise created new roles for men serving in the ranks in the form of innovations such as the mobile 'theatre trailer' (Figure 4.4). This mobile unit was designed 'to push an operating section forward' when the more static unit of the CCS as a whole would take too much time to pack up and move. Each trailer, comprising a pitch-pine frame and a 'lorry loaded with stretchers, blankets, cooking and feeding requisites for a hundred serious surgical cases for two days and... also a hospital marquee and operating tent', was staffed by four RAMC orderlies and two RASC drivers: 'These six men pack the loaded furniture in ten minutes.'⁹⁹ The orderlies would also, once in place, act as theatre and nursing staff, in place of the female nurses who remained in the more static main units. The work of these men thus required not only strength but also expertise.

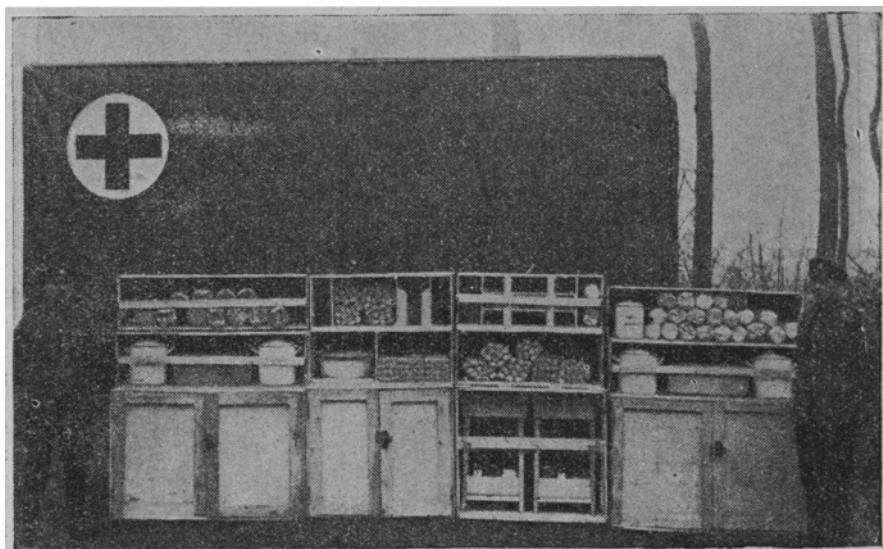


Fig. 4.4. A theatre trailer; 'The Royal Army Medical Corps and its Work', *BMJ*: 256.

⁹⁹ 'The Royal Army Medical Corps and its Work', *British Medical Journal*: 256.

While the theatre trailer represents a way in which medical innovation could enable RAMC rankers serving in CCSs to position themselves as significant contributors to the work of the unit, such repositioning can also be seen in a more continuous aspect of caregiving across the course of the war. Medical innovations such as blood transfusions and wound drainage via the Carrel-Dakin method, both of which women were intimately involved in delivering,¹⁰⁰ may have led to the development of a new space with the CCS, the resuscitation ward, where men often experienced seemingly miraculous recoveries.¹⁰¹ Nonetheless, the moribund ward, where men beyond saving were taken following triage, remained a significant space within these sites, one which remained the preserve of the men of the ranks of the RAMC. The mortuary also remained a feature of the CCS throughout the war, meaning that the role of gravedigger for those who died continued to be one that needed to be filled throughout the conflict. Such work formed a significant part of the construction of a specific unit identity and sense of expertise for the men of the Corps.¹⁰² It also serves to indicate the limits of both medical advances and a dichotomous gendered reading of care giving which the increased role of women in advanced medical units has tended to be read as. In the chaotic, over-burdened surroundings of a CCS at full capacity, nurses did indeed care for men in their final moments before death.¹⁰³ Nonetheless, male orderlies were still expected to take on the emotional labour of care for the dying in particularly rigorous circumstances because they were perceived as combining gentleness with a lack of the emotional fragility which was attributed to women. Where the medical advances of the war failed in their goal of saving life, it was often the men of the Royal Army Medical Corps who were there to provide comfort at the end.

Thus in spite of social and medical advances that made it easier for women to claim a role in front-line medical caregiving, there remained requirements for the physical and emotional labour of men in such spaces of care throughout the war. These developments, which served to expand women's professional experiences, horizons and claims to status, were more ambiguous for male medical carers, limiting, as they did, the sphere in which they could claim a specific form of non-professional expertise in the context of military effort. At the same time, technical advances in surgery and medical mobility opened up new spaces of care in which

¹⁰⁰ Pelis, 'Taking Credit': 271; Hallett, *Veiled Warriors*, pp.91–2.

¹⁰¹ Carden-Coyne, *The Politics of Wounds*, p.69.

¹⁰² Chapter 3, pp.124–5.

¹⁰³ Vera Brittain, *Testament of Youth: An Autobiographical Study of the Years 1900–1925* (Macmillan, 1933), p.178; Ellen La Motte, *The Backwash of War: The Human Wreckage of the Battlefield as Witnessed by an American Hospital Nurse*, in *Nurses at the Front*, edited by Higgonet, p.19.

forms of expertise could be displayed, particularly in relation to handling specialist equipment efficiently and carefully.

AUXILIARY HOSPITALS

While male medical caregivers other than doctors were able to maintain a presence, and indeed a sense of purpose, in CCSs and, to a lesser extent, Base and home military hospitals,¹⁰⁴ the same cannot be said for auxiliary hospitals, the final stage in the chain of evacuation for wounded men. These hospitals, based in Britain, were primarily utilized by the military medical services as convalescent units, although those classed as A were staffed by trained nursing personnel and supplied with suitable equipment for operations. Those classed as B were considered suitable for convalescents requiring little or no further treatment.¹⁰⁵ Comyns Berkeley and Victor Bonney, medical officers at the Middlesex Hospital at Clacton-on-Sea, noted that 'there were very few of our patients who required any further surgical treatment after they had left us, but we were always ready to, and did, on several occasions, go to various parts of the country to visit an auxiliary hospital at which our advice, as to the further treatment of some patient we had sent them, was wanted'.¹⁰⁶ Indeed, according the official history 'the employment of officers and men in the R.A.M.C. in [auxiliary hospitals] was permitted in very exceptional cases only'.¹⁰⁷ These sites of care were thus predominantly staffed by volunteers organized by the BRCS, although the War Office continued to provide oversight and the convalescent men remained under military discipline and were required to wear a uniform of 'hospital blues'.¹⁰⁸

This dilution of the medical services on the home front had important implications for the status of male medical care providers. The work undertaken by women in these spaces was not merely that which had been 'considered to be more appropriate for the orderlies',¹⁰⁹ as in military hospitals. It was, in cases such as that of several of the auxiliary hospitals attached to the 1st Southern General Hospital, Birmingham, *all* the work of caring, excluding men entirely from such roles. In taking on the

¹⁰⁴ Chapter 3, pp.89–94. ¹⁰⁵ Macpherson, *History of the Great War*, Vol. 1, p.85.

¹⁰⁶ Comyns Berkeley and Victor Bonney, *The Annals of the Middlesex Hospital at Clacton-on-Sea During the Great War, 1914–1919* (London: W. J. Clark and Co., n.d.), p.56.

¹⁰⁷ Macpherson, *History of the Great War*, Vol. 1, p.86.

¹⁰⁸ Reznick, *Healing the Nation*, pp.99–115. Convalescent officers were cared for in separate wartime convalescent homes and had privileges including being allowed to wear their own clothes.

¹⁰⁹ Watson, 'War on the Wards': 502.

work that would otherwise have been undertaken by men, these women increased the chance that the men they were replacing would be sent overseas or transferred into combatant service in the same way as the increased use of voluntary carers in medical transports already discussed. It also reinforced the cultural norms around caring as appropriate women's wartime work, ideas which, as we will see in the next chapter, worked through representation to actively diminish men engaged in such labour.

CONCLUSION

The technological and social changes that medical caregiving in the British armed forces underwent over the course of the war can thus be seen to be ambiguously progressive for RAMC rankers. Medical tools such as the Thomas splint and improvised versions thereof could enable semi-skilled non-combatants to help save lives through making their work of transport easier, safer and more effective. However, the increasing use of first aid techniques on the battlefield challenged the distinctiveness of the men of the RAMC as a unit providing first aid and medical care by placing the means of saving life in the hands of the unskilled combatant. With the concurrent development of specialist techniques such as the Carrel-Dakin treatment, which enabled trained nurses to position themselves ever more effectively as skilled experts in wound drainage, the caring space occupied by the RAMC bearer shrank, with his identity as a semi-skilled care provider challenged by association with the development of infection through delay in treatment.

Other ambiguities can be seen in developments in mechanical and transport technologies across the course of the war. Motorization reduced the area of expertise occupied by RAMC rankers in relation to the transport of the wounded as they found their roles increasingly occupied by both mechanical specialists of the RASC and the non-military members of voluntary aid units. However, the limits of such developments, most notably in the context of landscapes destroyed by the mechanical firepower of industrialized war, re-emphasized the importance of both the manual labour and the human ingenuity of the stretcher bearer all along the line of evacuation. Similarly, the limits of medical developments, however dramatic, in the face of the sheer scale and destructiveness of industrialized warfare meant that the men of the RAMC continued to have a role to play as orderlies on moribund wards and as gravediggers, as comforters and witnesses to the suffering and sacrifice of the dying and the dead.

The challenges that modernizing developments presented to RAMC rankers, however, were not only technological but also social, with the expansion of the role of women into spaces of care previously occupied by male care providers having multiple effects across the entire period of the war. While to some extent the origin of this particular development predated the war and, indeed, was a defining feature of the direction of development of the RAMC as a formal military medical unit in the second half of the nineteenth century, the acceleration of women's occupation of spaces of care ever closer to the front line during the war meant that, by the end of the conflict, the challenges posed by women's caring roles to the identity of the men of the RAMC had become acute. The shrinking of the spaces of care in which male medical caregivers could claim a right to perform, even on the field of battle, has tended to dominate analyses of the war in terms of gender progression. Yet the Corps emerged from the war with its reputation for effective, even efficient, care enhanced.¹¹⁰ How the men of the RAMC were able to construct an identity as a specialized and necessary unit of non-combatant servicemen in the context of a society engaged in total war, and how this was reflected in cultural representations of their work and roles, form the subject of Chapter 5.

¹¹⁰ Harrison, *A Medical War*, p.9; Furneaux, *Military Men of Feeling*, p.203.

5

From Slackers in Khaki to Knights of the Red Cross

Cultural representations of RAMC Other Ranks

In 1914 George Swindell did not want to be an RAMC stretcher bearer. As a merchant mariner, he initially attempted to enlist in the Navy, only to be told by the recruiting officer to ‘go away and grow’ due to his short height.¹ Several subsequent attempts to join other military units similarly failed, until Swindell encountered a recruiting sergeant looking for recruits of at least 5 foot 3 inches and a medical officer willing to look the other way when Swindell stood on his tiptoes during his physical examination. Newly enlisted, Swindell recalled in his memoirs that ‘I had not the slightest idea of what kind of work, or what the duties, of the Corps I had joined were, all I thought about was, I have got in, the Sergeant met me coming out, come here my lad, shake hands, you have joined one of the finest Corps in the British Army . . . and they will make use of you in the Hospital, not exactly what I wanted.’²

Self-conscious about both his explicitly unmanly height and the non-combatant nature of the work he had enlisted to undertake, Swindell, in his post-war memoir, consistently demonstrates his acute and long-lasting awareness of the lack of martial, and by extension masculine, status that his new position as a non-combatant military medical caregiver entailed. He records every one of the slights he and his comrades received from combatant colleagues, from the use of the epithets ‘Rob All My Comrades’, as an alternative interpretation of the initials RAMC, and ‘poultice wallah’ to the jokes about ‘going into action with stretchers at the alert’.³ Ward Muir, serving even further from the front line as a home hospital orderly, was similarly defensive about the status of non-combatant serviceman, writing a passionate defence in 1917 of both himself and the

¹ Swindell, ‘In Arduis Fidelus’, p.1.

² Ibid., p.3.

³ Ibid., p.72.

men he served alongside against accusations that they were ‘slackers in khaki’. ‘[I]t is hardly the place’, he wrote of civilian critics,

of persons not in khaki to bandy sneers about the comfortableness of the Linseed Lancers whose initials, when not standing for Rob All My Comrades, can be interpreted to mean Run Away, Matron’s Coming. The squad of orderlies unloading that procession of ambulances at the hospital door may not envy the wounded sufferers whom they transmit to their wards; but the observer is mistaken if he assumes that the orderlies have, by some questionable manoeuvre, dodged the fiery ordeal of which this string of slow-moving stretchers is the harvest.⁴

While Muir, a 36-year-old London journalist and member of the Chelsea Arts Club, and Swindell, an 18-year-old merchant mariner from Bolton, came from very different backgrounds which inflected their understandings of hegemonic masculinity,⁵ both their narratives reflect the questionable masculine status of military medical rankers in Britain’s wartime society. The commonalities between the two depictions of RAMC ranker masculinity in both Muir’s and Swindell’s writings point to the ways in which wartime masculine hegemonies coalesced around dominant ideals of uniformed combatant service. While not as potentially abject as civilian men in wartime Britain,⁶ the status of non-combatant servicemen engaged in medical caregiving was, nonetheless, viewed as questionable by a society at war which valorized the combatant soldier above all else.⁷ The men who made up the ranks of the RAMC were deeply conscious of the ambiguity of their roles as men in such a wartime society. The mass mobilization which redefined the category of citizen soldier during the war meant that these servicemen brought with them into their service all their civilian assumptions, prejudices, and aspirations.⁸ Although formed by distinctions of class, education, and region, the subjectivities of all these men were also shaped by the pleasure culture of war which was such a prominent part of turn-of-the-twentieth-century British society and which, as Michael Paris has shown, cut across class divides.⁹ Among other things, this pleasure

⁴ Muir, *Observations of an Orderly*, pp.155–6.

⁵ Ellis and Meyer, ‘Introduction’, p.5.

⁶ Ugolini, *Civvies*, pp.307–12.

⁷ Gullace, ‘Blood of Our Sons’, pp.49–50; Watson, *Fighting Different Wars*, pp.41–52.

⁸ Helen McCartney, *Citizen Soldiers: The Liverpool Territorials in the First World War* (Cambridge: Cambridge University Press, 2005), pp.4–5; Ilana Bet-El, ‘Men and Soldiers: British Conscripts, Concepts of Masculinity and the Great War’, in *Borderlines: Genders and Identities in War and Peace, 1870–1930*, ed. Billie Melman (London: Routledge, 1998), pp.73–94.

⁹ Graham Dawson defines the ‘pleasure-culture of war’ as ‘Images and stories about military war . . . [which] clearly provided pleasure and excitement for a very large number of men and boys’ (Dawson, *Soldier Heroes*, p.4). As Michael Paris has demonstrated, such

culture influenced the aspirational military ideals which Haldane had attempted to mobilize with the formation of the Territorials.¹⁰ While Lord Kitchener's distrust of the TA as a military force led him to insist on the raising of the new army in 1914,¹¹ the Territorial ethos continued to have a particular impact on the RAMC, given the important role played by the RAMC(T) in providing reserves throughout the war. This provided inspiration for lower-middle- and middle-class volunteers such as David Randle McMaster who, having volunteered for the unit specifically because of its association with the TA and the St John Ambulance Association, 'took care to let the officers see I was a "professional man".'¹²

Military service can thus be seen in both Swindell's and McMaster's accounts to be an important source of masculine status in wartime society, although the motivations for undertaking military *medical* service were mixed. Where Swindell's enlistment in the medical service was unintentional, for McMaster it was a deliberate choice to take on a uniformed but non-combatant service role. McMaster was the son of Nonconformist parents with sympathies towards the motives of those who resisted war on the grounds of conscience. Military medical service offered him a compromise between his desire for such status and the genuine reservations of conscience induced by his upbringing. Yet, like Swindell and Muir, he was also aware that military medical service had the power to compromise the very status he sought. Neither a medical nor military professional, neither heroic combatant nor self-sacrificing resister of war,¹³ the rankers of the RAMC, whatever their social background, had to negotiate complex personal and public perceptions and representations of their masculine status throughout the war.

RAMC ranker identities were never, however, simply those of compromised wartime masculinity. As Swindell's memoirs, Muir's essays, and McMaster's letters show, the masculine status of RAMC rankers acquired

images and stories were a fundamental part of pre-war British culture (Paris, *Warrior Nation*, ch. 3).

¹⁰ Beckett, *The Amateur Military Tradition*, p.213; Peter Simkins, *Kitchener's Army: The Raising of the New Armies, 1914–16* (Manchester: Manchester University Press, 1988), pp.19–20.

¹¹ Beckett, *The Amateur Military Tradition*, p.226; Simkins, *Kitchener's Army*, pp.40–6.

¹² Randle, letter to Mother and Father, 12 August 1914, Letters of David Randle McMaster.

¹³ Lois Bibbings points out that, while the dominant image of conscientious objectors in British culture during the war was as 'the antithesis of the soldier . . . assumed to be selfish as opposed to self-sacrificing and a coward rather than a hero . . . embody[ing] a whole range of unmanly qualities and . . . frequently cast as shirking, lazy, spineless, un-Christian, unpatriotic and un-English/British', within communities of resistance to the war they 'were . . . seen and saw themselves as patriots and heroes' (Bibbings, *Telling Tales About Men*, pp.89, 195).

a variety of complex, sometimes contradictory, associations and meanings over the course of the war. Thus Swindell was punctilious in noting not only the insults hurled but also the compliments bestowed on him and his unit, such as the comment of a 15-plus-stone man whom he had carried to Mont-Saint-Eloi during the Battle of Arras, who said, ‘well thanks mates, the chaps up the line don’t half call you some names, I did too, but I didn’t know what you had to do, and I withdraw now all I ever said’.¹⁴ Muir, meanwhile, reported how, when he entered an ambulance-train carriage to help members of the volunteer London Ambulance Corps (LAC) unload it:

a shout arose from the wounded lying there: ‘Here are some real soldiers!’ Khaki greeted khaki—simultaneously spurning the mere amateur, the civilian. I could have blushed for the injustice of that naïve cry. But it would be dishonest not to confess that there was something gratifying about it too. It was the cry of the Army, always loyal to the Army. These heroic bundles of bandages, lifting wild and unshaven faces from their pillows, hailed *me* (a wretched creature who had never heard a gun go off) as one of their comrades!¹⁵

Through their labours over the course of the war, RAMC rankers gained a reputation as good military comrades, if not in arms then certainly in service. As their knowledge and experience grew, they constructed for themselves a sense of non-combatant identity built specifically around their caregiving roles. Yet at the heart of this identity was the additional fact of their military service alongside combatants, allowing them to claim the status of servicemen in wartime.

The evolution of the image of the RAMC ranker occurred not only in the subjective understandings of servicemen themselves, but also in their public representation throughout the war. By the end of the war, as well as being mocked as a ‘slacker in khaki’, the RAMC ranker was also being valorized as a ‘Knight of the Red Cross’. This figure was constructed by observers of the RAMC rather than the rankers themselves, based on the shifting ideals of what masculine qualities were necessary to denote wartime bravery.¹⁶ The endurance required to face fire unarmed became a key marker of medical heroism for those who witnessed the RAMC at work. This perception was, in turn, mobilized by British propaganda to buttress home-front morale in ways which echoed the more familiar image of the nurse as ministering angel.¹⁷

¹⁴ Swindell, ‘In Arduis Fidelus’, pp.149–50.

¹⁵ Muir, *Observations of an Orderly*, p.214.

¹⁶ Meyer, *Men of War*, pp.141–5.

¹⁷ Carol Acton, ‘Negotiating Injury and Masculinity in First World War Nurses’ Writings’, in *First World War Nursing*, ed. Fell and Hallett, p.124; Sandra M. Gilbert,

This chapter explores these shifting understandings and cultural representations of RAMC ranker masculinity over the course of the war, focusing on the three dominant constructions of shirkers, comrades, and chivalric heroes. Using a variety of sources, including personal narratives, hospital journals, and newspapers, it examines the ways in which men's subjective anxieties over status shifted over the course of the war into a sense of personal attainment, while public representations moved from solely critical to encompassing a particular heroic ideal. By comparing these constructions to the representations of women in comparable roles, including professional nurses and VAD volunteers, it will argue that the cultural sphere provides an additional space within which the military medical masculinities of the men of the ranks of the RAMC were contested and defined across four and a half years of war.

'SLACKERS IN KHAKI'

The abject impression of the RAMC ranker in the early years of the war is not particularly surprising considering the status of the male military caregiver within British society during the previous half century. As Holly Furneaux has shown, the medical orderlies of the Crimean War had a poor reputation as brutal, clumsy drunkards, a reputation which became formalized in cultural memory through the campaigns of Florence Nightingale for a professional *female* nursing service.¹⁸ The gendered ideology of this campaign, which was based on the assumption of 'women's unique ability to minister to the sick', ensured that the 'collective heroism attributed to working men of "the thin red line" was firmly restricted to combat. Any idea of the heroism of the same soldiers risking their lives in cholera epidemics fulfilling their duties as orderlies in military hospitals had no cultural purchase.'¹⁹

The negotiations over professional identities in both the military and medical professions in the years after the Crimean War further cemented the lowly position of the medical serviceman within the military hierarchy. This was then reinforced in the eyes of the general British public during the medical shambles of the Second Anglo-Boer War.²⁰ While the men providing preventative healthcare in the form of sports and physical fitness training to the armed forces might have gained an increasingly popular

¹⁸ 'Soldier's Heart: Literary Men, Literary Women, and the Great War', in *Behind the Lines*, ed. Higonnet et al., pp.209–11.

¹⁹ Furneaux, *Military Men of Feeling*, pp.196–7.

²⁰ Summers, *Angels and Citizens*, p.205; Chapter 1, pp.24–5.

¹⁹ Ibid., pp.198, 216.

reputation in this period, reflecting the rise of muscular Christianity as a hegemonic ideal,²¹ the men who cared for the ill and wounded retrospectively remained a unit of low status, ripe for mockery both within the military and more broadly.

Thus the men who enlisted as non-commissioned servicemen with the RAMC in 1914, whether voluntarily or through lack of other options, were viewed as valid targets for mockery and, indeed, self-mockery. Such mockery could be found in the columns of hospital journals such as *The Gazette of the 3rd London General* and *The 'Southern' Cross*, journal of the 1st Southern General Hospital, Birmingham, both of which were sold to the public to raise funds for the hospitals.²² It also appeared in books such as Muir's *Observations of an Orderly* (1917) and *The Happy Hospital* (1918), which, again, were available for public purchase. In all these sources the image of the RAMC ranker, and in particular the home-hospital orderly, is caricatured as that of the 'orderlim'.

The 'orderlim' was originally the creation of cartoonist Stephen Baghot de la Bere, who, like Muir and a number of other members of the Chelsea Arts Club, enlisted as a private in the RAMC and was sent to work at the 3rd London General Hospital, Wandsworth. From 1915 onwards he contributed a series of cartoons to the hospital's *Gazette*, which depicted the 'orderlim' as a small, unprepossessing figure, physically overshadowed by both men and women, continually put upon by the ward sister, staff sergeants, and medical officers. He was the embodiment of unsoldierly masculinity, small, weak, physically unfit and elderly, an image emphasized by the unsigned cartoon of 'The Youngest Lance-Corporal' (Figure 5.1).

These visual images were reinforced in the *Gazette* by humorous articles such as E. G. Doré's story, 'The Admirable Hammond', whose protagonist is described as 'a little, insignificant looking man, with sparse hair and a heart that insurance companies wouldn't bet on. He also suffered from asthma and a dictatorial wife.' He was

right in the front row of candidates for military service when Germany threw down the gauntlet to us.... The doctors, however, looked sideways at Hammond. They told him he showed the right spirit, but they weren't there to enlist spirits. Brawn was the thing needed, and Hammond had none; so sorrowfully he returned home. Six times after that, at varying intervals, he presented himself to the military authorities, only to receive

²¹ Campbell. '*The Army Isn't All Work*', pp.104–5.

²² For discussion of the cultural significance of hospital journals in the provision of care in wartime, see Reznick, *Healing the Nation*, pp.65–98.

the same saddening verdict. . . . Then, for the seventh time, Hammond tried his luck at the recruiting office. With great good fortune he was cursorily examined by a medico who had lost his stethoscope in the previous evening's general pilgrimage to the Tubes. Hammond walked home that evening with a new light in his eyes. He was going to be a soldier, with nice brass buttons down his chest and a gun under his arm. A week afterwards he got the brass buttons all right but not the gun. The corps to which he became attached do not use a gun to kill folk with. Hammond was rather disappointed, but the loss of the gun was partially compensated by the benevolent feeling engendered in him by the presence of a Red Cross on his sleeve.²³

Fictionalized, this depiction of the volunteer orderly at once mocks the pretensions and reflects the lived experiences of men like Swindell.



Fig. 5.1. 'Our Celebrities, No. 4: The Youngest Lance-Corporal'; *Gazette of the 3rd London General Hospital* (December 1915).

²³ E. G. Doré, 'The Admirable Hammond', *Gazette of the 3rd London General* (February 1918): 121.

In doing so, it points to the dominance of combatant masculinities in the war enthusiasm of the early stages of the war.²⁴

Both de la Bere's cartoons and Doré's fiction place particular emphasis on the physical insufficiency of the RAMC ranker, reinforcing Muir's point, in defence of the 'slackers in khaki', that 'when the few fit men that our combings-out revealed had gone elsewhere, the unit was kept up to strength by the drafting-in either of C3 recruits or of soldiers who, having been at the front and been wounded, or invalided back, were marked for home duty only'.²⁵ Nor was it only hospital orderlies serving far from the front line whose bodies were viewed as physically frail or damaged. As discussed in Chapter 2, Swindell was only able to enlist by standing on tiptoes during his medical examination in order to be recorded as meeting the height requirement, while J. B. Bennett managed to enlist despite an astigmatism by telling the recruiting sergeant he had completed an eye test after the sergeant had been distracted by a telephone call.²⁶ In Swindell's account, the doctor was, as implied in the fictional case of Hammond, complicit in the deception, willing to turn a blind eye in the case of a man enlisting in a non-combatant corps and thus presumed not to need the height or strength of a combatant serviceman. Jay Winter has pointed out that the sheer numbers of men attempting to enlist in the early months of the war undermined attempts at stringent physical examinations, which had been instituted to assuage anxieties about the army's martial fitness after the Boer War.²⁷ Yet Swindell's and Bennett's experiences point to the influence of additional cultural assumptions about the physical attributes deemed necessary for military medical service.²⁸ In the minds of harried, overworked military doctors, medical service in the ranks was work appropriate for unfit, overaged men suffering from physical impairments which made them unsuitable for combatant service.

The image of the RAMC ranker as unsoldierly and consequently insufficiently masculine in British wartime society was further reinforced by depictions which acknowledge that the orderly's 'place in the scheme of things . . . is a humble place, and he knows it. His work is almost comically unromantic, painfully unpicturesque. Moreover—let us be frank—much

²⁴ Gullace, 'Blood of Our Sons'; Pennell, *A Kingdom United*.

²⁵ Muir, *Observations of an Orderly*, p.153. ²⁶ Chapter 2, pp.61–2.

²⁷ Winter, *The Great War and the British People*, p.50.

²⁸ Doctors were just as likely to have physical fitness requirements ignored as RAMC rankers, although for very different reasons. Officers in the corps were required to hold medical qualifications, severely limiting the potential pool of recruits and creating a particular manpower crisis which would dog the Corps throughout the war. (Whitehead, *Doctors in the Great War*, pp.32–59; Chapter 2, pp.55–6).

of it is uninteresting, after the first novelty has worn off.²⁹ Men such as de la Bere, Doré, and Muir used self-deprecation to help defend themselves against public accusations that they were ‘slackers in khaki’. By depicting themselves and their colleagues as physically insufficient as soldiers, and therefore implicitly as men, and by emphasizing the drudgery and boredom of the work they undertook, these representations served to directly address, and thereby counter, accusations of both physical cowardice and dishonest shirking.³⁰ They also served to undercut any accusations of effeminacy that might be thrown at them as men undertaking such feminine work as cleaning and caring.³¹

Yet such self-deprecation can be read as a more problematic characterization of the RAMC ranker when set against the female nurse and volunteer rather than the figure of the male combatant. While RAMC rankers served under the authority of medical officers all along the chain of evacuation, those serving in hospital settings served additionally under the authority of the trained nurses who worked as matrons and ward sisters in these settings. As Christine Hallett and Janet Watson have both demonstrated, these women’s own service was profoundly shaped by their anxieties over the need to embody and perform their work in defence of their roles both as women in war zones and professionals whose workspace was being penetrated by volunteers of both sexes.³² While these anxieties led most notably to the articulation of the tensions between trained nurses and voluntary VADs, with the latter feeling ‘they had a right to critique the apparent lack of emotionalism of nurses; [and] trained nurses [feeling] they had a right—even a duty—to critique the excessive emotionalism of the VADs, which they saw as a potential obstacle to a patient’s recovery’,³³ they also shaped nursing sisters’ relationships with the male

²⁹ Muir, *Observations of an Orderly*, p.154.

³⁰ Joanna Bourke defines shirking as ‘a range of activities aimed at avoiding particular duties.’ Malingering was ‘the physical manifestation’ of this phenomenon, which ‘In peace and war, . . . was regarded as an evasion of man’s duty to the state and to other men.’ (Bourke, *Dismembering the Male*, p.78.)

³¹ The performance of ‘feminine’ labour was regularly used to lampoon men as ‘unmanly’ in this period, particularly in anti-suffrage cartoons, where husbands of suffragettes were depicted cooking, cleaning, and childminding, usually badly, to emphasize the disruption to the natural order of separate spheres that female suffrage was deemed to represent. (Catherine H. Palczewski ‘The Male Madonna and the Feminine Uncle Sam: Visual Argument, Icons, and Ideographs in 1909 Anti-Woman Suffrage Postcards’, *Quarterly Journal of Speech* 91 (2006): 365–94, DOI: 10.1080/00335630500488325.).

³² Christine E. Hallett, “‘Emotional Nursing’: Involvement, Engagement, and Detachment in the Writings of First World War Nurses and VADs”, in *First World War Nursing*, pp. 94, 97; Watson, ‘War in the Wards’.

³³ Hallett, “‘Emotional Nursing’”, p.96.

orderlies. As Watson notes in the diary of Sister Alice Slythe, the mocking anecdotes she included about her male co-workers, such as records of their mispronunciation of French words, ‘served . . . as a means of establishing her educational superiority over the orderlies, who, as men drawn from the ranks, were unlikely to have had advanced schooling (or any medical training), but who, as members of the army, were not under the direct command of the trained nurses who ran the wards but were outside the official military hierarchy’.³⁴ In fact the social background of RAMC rankers was varied, reflecting the wider social intake of all branches of the military attendant on the mass enlistment of total war.³⁵ What very few RAMC orderlies had in comparison to a nursing sister such as Alice Slythe was formal medical training. Thus trained nurses were able to assert a form of professional dominance over these men in relation to medical hierarchies, even if their power was more uncertain in relation to military, class, and gender hierarchies.

The contested nature of the power relations between trained nurses and orderlies was reflected in the pages of hospital journals, where the orderly became a ‘gentle henpecked spouse’, while Sister and, above all, Matron, became looming figures of domestic tyranny.³⁶ In de la Bere’s cartoons, for instance, the physical insignificance of the ‘orderlim’ is reinforced by the large, rotund, masculine depiction of Matron, whose power is evident from her physical resemblance to the Sergeant Major (Figure 5.2). The figure of the ward sister is less physically repulsive and more obviously feminine in the imagining of the cartoonist of *The ‘Southern’ Cross* (Figure 5.3). Nonetheless, she is represented as physically larger than the ward orderly whom she dominates with her unreasonable demands.

The representations of contested power relations between trained nurses and RAMC orderlies were not all one way, however. A cartoon in the same issue of *The ‘Southern’ Cross* depicts a large orderly towering above the tiny figure of a nurse begging him on bended knee to do his work (Figure 5.4).

As one poet put it in the *Gazette*:

It’s ‘Orderly!’ here, and ‘Orderly!’ there,
And ‘Where is that dratted man now?’
He cannot be useless, as you often declare,

³⁴ Janet S. K. Watson, ‘A Sister’s War: The Diary of Alice Slythe’, in *First World War Nursing*, ed. Fell and Hallett, p.107.

³⁵ Chapter 2, p.71.

³⁶ The Balladmonger, ‘The Orderly’, *Gazette of the 3rd London General* (April 1918): 178.

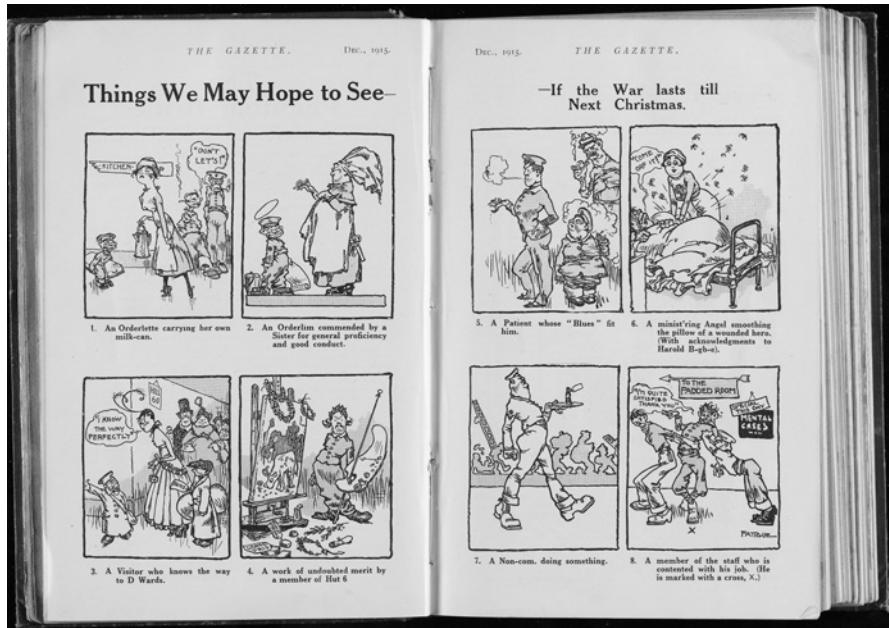


Fig. 5.2. 'Things We May Hope to See—If the War lasts till Next Christmas', Stephen Baghot de la Bere; *Gazette of the 3rd London General* (December 1915): 62–3.

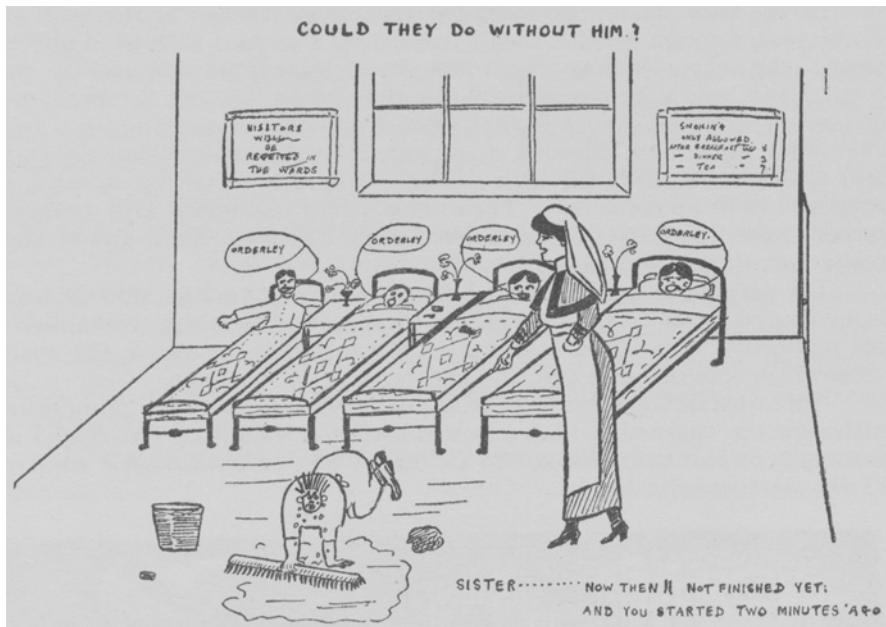


Fig. 5.3. 'Could They Do Without Him?'; *The 'Southern' Cross* 1, no. 1 (January 1916): 9.



Fig. 5.4. 'Hospital Life'; *The 'Southern' Cross* 1, no. 1 (January 1916): 7.

So surely you're forced to allow
That without his deft touch
Your ward would be much
Less orderly.³⁷

³⁷ RAMC(T), untitled, *Gazette of the 3rd Southern General* (December 1917): 73.

Relationships between orderlies and trained nurses were thus represented as a struggle over the gendered division of labour within hospitals, but one in which both sides were equally mockable as transgressing gendered norms—the nurses through the power they wielded over men, the men through the domestic labour they were being ordered to undertake.

The relationship between the hospital orderly and the trained nurse was not, however, the only one through which the orderly's gender identity was defined as problematic. As the manpower crisis deepened throughout 1915, culminating in the 1916 Military Service Acts, the construction of the RAMC ranker as a gendered figure of fun altered significantly, as reflected in the pages of hospital journals. As noted in Chapter 4,³⁸ the dilution of medical services through the growing employment of women in Base and home hospitals had important implications for the work undertaken by RAMC rankers from 1915 onwards, which, in turn, threw the question of gender relations on the hospital ward into sharp focus. That dilution was perceived as a direct threat by many orderlies, something made abundantly clear in the pages of both the *Gazette* and *The 'Southern' Cross*. De la Bere, for instance, created a female equivalent to the 'orderlim' in the form of the 'orderlette', an attenuated flapper, far too weak and wilting to undertake heavy labour, instead relying on her charms to woo recuperating soldiers into doing it for her (Figure 5.5).³⁹

In *The 'Southern' Cross*, a cartoonist produced a rather kinder image, although he still mocked the assumed vanity of women who would take time to primp before undertaking (incompetently) stretcher bearing duty (Figure 5.6).

In its commentary, however, the journal was as disparaging of trained Territorial Forces Nursing Staff (TFNS) nurses as de la Bere was of Red Cross VADs, with the description of the 'Femina Felina (Var. T.F.N.S.)' noting that, following dilution:

One must not suppose, however, that women now perform the work of the hospital—such occupation would be quite 'infra dig'. Section C of our long-suffering Corps was captured with the building, and these unfortunate men 'carry on' under the imperative direction of the new comers, whose time is divided between researches in modern fiction and playing parlour games, with frequent intervals for tea and chocolate.⁴⁰

³⁸ Chapter 4, pp.125–6.

³⁹ This posed another form of threat, as recuperating patients were often employed in orderly roles in hospitals. See Carden-Coyne, *The Politics of Wounds*, p.211.

⁴⁰ P.A. and S.D. 'Femina Felina (Var. T.F.N.S.): The Woman of the Moment', *The 'Southern' Cross* 1 (July 1916): 150.



1. An Orderlette carrying her own milk-can.

Fig. 5.5. 'Things We May Hope to See—An Orderlette carrying her own milk-can', Stephen Baghot de la Bere; *Gazette of the 3rd London General Hospital* (December 1915): 62.

In the *Gazette*, the threat the female VADs posed to male orderlies was made explicit in A. Pirie's mocking article, 'The Last Orderly':

He was the last R.A.M.C. orderly left in the hospital, and how he had so long escaped the small tooth comb of the military authorities was a marvel....

The war was over, and when at last labour could be spared to take down the huts there crept from the wreckage a gaunt figure with long, grey hair and beard.

'Is the war over?'
 'Years ago,' they answered.
 'Are they all gone?'
 'Who?'
 'The women.'
 'Years ago. Who are you?'



Fig. 5.6. 'Women to Replace Male Staff in Our Hospitals at Home'; *The Southern Cross* 1, no. 2 (February 1916): 40.

A look of triumph came in his face. 'I am the last orderly, the Rip van Winkle of Wandsworth. Lead me to the office of the *Daily Chronicle*'.⁴¹

Such mockery is perhaps unsurprising given the threat posed by female volunteers to the place of male military care providers in these sites of healing. Their very presence implied that the men they worked alongside belonged instead overseas, closer to the masculine spaces of the front.

For those serving in home hospitals who were, due to their age and health, not directly threatened by overseas service, the 'orderlette' posed a more subtle threat, this time to the male orderly's psychic rather than his physical integrity. The work of the female orderly highlighted the unfitness of these men for overseas service. Instead, they were only capable of serving their country within an increasingly feminine sphere. As one joke printed in *The 'Southern' Cross* had it, the difference between a soldier and a ward orderly was 'A difference of "a-pinny-on"'.⁴² Indeed, a later joke unsexes the hospital orderly entirely:

On page 875 will be found a paragraph dealing with 'Ferrets.' These pretty little animals are in great demand and much care is needed when ordering any. The number required should be stated to the nearest dozen, also colour, size, sex, etc., and purpose for which they are required.

The following table may be taken as a guide: —

<i>Article Required</i>	<i>No.</i>	<i>Purpose.</i>
Ferret	15	(a) Hunting
		* (b) Bottle-washing
		(c) Night Watchman

*If required for Bottle-washer, specify 'Bushy-tail'....

- Sex*
- (a) Male.
 - (b) Female.
 - (c) Orderly.⁴³

Even when identified as human, if not fully so, the male orderly was represented as generally incompetent and less efficient than the women he served alongside. A mock examination paper in the *Gazette* set questions:

IV. For boy and slave orderlies.

- (1.) Show how sixty plates and twenty glasses may be decently wiped, after washing, with four small, damp teacloths. Produce six plates and one glass so

⁴¹ A. Pirie, 'The Last Orderly', *Gazette of the 3rd London General Hospital* (October 1917): 20–1.

⁴² 'Conundrum', *The 'Southern' Cross* 1 (April 1916): 87.

⁴³ 'Requisition Hints', *The 'Southern' Cross* 1 (August 1916): 179.

treated. Two marks off for every smear. N.B.—No help may (or will) on any account be given, in this operation, by a V.A.D. or other female, this being particularly a male occupation.⁴⁴

This form of mockery plays both on the centrality of maturity to dominant ideals of masculinity,⁴⁵ with immature ‘boy’ orderlies having the same status as slaves, and on the inversion of gendered divisions of labour implied by the particularity of dishwashing as a male occupation. The arrival of the VAD thus reinforced the unmasculine nature of the service of the male orderly on multiple levels, appearing to place him yet more firmly under the authority of women who treated him unequally and required him to undertake unmasculine work inappropriate for his status as a uniformed serviceman.

The representation of the work of male caregiving as unmanly was reinforced from 1916 onwards not only by the increasing substitution of women for men in orderly roles in Base and home hospitals, but also by the effects of the Military Service Acts, which saw an increasing number of conscientious objectors undertaking medical roles.⁴⁶ The semi-formal association between conscientious objection, particularly religious objection, and the provision of low-status medical services brought with it a number of cultural associations, many of them negative. As Lois Bibbings has argued, conscientious objectors of all types were represented in British wartime culture as:

the antithesis of the iconic figure of the soldier in wartime. . . . Indeed, at a time when war and soldiering were seen as offering the potential for adventure, competition, sport and heroism as well as being a natural choice for boys and men, the notion that some men would reject the military called their maleness into question. . . . In addition, to do so at a time of national need was hard to fathom and, at the very least, was often taken to be sign that the objector was less than a man.⁴⁷

In parts of popular culture objectors were represented as both physical and mental degenerates, often effeminate, always unmasculine.⁴⁸ That such men were deemed suitable to serve in the roles also occupied by RAMC rankers, men who willingly undertook military service and the associated

⁴⁴ Tom Roberts, ‘Examination Paper’, *Gazette of the 3rd London General Hospital* (May 1917): 224.

⁴⁵ Meyer, ‘Separating the Men from the Boys’: 4–8; Stefan Collini, *Public Moralists: Political Thought and Intellectual Life in Britain, 1850–1930* (Oxford: Oxford University Press, 1991), pp.186–7.

⁴⁶ Introduction, p.12.

⁴⁷ Bibbings, *Telling Tales About Men*, pp.95–6.

⁴⁸ Ibid., pp.111–18.

military discipline, re-emphasized the lowly status of these men within military and cultural hierarchies of esteem.

In this context, the contributions of de la Bere, Muir, and Doré can be read as ironic appropriations of cultural imagery in defence of their threatened cultural status. The journals in which they represented themselves were not simply spaces within which soldier patients and their carers (both male and female) negotiated power, whether through the assertion of order⁴⁹ or the reclamation of agency.⁵⁰ They were also arenas in which specifically gendered relationships among carers were negotiated. Unlike the sexual anxieties which marked the relationships between patients and female caregivers,⁵¹ however, the gendered relations of power between RAMC orderlies and the female staff they served alongside reflected anxieties over professionalism and gendered social roles similar to those which shaped the relationships between trained nurses and volunteer VADs. The abject figure of the orderly as a male caregiver in wartime served as a useful foil both for trained nurses, concerned about their status as proto-professionals whose expertise should not be undermined, and VADs, anxious to have their work recognized as the equivalent of male combat voluntarism.⁵² Within this context, the RAMC orderly, neither a medical professional nor an appropriately male volunteer combatant, was reduced to a figure who could be described as the ‘most immaterial of men’.⁵³

COMRADES IN SERVICE

While the figure of the male medical caregiver in wartime could thus be cast as diminished and compromised as a man, he was a far from silent figure. The appropriation of abjection by men like de la Bere, Doré, and Muir enabled them to articulate ironic forms of resistance to cultural constructions of orderly unmanliness and the threat of feminization posed by trained nurses and VADs. Muir, the founding editor of the *Gazette* and a journalist who continued to write for periodical publications throughout the war, possibly forms the clearest example of this tactic throughout his wartime writings. He also, however, strove to present a

⁴⁹ Carden-Coyne, *The Politics of Wounds*, p.320.

⁵⁰ Reznick, *Healing the Nation*, p.65.

⁵¹ Acton, ‘Negotiating Injury and Masculinity’, p.124; Carden-Coyne, *The Politics of Wounds*, pp.242–9; Das, *Touch and Intimacy*, pp.206–14.

⁵² Watson, ‘War in the Wards’, 499–508.

⁵³ Auxiliary Hospital, ‘The Longer V.A.D. Catechism’, *The ‘Southern’ Cross* 1 (August 1916): 174.

more positive vision of the male caregiver in his writing, describing the RAMC ranker not in relation to the women he worked under and alongside but relative to the wounded men he cared for. In doing so, Muir constructed the ranker as a comrade in service, motivated by a similar sense of duty to country and comrades as the combatant, although that duty was undertaken without bearing arms.

In Muir's writings the primary symbol of this comradeship of service was the military uniform which RAMC servicemen, like those in combatant units, wore.⁵⁴ It was the desire to be in uniform in wartime society which, according to Muir, motivated many men, however seemingly physically insufficient for military service, to enlist in the Corps. For example, Muir describes how one nameless orderly 'envisages the sheer, cowardly inquietude which would be his lot were he forced to walk the world in a dress other than this safe and calmness giving khaki. His self-respect is now secure. Without the label which khaki attaches to him he perceives that he would be eternally wanting to stop the passers-by and explain.' Instead, 'by the quite simple process of putting on a khaki suit, he suddenly found a calm which he had not experienced for one minute since the war's outbreak. . . . [H]e was genuinely in the army; not as the heroic Tommy Atkins of the battlefield, but as an unmistakable Tommy Atkins all the same, with a number, and a separation allowance, and a "Religion".'⁵⁵

In making him an unmistakable soldier, the khaki uniform provided the RAMC ranker with an appropriate wartime identity which masked his non-combatant role and absorbed him into the military community. Muir is quite explicit about the extent of this community identification in his story of helping members of the volunteer LAC, who wore distinctive blue uniforms which earned them the sobriquet 'Bluebottles', to unload wounded men from an ambulance train in which the men of RAMC were identified as distinct from the volunteers:

It was seldom our custom to enter the hospital trains. An unwritten law decreed that Bluebottles only should enter the train: the R.A.M.C. limited themselves to carrying work outside, on the platform and stair. On this occasion the supply of Bluebottles had, for the moment, run short, and our

⁵⁴ For a discussion of the significance of military uniform to men's soldierly identity in wartime, see Ugolini, 'War-stained', 155–71. The particularly gendered nature of the identity associated with military uniform is demonstrated by the debates over the wearing of uniforms by women volunteering in auxiliary roles, as discussed by Lucy Noakes in "Playing at Being Soldiers?", in *British Popular Culture and the First World War*, pp.123–45. The issue of nurses' uniforms was less contentious, with both trained nurses' and VADs' uniforms being based on pre-existing designs.

⁵⁵ Muir, *The Happy Hospital*, pp.17–19.

party took a turn at going up the gangways and evacuating the van-wards. As it happened, I and my mate on the stretcher were the first khaki-wearers to invade that particular van-ward. And as we steered our stretcher to the door and down the aisle of cots a shout arose from the wounded lying there: 'Here are some real soldiers!'

It was too bad. It was base ingratitude to the devoted band of Bluebottles who had, up till that instant, been toiling at the evacuation of the ward . . . But—well, there it was. 'Here are some real soldiers!' Khaki greeted khaki—simultaneously spurning the mere amateur, the civilian. I could have blushed for the injustice of that naïve cry. But it would be dishonest not to confess that there was something gratifying about it too.⁵⁶

The wearing of military uniform enabled Muir to represent himself as a comrade of the wounded combatants in a way that was denied to the nominally civilian (if heroic) Bluebottles. It also provided Muir with both a military and professional identity in spite of his status as both a non-combatant and a wartime volunteer. Even for non-combatants, therefore, the status of 'citizen soldier' in British wartime society formed a distinctive and valorized identity.

It was not, of course, only men who could lay claim to a sense of service identity and consequent comradeship through the wearing of a uniform. As Muir pointed out, the wounded combatant 'comes in contact with a host of women, especially after he is wounded: not only nursing women, but women on the ambulances, women who serve refreshments at halting-places, women clerks who take his particulars, women who trace casualties, women who transact postal errands, and so on. One and all these women, whether paid or otherwise, are serving him and his fellows in some form or another: one and all they are uniform-wearers.'⁵⁷ Female VADs in particular used their assumption of their own distinctive uniform, as specified in great detail by the Joint War Committee of the British Red Cross and Order of St John of Jerusalem,⁵⁸ to underpin their claims to cultural approbation as wartime volunteers, the moral equivalent of male volunteer combatants.⁵⁹ Indeed, the *Reports* included eight images of appropriate uniforms for volunteers, including both indoor and outdoor uniforms for nurses, and uniforms for both BRCS and St John

⁵⁶ Muir, *Observations of an Orderly*, pp.213–14. The Bluebottles' uniforms shared their colour with the much despised 'hospital' or 'convalescent' blues worn by patients and which served to discipline and infantilize their wearers (Reznick, *Healing the Nation*, pp.99–112).

⁵⁷ Muir, *The Happy Hospital*, p.35.

⁵⁸ *Reports by the Joint Committees*, pp.109–12.

⁵⁹ Watson, *Fighting Different Wars*, p.87. Uniforms were also important for military nurses as a symbol of their training, during which 'they learned the rules of uniform, practice, and behaviour by which a trained nurse could be recognized among her peers' (*ibid.*, p.74.).

Ambulance drivers. So important was the question of uniform as a way of distinguishing different medical care providers in the military context in wartime that the *Official History* noted that:

with the exception of the voluntary aid detachments, there was no prescribed active service uniform for other personnel of the British Red Cross Society. The Society consequently submitted details of a uniform to the War Office, but, as it was more or less the same as the uniform of enlisted soldiers and commissioned officers, it was considered that a uniform of that description should only be worn by personnel of voluntary organizations employed under the Director of Medical Services on the Expeditionary Force. Eventually the difficulties of a distinctive uniform were overcome to some extent by granting honorary commissions in the army to the Commissioners, Assistant Commissioners and others employed in responsible duties connected to the voluntary aid organizations.⁶⁰

The BRCS itself observed in its report that ‘representations were made to the Army Council with a view to economising in packing, transport and labour by permitting our staff in France to wear the same uniforms as the Army and to draw it from the Ordnance Stores on payment by us, but it was found not possible to comply with this request.’⁶¹ The *Report* also stated:

There is no doubt that at the beginning of the War a certain number of irresponsible ladies clothed themselves in attire which had some resemblance to uniform, assumed the Red Cross, and attempted to set up hospitals at their own expense, intending to nurse in them themselves. Others offered their services to Allied countries, which accepted them. Many were photographed in the costumes they had adopted, and the casual observer naturally supposed that they had some connection with the British Red Cross Organization. Some were ultimately brought into line with our regulations. Others gave up, on learning the conditions.⁶²

Uniform thus formed a key distinguishing marker of medical service and subject for debate and distinction for women as well as men throughout the war years.

For men serving in the RAMC, however, the status of their uniforms as the same as those of combatant soldiers, distinguished only by a small Red Cross badge on the sleeve, was a point of no little sensitivity.⁶³ The

⁶⁰ Macpherson, *History of the Great War*, Vol. 1, p.219.

⁶¹ *Reports by the Joint Committees*, p.107.

⁶² *Ibid.*, p.81.

⁶³ Ugolini, ‘War-stained’: 163. Regimental and Field-Ambulance stretcher bearers additionally wore an armband or brassard emblazoned with a red cross when working in the field.

'Southern' Cross was filled with jokes based around orderlies being taken for (or failing to be taken for) combatant servicemen:

Overheard in the street: 'Say, Bill, here are two soldiers coming.' 'Garn, silly, they're Red Cross men.'⁶⁴

Dear old lady, to one of 'Ours': 'Oh yes, my boy is in khaki. No, he is not in the R.A.M.C., he is a *proper* soldier.' (Turns out that he is C3 (home-sedentary)).⁶⁵

While the civilians may be the butt of these jokes, the underlying anxieties about the extent to which the uniform made the RAMC ranker the equal to a combatant serviceman provides much of the humour.

RAMC servicemen thus needed to look beyond uniforms to fully define themselves as fulfilling the hegemonic norms of martial masculinity which shaped British wartime culture and society. To do this, they used two tactics, pointing, on the one hand, to their specific role within the armed forces and the expertise that underpinned it, and, on the other, to the equality of their sacrifice through service with that of combatants. The first of these points was potentially the more difficult idea to lay claim to. The structure of the RAMC, which privileged the professional identity of the male doctors who formed the officer corps,⁶⁶ militated against men of the Other Ranks of the Corps defining themselves as medical professionals. Thus McMaster, who initially hoped to get a commission in the Corps on the basis of his pre-war training with the Red Cross and Boy Scouts,⁶⁷ was forced to concede to his parents that 'I think medical training would be necessary' to gain a commission as an officer in the Corps.⁶⁸

Despite this, McMaster continued to present his training and experience relevant to medical caregiving as forms of qualification for the specific branch of service he had volunteered for. He explained to his parents that 'I have not chosen this as pleasant work because it will probably be pretty unpleasant to work amongst the sick + wounded, but I feel that this

⁶⁴ The 'Southern' Cross 1 (February 1916): 45.

⁶⁵ 'The Stock Pot', *The Southern' Cross* 2 (May 1917): 132. The question of mistaken identity and the role of serviceman in wartime was an issue of no small anxiety in relation to military medical uniforms, or lack of them, throughout the war. Fears that service patients would use their lack of uniform to evade military discipline influenced the decision to introduce the uniform of 'convalescent blues' (Reznick, *Healing the Nation*, pp.103), while the dangers of misidentifying a disabled ex-serviceman in civilian clothes for a shirker could be used to undermine the moral authority of young women distributing white feathers to perceived shirkers (Gullace, 'The Blood of Our Sons', pp.92–4).

⁶⁶ Whitehead, *Doctors in the Great War*, pp.11, 112.

⁶⁷ Randle, Letter to Mother and Father, 6 August 1914, Letters of David Randle McMaster.

⁶⁸ Randle, Letter to parents, undated, Letters of David Randle McMaster.

is the place for me with my ambulance training.⁶⁹ Non-combatant work was thus transmuted from a space for shirkers and cowards fearful of death, injury, or discomfort to a form of emotional sacrifice appropriate for men with relevant experience to undertake in wartime. Similarly, Muir was quick to point out the importance of professional identity to RAMC servicemen: 'However newly enlisted he is, the C3 youth who wears the Red Cross is a professional, and, consciously or otherwise, comports himself as such.'⁷⁰

As we have seen, however, despite efforts to formalize the medical training of rankers by the RAMC before and during the war, such training remained partial and erratic. Thus despite many rankers' undoubted sense of pride in their specialist knowledge and experience, their attempts to construct a professional medical identity as a basis for claims to appropriate wartime masculinity were always limited. Certainly, such struggles for professional recognition can bear no comparison with those of either doctors or trained nurses, for whom the specific context of wartime society presented both a challenge and an opportunity.⁷¹ RAMC servicemen turned, therefore, to the other key facet of their wartime identity—that of the soldier—in their attempts to construct their social status in wartime as appropriate, focusing in particular on the hegemonic ideals of masculine self-sacrifice and endurance which came to define the soldier hero during the war.⁷²

The drawing of equivalences between the service of combatants and non-combatants was, of course, not without its problems. Thus while Muir boasted that

No sooner was I in khaki than I had the job of helping to evacuate these same trains and to carry a mournful string of stretchers. Not once did that lump-in-the-throat trouble me. The second night after my enlistment I was allotted to the task of removing a dead body and depositing it in the shell in the mortuary. I had never handled a corpse before; but now it was my business to do as I was told, and I did as I was told,

he also acknowledged that 'any discomfort to which the orderly is exposed is negligible—an affair positively to blush for—compared with the sufferings and unavoidable physical humiliations of the patient'.⁷³ The comparison between the discomforts of the life of the home hospital orderly, however much stoicism they might demand of the individual, and the dangers faced

⁶⁹ Ibid. ⁷⁰ Muir, *The Happy Hospital*, pp.102–3.

⁷¹ Whitehead, *Doctors in the Great War*, pp.255–7; Watson, 'War on the Wards'.

⁷² Meyer, *Men of War*, pp.155–6.

⁷³ Muir, *The Happy Hospital*, pp.102–3.

by the soldier patients he encountered, which were, by then, brutally inscribed upon their bodies, was stark.

The ability to draw comparisons was somewhat easier for men serving further up the chain of evacuation, as they faced similar dangers from shelling and, particularly in the case of stretcher bearers, gunfire. Richard Capell, a lance corporal in the 6th London Field Ambulance, might express ‘every feeling of humility at the thought of the far greater pains and perils that our fellows in the infantry faced and endured in those tragic times’.⁷⁴ Here, as with other caregivers, Capell subsumes his own trauma and the resilience with which he faced it within his admiration for those cared for.⁷⁵ Nonetheless, he was willing to construct his own experience as a bearer at the Battle of the Somme as a trial of his powers of masculine endurance: ‘little but one black nightmare of what seemed almost futile effort and brutalising fatigue’.⁷⁶ He also emphasized that the unit member who won the French *Médaille militaire* at the battle had ‘earned it’⁷⁷ (emphasis in original). J. B. Bennett, meanwhile, used his diary to record his regular experiences of coming under shellfire at Gallipoli with a detachment which echoed the records of combatants.⁷⁸ In his post-war memoir he would recall how ‘we had to carry loaded stretchers long distances without slings by devious routes as there were no roads, only tracks through scrub, and as it was done at night in inky darkness it was best [sic] with hazards including sniping as my experience testified. . . . None of these efforts were free from rifle fire and gradually one gained a sixth sense of self preservation and an awareness of risks and dangers’.⁷⁹ Here Bennett’s construction of his actions as demonstrating a stoic endurance of danger bears comparison with the personal narratives of combatants.⁸⁰

Sharing physical danger meant that RAMC rankers were also able to draw equivalences between themselves and their combatant comrades around the shared experience of trauma.⁸¹ The descriptions of providing

⁷⁴ Capell, ‘Stretcher-Bearers on the Somme’, *6th London Field Ambulance History*, p.1.

⁷⁵ Acton and Potter, *Working in a World of Hurt*, pp.33–4, 43–6.

⁷⁶ Capell, ‘Stretcher-Bearers on the Somme’, *6th London Field Ambulance History*, p.1.

⁷⁷ *Ibid.*, p.5.

⁷⁸ Bennett, Diary, 15–20 August 1915, Papers of J. B. Bennett. On combatant diary records of shellfire, see Meyer, *Men of War*, p.54.

⁷⁹ Bennett, ‘Memories of Gallipoli, Aug 1915–December 1915 at Sulva Bay and Anzac’, pp.12–14, Papers of J. B. Bennett.

⁸⁰ Meyer, *Men of War*.

⁸¹ Carden-Coyne, *The Politics of Wounds*, pp.61–9; van Bergen, *Before My Helpless Sight*, p.401; Carol Acton and Jane Potter, “‘These frightful sights would work havoc in one’s brain’: Subjective Experience and Trauma in First World War Writings by Medical Personnel”, *Literature and Medicine* 30 (2012): 61–85, doi: 10.1353/lm.2012.0010.

care that Frank Ridsdale gives in his diary entries from the Somme clearly echo the exhaustion and terror experienced by combatants:

[A]rrived Knightsbridge midnight, sent on dressing wounds straight away working all night, terrible wounds, doing dressings in a dug out by the light of a Candle. Very tired, one death in the night, men moaning + in agony with pain, terrible bombardment all night shaking the place, never to be forgotten night . . . very tired, relieved off dressing 9 am, just down for a little rest + then called up to go to the trenches to dress wounded + get them back, terrible bombardment on, awful sights in first + second lines, dead bodies laid all over, part of bodies scattered on trench sides, terrible carnage + slaughter, brought many wounded down, hard + difficult work in the very narrow trenches, parts of parapet blown away, dug-outs filled with dead + wounded, a terrible smell + many flies + rats, many men unable to be brought in owing to heavy firing, very hard day for all . . . feeling the want of food + sleep, but still going on. . . .

Up at 5-30 am, away to trenches for many Wounded again, terrible bombardment on, parapets being blown away, an awful hard task getting men-down [*sic*], carried some down on my back with awful wounds, more dead + parts of bodies all over, a terrible stench, many buried + awful wounds, some of the men been wounded 2 days + laid out all time, wounds smelling badly, more scenes of carnage + slaughter, stretcher bearer of Hants badly wounded, dressed him, fractured arm + leg + wound in face, just finished dressing him + got him away + then we were ordered back to Acheux.⁸²

Such entries compare with J. C. Tait's diary entry from a month earlier, when he wrote of 'Dead and wounded . . . strewn everywhere. . . . Some wounded were being carried out—some on stretchers, other struggling along with the help of a comrade. . . . The dead were thrown aside until the wounded are all away. It was a veritable nightmare.'⁸³

The experiences of stretcher bearers in Gallipoli made an equally vivid impression:

Strangely enough the bullets worried us not at all, it was the nerve-strain of the whole thing, the knowledge that we were just as likely to be making for the enemy's lines as our own; the smell of the thyme mingled with that of the dead who, it seemed, were piled up everywhere; our own weariness, everything combined to make that first night remain vividly in our minds. For four days and nights very few of us got more than a few hours sleep, the number of wounded seemed countless and in addition our lines and their

⁸² Ridsdale, Diary, 1–3 July 1916, Papers of Frank Ridsdale.

⁸³ J. C. Tait, MS diary, 1 June 1916, Papers of J. C. Tait, Documents.9897, IWM.

immediate vicinity were heavily shelled morning and afternoon and we saw many men mangled or killed quite close to us.⁸⁴

Such testimony demonstrates the extent to which RAMC rankers understood themselves to share the traumas of front-line service simply because they were there.⁸⁵

While George Swindell might argue that, even with the shared experience of trauma, his labour bore no comparison to the trials of the infantry,⁸⁶ that labour was the final way in which RAMC rankers positioned themselves as equal to their combatant comrades. As we have seen, one of the key jobs undertaken by men serving with the RAMC was not that of care provision but rather of construction. The work which men undertook building hospitals and aid posts, improving roads and reinforcing sites of care was particularly significant in structuring their identity as servicemen. The work of the majority of British servicemen on the Western Front was that of the labourer rather than the soldier. The dominance of fatigues and working parties meant that the work of construction which shaped many men's civilian lives was also the dominant trope of their military experiences.⁸⁷ In undertaking the manual labour of construction, RAMC servicemen were serving in exactly the same way as their combatant colleagues, without arms or killing, but in the service of the national military endeavour. Such service formed one key way in which RAMC servicemen viewed their war work as an appropriately masculine form of service, equal to that of the combatant.

Construction was not, however, the only form of physical labour that RAMC rankers undertook, and the physical effort required in the evacuation process could also be used to create a point of comparison between combatant and non-combatant service. Stretcher bearers in particular used the labour of carrying heavy stretchers long distances to position themselves as being as stoical and able to endure as the men they carried. C. Midwinter's memoirs of the 32nd Field Ambulance, for instance, noted that 'carrying in the wounded on Gallipoli, under fire, was terribly hard work. The ground made the going very rough. Stretchers had to be lowered over ledges, steered through narrow paths and thorn bushes.'⁸⁸ H. L. Chase's history of the 2/1st London

⁸⁴ Whyte, 'Memoirs of the Great War, 1914–18', p.20, Papers of A. L. G. Whyte.

⁸⁵ Hynes, *The Soldiers' Tale*, pp.1–30. ⁸⁶ Swindell, 'In Arduis Fidelus', p.150.

⁸⁷ Rob Thompson, '"By the leave o' the ground": The Engineers at Third Ypres', Leeds Legacies of War Seminar Series, 9 December 2012, <https://www.youtube.com/watch?v=coQ3wTU2ypc>, 38:15–40:30.

⁸⁸ Midwinter, *1914–1919 Memoirs*, p.22.

Field Ambulance describes the work of the bearer companies at Ypres in August 1917 as:

an almost overwhelming task [involving] carrying wounded through Sanctuary and Chateau Woods past the Hooge Crater and down the Menin Road, where they were met by the motor ambulances which relieved them of their loads and then sped away down the Menin Road . . . while the bearers returned to the regimental aid posts for more wounded. The carrying track was nothing more than a single line of duckboards winding its way along through a veritable sea of mud, and one false step might well have proved fatal, as was evident from the numbers of drowned men (and horses) who could at intervals be seen almost completely submerged in that dreadful swamp.⁸⁹

Swindell similarly recalled the effects of weather: ‘it was easy carrying wounded on a stretcher, on dry duck-boards, but when the rain had soaked them, and also washed some pieces of mud onto them, it was like trying to walk, the greasy pole’.⁹⁰ The slipperiness of muddy duckboards was nothing to the difficulties of walking through the sand of the Egyptian desert with a wounded man as burden, however. W. D. Fothergill recalled, when evacuating men across the Sinai Desert, ‘being issued with snow shoes as an experiment to see if we could make better progress in the sand—we didn’t’.⁹¹ The effort and ingenuity involved in such labour were used by RAMC rankers to position themselves as adaptable and self-sacrificial comrades to the men they carried, sharing the labour as well as the danger of war.

The importance of the shared experiences of danger, trauma, and labour to the construction of RAMC rankers as servicemen is reflected in the citations for military awards that men received. Sergeant Major Frank Hulbert, for example, received the Military Cross for working ‘continuously for 72 hours under heavy shell fire and set[ting] a splendid example of pluck and initiative in removing the wounded from a barn which was being heavily shelled’.⁹² In his *Short History of the Royal Army Medical Corps*, Fred Smith names ten men of the ranks who received the Distinguished Conduct Medal for evacuating the wounded under fire, and one, Private F. Bennison, who received the medal for ‘volunteering for isolation with cerebro-spinal fever patients, and nursing them devotedly for many weeks’.⁹³ These actions of caring in the context of the dangers of

⁸⁹ Chase, *The 2/1st London Field Ambulance*, p.56.

⁹⁰ Swindell, ‘In Arduis Fidelus’, p.95.

⁹¹ W. D. Fothergill, TS memoir, p.4, LIDDLE/WWI/GS/0575, LC.

⁹² Fred Smith, *A Short History of the Royal Army Medical Corps*, 2nd edn (Aldershot: Gale & Polden, Ltd, 1931), p.82.

⁹³ Smith, *A Short History of the Royal Army Medical Corps*, p.86. Smith gives the total number of awards made to the Corps as a whole during the course of the war as follows: 7 Victoria Crosses, 2 with bar; 499 Distinguished Service Orders, 25 with bar; 1,484 Military

war were acknowledged by the military authorities as equivalent to the acts of combatant service worthy of formal recognition. As David Rorie, MO with the 51st (Highland) Division noted, ‘of all the fellows who won the war, none was stouter-hearted than the stretcher-bearer: none carried out his job more steadily and efficiently during the campaign. He was never treated to the limelight and he never asked to be: but he is well worthy of the highest tribute that can be paid to his pluck and his endurance’.⁹⁴

If the greatest quality of courage during the war was, as Max Plowman suggested, that of ‘caring for your pals more than yourself’, then, as Bennison’s citation demonstrates, RAMC rankers were judged to have passed this ‘very basic test of manhood’.⁹⁵ Stretcher bearers and orderlies both proved themselves to be as worthy of this accolade as witnesses and caregivers to fellow servicemen in moments of pain and fear, from the battlefield through the dressing station to the operating theatre, and even into the home, a space made alien and fearful by permanent injury.⁹⁶ While a combatant’s comrades were judged on the fact of their ‘being there’ in moments of danger and boredom, the RAMC rankers’ ability to both share and bear witness to men’s pain, resilience, and rehabilitation enabled them to lay claim to the wartime masculine identity of comrade.

KNIGHTS OF THE RED CROSS

The RAMC ranker could, then, be constructed as the equivalent of the combatant serviceman through the fact that he faced danger, endured physical hardship, and acted as witness to wartime sacrifice. He could also, however, be constructed in a more mythic vein as the Red Cross Knight, a figure which functioned both as the male equivalent of the angelic nurse and as the non-combatant version of the apotheosis of heroic wartime masculinity achieved by combatants through death.⁹⁷ While rankers themselves used the image of the staunch comrade to define their own

Crosses, 161 with bar, 22 with 2 bars, and 1 with three bars; 3 Albert Medals; 395 Distinguished Conduct Medals, 19 with bar; 3,002 Military Medals, 195 with bar, 4 with 2 bars; 1,111 Meritorious Service Medals, 1 with bar. He only publishes the citations of a small selection, however (p.67).

⁹⁴ Rorie, *A Medico’s Luck in War*, p.3.

⁹⁵ Mark VII [Max Plowman], *A Subaltern on the Somme in 1916* (London: J. M. Dent and Son, 1927), pp. 100–1.

⁹⁶ Chapter 3, pp.104–5. For full analysis of this episode, see Jessica Meyer, “‘A Blind Man’s Homecoming’: Disability, Masculinity, and Medical Care-Giving in First World War Britain”, in *Phallacies: Historical Intersections of Disability and Masculinity*, ed. Kathleen M. Brian and James W. Trent, Jr (Oxford: Oxford University Press, 2017), pp.153–70.

⁹⁷ Meyer, *Men of War*, p.96.

wartime identities, and both orderlies and their critics employed the figure of the abject orderly in their commentaries, the Red Cross Knight was an ideal constructed predominantly by those observing the work of RAMC rankers from an external standpoint, perspectives that were key to the language and imagery utilized in the figure's construction. The principal creators of this image of the RAMC ranker were not only the men they cared for along the chain of evacuation but also the doctors, nurses, and chaplains who worked alongside them in the dressing stations, CCSs, and hospitals. The Red Cross Knight, therefore, was one defined by traditional ideals of heroism as expressed through religious language and chivalric imagery, both of which served to elevate the male military caregiver from simply appropriately masculine to profoundly heroic.

As with the abject orderly, the Red Cross Knight, who stands at the other extreme of appropriate wartime masculinity, appears most often in the pages of hospital journals. Where the abject orderly is a figure of fun and mockery, however, the Red Cross Knight is one of sentimentality. In the pages of *The 'Southern' Cross* he is visualized as comparable to questing knights in a poem entitled 'The Red Cross Knight', which concludes: 'The Red Cross Knight the stretcher bears, / The "MASTER" carries he. / "As ye did unto one of these / Ye did it unto ME"'⁹⁸ (Figure 5.7).

The religious language of the poem is an almost exact echo of the better-known 'Woodbine Willy' poem 'To Stretcher Bearers', which concludes, 'Ere we are now, stretcher-case, boys, / Bring him aht a cup 'o tea! / Inasmuch as ye have done it / Ye have done it unto me.'⁹⁹ In this well-known chaplain's verse the stretcher bearer becomes sanctified as a St Christopher, a bearer not simply of the suffering but of Christ himself.

The sanctification of the stretcher bearer is further reinforced in the Scottish-Canadian poet Robert Service's poem 'The Stretcher Bearer', in which the eponymous bearer has the temerity to demand directly of God, "ow long? 'ow long?". Where God may 'in 'Eaven's height / . . . turn away 'Is face', the stretcher bearer cannot. Instead he must stand as a witness despite being 'sick with pain / For all I've heard, for all I've seen'. The bearer as witness becomes a Christ-figure himself, bearing the weight of humanity's pain:

I don't care 'oose the Crime may be;
 I 'olds no brief for kin or clan;
 I 'ymns no 'ate: I only see
 As man destroys his brother man;
 I waves no flag: I only know,

⁹⁸ Orderly, 'The Red Cross Knight', *The 'Southern' Cross* 1 (August 1916): 231, ll. 5–8.

⁹⁹ 'Woodbine Willie' [Geoffrey Studdert Kennedy], 'To Stretcher Bearers', *More Rough Rhymes of a Padre* (London: Hodder & Stoughton, 1919), pp. 9–10, ll. 41–4.



Fig. 5.7. 'The Red Cross Knight'; *The 'Southern' Cross* 1, no. 8 (August 1916): 231.

As 'ere beside the dead I wait,
A million 'earns is weighed with woe,
A million 'omes is desolate.¹⁰⁰

¹⁰⁰ Robert Service, 'The Stretcher Bearer', *Rhymes of a Red Cross Man* (New York: Barse & Hopkins, 1916), ll. 9–16. Service served as a stretcher bearer and ambulance driver with

As such, he is the moral equivalent of the dead soldier, constructed as Christlike in his sacrifice of life for the sake of humanity.¹⁰¹

It is notable that the pseudonymous author of 'The Red Cross Knight', like Studdert Kennedy and Service, specifically identifies the valorized figure at the centre of his poem as a stretcher bearer, while signing himself as 'Orderly'. The association between stretcher bearers and the religiously inflected self-sacrifice of St Christopher was an easier one to make than between such figures and the hospital-bound nursing orderly. It was not merely that bearers' labour was literally that of carrying, but also that bearers could more easily earn admiration for their courage because their work was so often undertaken under fire. While RAMC bearers were not officially supposed to carry men from no man's land, which was the role of regimental stretcher bearers, their work nonetheless involved moving regularly towards the danger of the front line to collect their loads, and many would enter no man's land if necessary.

Importantly in this context, they did so specifically unarmed. This fact served to burnish bearers' heroic credentials, as it was generally acknowledged that being unarmed in the face of danger put these men at a psychological disadvantage. As A. E. Francis commented, it was one thing 'to do gallant deeds with arms in hands and when the blood is up but the courage demanded to walk quietly into a hail of lead to bandage and carry away a wounded man, that is worth talking about'.¹⁰² To face death and danger without the power to fight back made the labour of the stretcher bearer, in the eyes of his combatant colleagues, not chivalric or even sanctified but simply heroic. As we have seen, nursing orderlies serving along the line of communication would sometimes volunteer to act as bearers. Doing so meant that they could lay claim to having faced danger not merely through coming under shellfire but in a role fully defined as self-sacrificial.

However, such voluntarism was not always deemed necessary for the work of nursing orderlies to be defined as heroic—certainly not from the perspective of the men they cared for. For men in pain, the men who nursed them could be seen as equally heroic to their bearer comrades, as

the AFSU from September 1915 until the spring of 1916. He spent the winter of that year in Neuilly-sur-Seine, home of the American Hospital, a voluntary unit caring for the casualties of the war. (James Mackay, *Vagabond of Verse: A Biography of Robert Service* (Edinburgh: Mainstream Publishing, 1995), pp.239–45.)

¹⁰¹ Stefan Goebel, *The Great War and Medieval Memory: War, Remembrance and Medievalism in Britain and Germany, 1914–1940* (Cambridge: Cambridge University Press, 2006), pp. 231–85; Winter, *Sites of Memory, Sites of Mourning*, p.90.

¹⁰² A. E. Francis, *History of the 2nd/3rd East Lancashire Field Ambulance: The Story of a 3rd Line Territorial Unit, 1914–1919* (Salford: Francis Jackson, 1930), p.87.

reflected in Private W. H. Atkins's poem in *The 'Southern' Cross* entitled 'The R.A.M.C.':

Oh! it's weary work in the white-washed ward,
Or the blood-stained Hospital base,
To number the kit of the man who was hit
And cover the pale, cold face,
Or hand out fags to the brave boys in rags,
Who'll stick it and cheerfully grin,
As the deftly used knife cheats grim death of a life
While the grey of the dawn creeps in.
To hold the hot hand of the man who talks wild
And blabs of his wife or his kids,
Who dreams he is back in the old home again,
Till the morphia bites, and he loses his pain
As sleep settles down on his lids.
The 'Hospital Orderly' doing his bit,
Of V.C.'s not many they score,
Yet are earned every day in a quiet sort of way
By the 'Royal Army Medical Corps.'¹⁰³

It is the emotional rather than the physical labour of these men that is valorized here, drawing heavily on ideals of reparative and sentimental masculinity.¹⁰⁴ In associating caring acts more commonly associated with female caregiving with the explicitly heroic symbol of the Victoria Cross (VC), the poet defines and celebrates the work of the orderly as not merely masculine but also heroic. His emotional labour is viewed in parallel with that of the stretcher bearer, urged in the first stanza to 'Turn him gently, now bandage his head', allowing the work of both groups to be ultimately defined in the final stanza as that of 'the Red Cross Knights'.¹⁰⁵

CONCLUSION

Writing of the work of Regular Army nursing orderlies in the early days of the war, Charles Vivian argued, 'Nursing the sick is an ideal occupation—at a distance; at close quarters it is an occupation that demands far more courage than actual fighting, for it calls for patience and self-repression, for self-forgetfulness and the finer qualities which win no Victorian [sic] Crosses, but demand that the very best men have to give shall be given

¹⁰³ Atkins, 'The R.A.M.C.', ll. 18–34.

¹⁰⁴ Furneaux, *Military Men of Feeling*, pp.214–15.

¹⁰⁵ Atkins, 'The R.A.M.C.'

night and day.'¹⁰⁶ Philip Dana Orcutt, an American *ambulancier* with the American Field Service Unit, similarly placed the work of French and Belgian stretcher bearers at the heart of the military effort: 'The Staff is the brains of the army; Aviation, the eyes; the Artillery, the voice; the Infantry and Cavalry, the arms; the Engineers, the hands; the Transportation, the legs; the People behind it, the body; but the *Brancardier* [stretcher bearer] is the soul.'¹⁰⁷ The valorization of military medical servicemen can thus be seen to extend beyond the civilian-infused ranks of the RAMC during the First World War to include the medical services of allies as well. Nor were British RAMC servicemen the only medical servicemen to come under attack for their perceived lack of masculinity. As Laura Boyd has shown, French *brancardiers* struggled with perceptions of insufficient masculinity throughout the war,¹⁰⁸ while the American William Stevenson was deeply dismissive of the French old men and boys left to act as orderlies in the American Hospital in Paris, when younger, fitter, more intelligent men went off to fight.¹⁰⁹

Yet, as this chapter has shown, popular cultural production in wartime provided spaces within which the status of medical caregiving as a masculine activity could be mocked, acknowledged, and even celebrated by a variety of practitioners, recipients, and observers. In hospital magazines, the abject orderly became an important figure in the gendered 'war on the wards' over professional medical status and voluntarism. In personal narratives nursing orderlies and stretcher bearers along the line of communication took up the themes of experience and expertise as a way of identifying their war work as equal to that of the combatants they carried and cared for. And in the poetry of patients and other observers the men of the RAMC were transfigured by their service and sacrifice into warrior saints and Christ-figures, the moral equivalents not simply of combatants but of the 'glorious dead'.

In 1914, George Swindell may not have wanted to join the RAMC; by 1919 the anonymous author of *A Mounted Brigade Field Ambulance in Peace and War* could write that the glory of his small, non-combatant unit, 'if it burnt with a lowlier flame, shone no less steadily than that of the famous regiments whose names are written in the history of the British

¹⁰⁶ Charles Vivian, *With the Royal Army Medical Corps (R.A.M.C.) at the Front* (London: Hodder & Stoughton, 1914), pp.93–4.

¹⁰⁷ Philip Dana Orcutt, *The White Road of Mystery: The Note-book of an American Ambulancier* (New York: John Lane Company, 1918), p.60.

¹⁰⁸ Laura Boyd, 'Perception and reception: The status of British and French non-combatant men during the First World War', PhD diss., University of Leeds, n.d.

¹⁰⁹ William Yorke Stevenson, *At the Front in a Flivver* (Boston: Houghton Mifflin Company, 1917), p.23.

Army'.¹¹⁰ While the abject orderly never disappeared from the pages of the *Gazette* during the war, the four and a half years of conflict saw at least a partial transformation in the reputations of the men who formed the Royal Army Medical Corps from simply slackers in khaki to more complex figures laying claims to both martial and reparative masculine identities. In this their cultural representations develop on earlier narratives.¹¹¹ Yet the fact that they still had to fight against this image of compromised, abject masculinity throughout the war demonstrates the extent to which the status of the RAMC ranker in the eyes of the British public had failed to alter dramatically. The First World War did effect some noticeable change, with collective acts of carrying, cleaning, and caring—and the courage and resilience needed to do so in the context of war—acknowledged and even celebrated as appropriately masculine wartime endeavours. Nonetheless, the military medical serviceman, the uniformed non-combatant undertaking work increasingly culturally associated with women, would remain a problematic figure. In the war's aftermath he would become, at least initially, an increasingly forgotten one in the British memory and commemoration, only finding his place within that memory again in the changed cultural perceptions of wartime heroism of the early twenty-first century.

¹¹⁰ A Mounted Brigade Field Ambulance in Peace and War (1919?), p.47, C-40/ MOU, LC.

¹¹¹ Furneaux, *Military Men of Feeling*, pp.187–216.

Conclusion

In 1919 the RAMC issued a recruitment poster urging the viewer to 'Join the R.A.M.C. and learn a useful occupation which may help you later in civilian life' (Figure 6.1). At its centre is the figure of an enlisted RAMC serviceman standing proudly, hands on hips, in front of a red cross superimposed on a blue background. In each quadrant created by the cross are listed the various roles that this man might fill—pharmacist, dispenser, dental mechanic, laboratory attendant, X-ray attendant, operating-room attendant, mental attendant, masseur, optician, nursing orderly, hospital cook. The image of the man himself is one of uniformed virility. Physically whole and strong, in a clean, complete uniform, he smiles broadly, his appropriate level of maturity signalled by the cheerful crow's feet around his eyes and the pipe clenched in his teeth.

This was the image of post-war military medicine that the RAMC wanted to portray, one that could be presented as 'a source of national pride, used in propaganda material such as films... which reassured the public about the care taken of soldiers'.¹ Nowhere does this image hint at the challenges posed to either the military or medical identity of the men of the RAMC that, as we have seen, recurred throughout the war. The serviceman in the poster does not face questions about the necessity of his uniformed service and whether it can be done as well by voluntary humanitarian-aid providers and women. His labours are classified as various, specialist, and applicable in civil as well as military contexts, both during his period of service and after. His age, health, and fitness are not abject or problematic, requiring defensive explanation. Neither is he a sanctified hero, emblematic of and witness to war's sacrifice, potentially suffering trauma consequent to such witness-bearing.² Rather, he is representative of a figure identified by Sonya Rose as emerging more

¹ Furneaux, *Military Men of Feeling*, p.203.

² Acton and Potter, *Working in a World of Hurt*, pp.31–54.

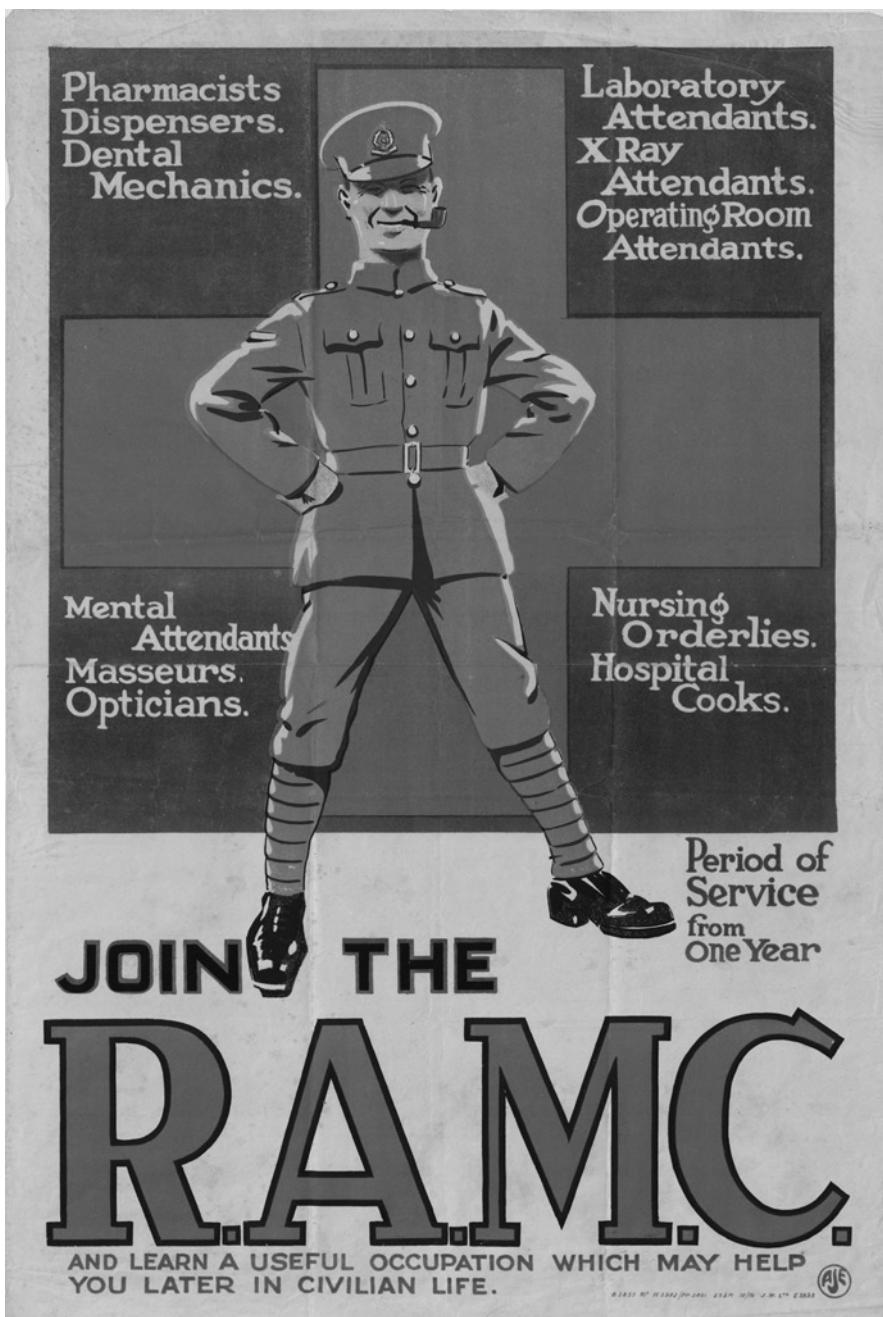


Fig. 6.1. 'Join the R.A.M.C.'; LIDDLE/MUS/AW/118, LC.

definitively some years later, during the Second World War—that of the ‘temperate hero’.³

As this book has shown, elements of this image of the RAMC serviceman as a masculine figure were an accurate reflection of the identities constructed by and for men of the RAMC over the course of the First World War, but this tells only part of the story. While these men did forge a distinctive identity based on their status as uniformed servicemen and their training and experience in first aid and paramedic care, they continued to face challenges to the coherence of their masculine subjectivities. These challenges included the growth of the humanitarian first-aid movement, both nationally and internationally, and the growing strength of the claims made by women engaged in nursing practice to professional recognition based on their war service. The gendered understandings of care for soldiers which originated in the nineteenth century not only continued into the early years of the twentieth century but gained impetus during the war years. The potential contradictions that these narratives exposed, between enlisted RAMC servicemen’s identities as servicemen and non-combatants, as caregivers but without professional qualifications, and as men undertaking work associated with women and the domestic, were reinforced by the patterns of recruitment which saw the Corps increasingly reinforced by overaged and physically unfit men. In response, Corps training sought to rationalize these tensions. It emphasized, on the one hand, the uniform and martial labour which the military used to turn civilians into effective soldier,⁴ and, on the other, specialist drill, first-aid knowledge, and improvisation. This helped enable individual men of the ranks of the RAMC to construct subjective identities as servicemen in relation to a definable skill set which distinguished them from their combatant comrades. Such training could not, however, entirely distinguish their work from that of the voluntary humanitarian medical care providers who served in the war under the authority of the BRCS rather than the War Office. The involvement of the St John Ambulance Brigade in the provision of training for the RAMC(T) in particular meant that the status of RAMC rankers who benefited from this training as military servicemen would continue to be questioned. The work of units such as the FAU would additionally create complicated associations around medical military service due to the cultural constructions of conscientious objectors as cowards and slackers, associations which would further undermine RAMC servicemen’s claims to appropriate wartime masculinities.

³ Sonya O. Rose, ‘Temperate Heroes: concepts of masculinity in Second World War Britain’, in Dudink, Hagemann, and Tosh, *Masculinities in Politics and War*, pp.177–95.

⁴ Ugolini, ‘War-stained’: 156.

While the recruitment and training of RAMC rankers can thus be seen to challenge the visual image of the serviceman represented in the recruiting poster as strong, fit, and appropriately uniformed, the work undertaken by these men challenged the neat categorization of the roles occupied by RAMC rankers by qualified titles, as in the poster. Of the eleven roles listed, only one—that of mental attendant—did not experience some level of dilution by women, whether trained nurses or volunteers, over the course of the war.⁵ Both in terms of spaces of care and developments in medical and transport technologies, the work of the RAMC defined as necessary or appropriate was increasingly restricted, again challenging their wartime status as caregiving servicemen. Yet, just as with their training, RAMC rankers found ways in which to use their experiences to define their work as appropriate forms of military service, both during the war and in their post-war narratives.⁶

By focusing on the physical and emotional labour of carrying, cleaning, and caring at all points along the chain of evacuation, and the development of improvisational practices and niche skill sets in response to the changing nature of industrial war, RAMC servicemen strove to construct a coherent identity as male uniformed care providers through both space and time. Arguably they were more successful in the former than the latter, achieving a measure of continuity in the roles they undertook all along the chain of evacuation from RAP to home hospital. Such continuity was, by contrast, not possible in the face of the medical and transport developments which democratized the provision of first-response medical care as effectively as mass mobilization and increased female dilution of the medical services. Men of the ranks of the Corps sought to distinguish their labour from that of both the Service Corps drivers and the women they worked alongside by emphasizing the hard physical and emotional labour that carrying, cleaning, and caring continued to entail, in spite of technical and medical progress. In particular, the physical and emotional labour of bearing undertaken across sites of healing could be bracketed with that of doctors and trained nurses, giving the men of the Corps claims to a form of semi-professional identity by association. The work of building and the occupation of front-line spaces defined by danger could also be compared to the roles and experiences of combatant service personnel. If,

⁵ I have been unable to locate specific evidence with relation to the dilution of the specialized roles of optician or dental mechanic. The history of dentistry in the war in particular is one which deserves fuller scholarly study beyond the scope of this book.

⁶ Michael Roper, 'Re-remembering the Soldier Hero: The psychic and social construction of memory in personal narratives of the Great War', *History Workshop Journal* 50 (2000): 183–5; Todman, *The Great War*, pp.187–219.

as I have argued elsewhere,⁷ the endurance of suffering and sacrifice of physical and emotional health became more central during the war to the definition of heroic wartime masculinity than the inflicting of violence or the taking of life, then RAMC servicemen were able, through their labours, to lay claim to a form of heroic identity.

The extent to which they did so, and to which other members of British society, both civil and military, associated such an identity with them, undoubtedly increased over the course of the war, reflecting, in part, Harrison's assertion that 'The medical services were now clearly essential to military efficiency and their improvement was part and parcel of their vital managerial reforms undertaken by Haig during his period as commander-in-chief.'⁸ As with individual experiences of wartime labour, however, such constructions of status were by no means uniform or unambiguously positive. Indeed, in cultural representation of the RAMC serviceman during the war, the contradictions between the role of non-professional male medical serviceman and the gendered social expectation of appropriate male service in wartime were laid most starkly bare. The figure of the abject orderly as, in part, a defensive construct of RAMC home-hospital orderlies speaks to the anxieties that the contradictions posed by military medical service raised for individual men of the ranks and their subjective understandings of themselves as men. Yet in spite of the cultural cringe of men like Ward Muir and George Swindell, the 'slacker in khaki' was by no means the dominant representation of the RAMC serviceman in British wartime culture. Here the imagery of the propaganda most closely reflects an element of reality, with the temperate heroism of the RAMC serviceman emerging in the figure of the comrade in service, the man who was there, physical and emotionally, to bear witness to the suffering of his combatant counterpart. By contrast, the valorization of these men as heroic Knights of the Red Cross, figures with profound Christian overtones of sacrifice,⁹ associated men whose non-combatant role theoretically precluded facing enemy fire with the bodily sacrifice of the 'glorious dead' through poetic constructions of stretcher bearers as Christlike.

* * *

These cultural constructions of military medical service would, like those of the British First World War serviceman more generally, undergo

⁷ Meyer, *Men of War*, p.164.

⁸ Harrison, *The Medical War*, p.9.

⁹ Joanne Begiato, 'English Manly Intimacy and Power in Representations of St George and the Dragon c. 1750–1950', p.14, unpublished conference paper, shared by the author, 2016; Goebel, *The Great War and Medieval Memory*, pp.190–2.

significant changes in the war's aftermath.¹⁰ The valorization of the dead and the sense of social disaffection which troubled ex-servicemen of all branches of military service in the interwar period would affect the men of the military medical service no less than those of other units. While many RAMC establishments would continue in service beyond the armistice, offering relief care in Belgium and Germany¹¹ and continuing to staff the hospitals where wounded and disabled men were being treated for ongoing illnesses and impairments,¹² after May 1919:

the number of demobilized men previously retained as necessary for the machinery of demobilization showed a steady decrease. This was aided by the rapid decreases which were now taking place in the hospital population, by the employment to the greatest possible extent of voluntary aid detachment general service and labour women, and later, as demobilization progressed and recruiting for the R.A.M.C. fell far short of the numbers required, by the general employment of civilian hospital orderlies.¹³

As British society as a whole attempted to demobilize, both socially and culturally, after four and a half years of war, the men who had served in the ranks of the medical corps, like other ex-servicemen, sought to pick up the threads of their civilian lives, by either returning to old jobs or starting out on careers which hadn't had time to begin when war broke out.

There is no clear evidence, particularly for younger men who saw non-commissioned service in the RAMC, whose career trajectories had been interrupted near the start by the outbreak of war, that RAMC rankers were influenced by the work they pursued in the years after the war. On the contrary, Frank Ridsdale returned to market gardening near Wetherby; Richard Capell, after serving as a lance corporal with the 6th London Field Ambulance, continued his career as a journalist and music critic with the *Daily Mail* and later *The Telegraph*.¹⁴ There is little material to suggest that men's exposure to the work of caregiving in wartime inspired them to undertake medical careers in the war's aftermath. Those already engaged with the work of medical caring in a professional capacity, that is, the doctors who made up the officer corps of the RAMC, appear to have continued, for the most part, along these career trajectories,¹⁵ indicating

¹⁰ Bourke, *Dismembering the Male*, pp.242–50; Samuel Hynes, *A War Imagined: The First World War and English Culture* (New York: Atheneum, 1991), pp.269–465.

¹¹ Rorie, *A Medico's Luck in the War*, p.264; Papers of Frank Ridsdale.

¹² No. 2 Northern General Military Hospital in Leeds, for example, did not close until 1926, when the remaining 200 orthopaedic patients were transferred to the Ministry of Pensions-run Chapel Allerton Hospital (Wilcox, *Tales from a War Hospital*).

¹³ Macpherson, *History of the Great War*, Vol. 1, p.233.

¹⁴ Papers of Frank Ridsdale; 'Mr. Richard Capell', *The Times* (22 June 1954): 10.

¹⁵ Whitehead, *Doctors in the Great War*, p.258; Hallett, *Veiled Warriors*, pp.258–60.

the extent to which their wartime service involved the mobilization and militarization of their civilian identities. After the war, the military elements of these identities appear to have been, by and large, set aside, but do not appear to have fundamentally altered the cultural construction of the medical profession in Britain as a whole. The officers of the RAMC were citizens who became soldiers for the duration of the war and returned to their civil status in its aftermath.¹⁶ This continuity in employment patterns, apparently among all ranks of male medical care providers, reemphasizes the extent to which war service in Britain was understood by the majority of these men, both doctors and rankers, as a temporary deviation from civilian social identities.¹⁷

The desire at all levels to re-establish continuity with pre-war society and culture combined with a shift in practices of commemoration in the war's immediate aftermath, from celebrations of survival to valorization of the sacrifice of the dead, to shape the ways in which wartime medical service was remembered and commemorated. This is comparable to the commemoration of war service more broadly.¹⁸ As with other units, initial written commemorations were dominated, in the first instance, by the official histories and officers' memoirs. Unit diaries and collective memoirs also appeared, although many of these, like personal narratives of individual men of the ranks of the Corps, remained unpublished.¹⁹ Such publications were used to celebrate both medical progress and unit identity, serving the social function of justifying the work of the medical services within rationalizations of the war as a whole. The personal narratives of trained nurses, by comparison, were used as part of the attempt to gain official recognition for their particular form of gendered service. Later, the 'war books boom' of the late 1920s enabled VADs such as Vera Brittain to position themselves, through their memoirs, as volunteers equivalent in moral status to the enlisted men whose own, increasingly disillusioned, narratives of war, were coming to dominate literary representations of war experience.²⁰ Such narratives of disillusionment posed a direct challenge to the progressive medical narratives of official histories and medical-officer memoirs, often representing

¹⁶ This narrative of continuity is a profoundly gendered one, as the women of the nursing services, both trained and voluntary, were positioned differently in relation to both professional identity and citizenship of the state after the war. For them, their mobilization was a tool that could be used to leverage recognition from the state. (Fell, 'Afterword', in *First World War Nursing*, ed. Fell and Hallett, p.185.)

¹⁷ McCartney, *Citizen Soldiers*.

¹⁸ Winter, *Sites of Memory, Sites of Mourning*; Todman, *The Great War*.

¹⁹ Roper, 'Re-remembering the Soldier Hero'.

²⁰ Karen Petrone, 'Gender and Memory', in *Gender and the Great War*, ed. Susan R. Grayzel and Tammy M. Proctor (Oxford: Oxford University Press, 2017), pp.230–47.

medical caregivers, particularly doctors, as drunken, incompetent, and heartless.²¹

The focus of disillusioned criticism of medical practice on officers, and the regimental medical officer in particular, may have meant that the men of the ranks escaped direct criticism of their work. However, in these narratives, far from retaining the status of good comrades, they all but disappear, in an echo of the painting-out of orderlies' service in Crimea in favour of that of female nurses.²² Where these men were represented in interwar culture, it was generally in a neutral manner rather than in either the negative terms applied to some doctors or the hagiographic terms associated with nurses. 'I have had some experience of death and accidents. I was a stretcher-bearer during the war,'²³ notes Mr Daniels in Dorothy L. Sayers's novel *Murder Must Advertise* (1933), in his inquest evidence on the death of Victor Dean. This service appears to have no connotations for the wider characterization of this very minor character in terms of class, age, or gender status, with his identity being otherwise entirely defined by his post-war professional status as an advertising executive.

The Corps as a whole, like other non-combatant military units, was officially recognized in the interwar period through war memorials commemorating those who died in service. A plaque to the men of the RAMC was unveiled in Westminster Abbey in 1922, accompanied by a book of remembrance created by the novelist and calligrapher Graily Hewitt, which was made public in 1925. Yet in comparison with the cultural commemorations of combatant experiences of and losses in war, the figure of the male military caregiver, particularly the man of the ranks, can be said to have slipped out of view in the war's aftermath. Even as the war came into renewed focus as a locus of cultural commemoration from the 1960s,²⁴ the particular work and experiences of male medical care providers remained largely hidden, the subject of family rather than national memory.

More recently, however, the work of the medical services in the war has become the subject of increased investigation and celebration, although now with persistent elisions between the work of voluntary medical aid

²¹ See, for example, Mark VII, *A Subaltern on the Somme*, p.190. As Joanna Bourke points out, some of this poor reputation derived from the primary encounter between combatant servicemen and medical officers occurring in circumstances where the doctor was acting primarily as a detective, seeking to uncover malingering. (Bourke, *Dismembering the Male*, pp.89–94.)

²² Furneaux, *Military Men of Feeling*, pp.193–4.

²³ Dorothy L. Sayers, *Murder Must Advertise* (New York: Harper Paperbacks, 1995; 1st edn London: Victor Gollancz, 1933), p.21.

²⁴ Todman, *The Great War*, pp.157–8, 192.

providers, regimental stretcher bearers, and the men of the RAMC.²⁵ The understanding of medical care, both military and humanitarian, as a symbol of humanity in a futile, inhuman war was reflected in the BBC's decision in 2014 to use Robert Service's poem to introduce its *World War One at Home* series of local radio broadcasts both at national roadshows and online.²⁶ The voice of a first medical responder as witness to the suffering of war thus became the signifier of a significant national and regional act of commemoration. As with so much commemorative practice around the First World War, this focus on the humanity and witness of medical care providers reflects contemporary cultural attitudes about the war, violence, and military medical care provision more broadly. The provision of humanitarian aid in conflict is generally viewed as being as, if not more, worthy of celebration and commemoration than the ethically complicated violence associated with the military's defence of the nation.²⁷ As British involvement in international conflicts becomes ever more contentious in the age of global terror, and the armed forces face increasing criticisms and cuts to their funding, the army medical services tend to be, by comparison, the subject of praise for their innovation in saving lives and the humanitarian aid they provide to civilians in conflict and disaster zones, a very different position from their relative interwar anonymity. In this contemporary context, commemoration of the men of the RAMC during the First World War can be seen to reflect the values of the society engaged in commemorating as much as those of the men being commemorated.

* * *

Yet understanding the history of the work of the men of the RAMC in the era of the First World War remains significant beyond simply acknowledging or even celebrating the work they undertook in saving lives and providing humanitarian aid. It also shows how, like both the combatants and the other medical caregivers they served alongside, these men bore witness to the suffering of war, to the damage industrial conflict inflicts on

²⁵ See Andrew Czyzewski, 'Uncovering the unsung medical heroes of the Great War', Imperial College London, 4 February 2013, http://www3.imperial.ac.uk/news_andevents/pggrp/imperialcollege/newssummary/news_4-2-2013-9-52-58, last accessed 18 December 2017.

²⁶ *World War One at Home*, <http://www.bbc.co.uk/programmes/p01nhwgx>.

²⁷ These perspectives on aid and violence have been reflected in recent political debates in Britain around the concept of the military covenant. On the shift in cultural understandings of the war as viewed through commemorative practice, see Helen B. McCartney, 'The First World War Soldier and his Contemporary Image in Britain', *International Affairs* 90 (March 2014): 299–315, DOI: 10.1111/1468-2346.12110.

the bodies and minds of those caught up in it.²⁸ By being ‘the men who were there’ for fellow servicemen in moments of pain and fear, from the dressing station to the operating theatre, the men of the RAMC were able to lay claim to a shared sense of service and duty and, therefore, a patriotic masculine identity.

By viewing these men’s work and experiences through the lens of gender and the cultural construction of masculinities in wartime Britain, this book has sought to complicate dominant narratives of the war which, in focusing on the combatant aspects of the war at the expense of the vast amounts of non-combatant labour required, often perpetuate dichotomies around the gendered division of labour which do not fully capture the historic reality. Exploring a particular form of non-combatant work, one intimately associated with both the violence of war and the domesticity of peace, illuminates the ways in which such labour was understood as a form of war service for both men and women. The ease with which service based on care was accommodated with definitions of appropriated service, both male and female, serves to remind us of the totalizing nature of the First World War, while the difficulties that men who undertook such service faced in relation to their wartime status reinforces the ways in which gendered divisions of labour were mobilized in wartime.

The militarization of medical care at all levels, not merely that of professional practice, would have profound implications for a post-war society where the unprecedented levels of disability created by the violence of war raised questions about the responsibility of the state for ensuring the health of the nation. The tensions which the men of the RAMC negotiated—between professional medicine and first-aid practices, between the exclusivity of specialization based on innovation and the popularizing of basic concepts of hygiene and wound care through military instruction to a mass audience—would inform the debates, both political and medical, which would ultimately lay the foundation for the National Health Service in the wake of another world war.²⁹

Additionally, the work of the RAMC as gendered labour in wartime not only exposes the complexity of the memory of the First World War as either a futile or heroic endeavour, both individually and nationally. It also challenges constructions of both the military and medicine as spheres structured unproblematically by gender in this period. While gender has been shown to play a significant role in structuring military medical services, it is not in the form of the purely dichotomous double helix

²⁸ Acton and Potter, “These frightful sites would work havoc on one’s brain”.

²⁹ Barry M. Doyle, *The Politics of Hospital Provision in Early Twentieth Century Britain* (London: Routledge, 2014).

whereby, whatever disruption war causes to gender relationships, ‘In the long run . . . the dynamic of gender subordination remains as it was’, with female labour always devalued relative to male roles.³⁰ Nor do class distinctions map neatly on to those of rank for either men or women. Rather, the hierarchies of military medicine can be seen to be founded on unstable, shifting bases of gendered and classed understandings of caring. Through their work of carrying, cleaning, and caring as appropriate forms of male service in wartime, RAMC servicemen played a role in disrupting cultural norms of gender and class in relation to both the military and the medical profession. The extent to which such disruptions persisted into the interwar period is a subject which deserves further scholarly exploration, beyond the scope of this book.

The work and experiences of the men of the Royal Army Medical Corps can, therefore, be seen to have profound significance for our understandings of wartime violence, the memory of the war, and the gendered practice of medicine in twentieth-century Britain. In ‘fac[ing] the worst that cruel war meant’³¹, they not only ‘brought mercy to the strife’ but also played their part in shaping the practice of medical care in twentieth- and twenty-first-century Britain through their labour, experience, and the witness which they bore. In doing so, they undoubtedly bore an equal burden of service and sacrifice to that of any of the combatants they served alongside.

³⁰ Higonnet and Higonnet, ‘The Double Helix’, p.35.

³¹ ‘A Hymn for the Fallen of the Royal Army Medical Corps’, *Journal of the Royal Army Medical Corps* 88 (1947): 199, ll.10–11.

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