

## ORIGINAL PAPERS

### The Organisation of the RAMC during the Great War

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#### ABSTRACT

##### Introduction

At the 90 year anniversary of the Battle of the Somme, it is important to remember the members of the RAMC who served in the Great War, especially the more than one thousand Medical Officers who gave their lives.

##### Leadership

The RAMC during the First World War was a Corps led by some able officers such as Sir Arthur Sloggett in France and Sir Alfred Keogh in London. Sir Douglas Haig was in overall command, his leadership style impacting on the RAMC.

##### Recruitment of MOs

There were problems in filling the ranks of the Corps, both before the conflict, as well as well as during the War, and a significant number of civilian medical practitioners were recruited to the RAMC. Shortages were only really addressed when the Americans joined the conflict.

##### Training of Civilian MOs.

The great need for MOs meant that there was little time for formal training of civilian MOs and many felt unsuited for war work. This was recognised by the authorities, who gradually set up centres of instruction.

##### Work of RMOs

The workhorse of the organisation was the Regimental Medical Officer, who had an important role in disease prevention and the conservation of manpower, in a type of conflict (trench) that required a ready supply of personnel. Although an important role, some doctors found the job frustrating.

##### Casualty Evacuation

During the War, the RAMC managed to improvise an efficient sys-

tem for handling casualties, the aim to give speedy treatment and to return the men to the front in the shortest possible time.

##### Conclusions

The RAMC during the Great War was a highly structured and efficient organisation, geared towards maximising its available manpower, important in trench warfare.



##### Introduction

Following the 90 year anniversary of the Battle of the Somme, it is timely to remember the work of the RAMC during the First World War, the Corp's first major test in battle. The War took a heavy toll on Medical Officers (MOs), over one thousand perishing during the conflict.

##### Leadership

The RAMC at the outbreak of the Great War was an important branch of the British Army. Travers argues that the officer corps of this army was a faithful reflection of middle and upper class Edwardian society, which wished to retain Victorian moral certainties and social structure(1). This meant that the system did not operate as a meritocracy, but instead through the influence of dominant personalities, social traditions, personal friendships and rivalries(2). This 'personalized' system in turn led to an idiosyncratic promotions and removals system, based on rivalry and personal favouritism(3). In spite of this, Sir Douglas Haig, appointed as Sir John French's replacement at the end of 1915, has been recognised as an ambitious, politically conscious, and self-confident soldier(4). According to Prior and Wilson, the Boer War

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gave Haig an opportunity to establish himself as a first-class staff officer(5). Among those who were impressed by his conduct was Lord Kitchener, who appointed him in 1903 his Inspector-General of Cavalry, with the rank first of Colonel and then of Major General, making him the youngest officer with this rank in either the British or the Indian army. Haig also attracted the attention of Lord Esher, who was involved in revamping the nation's armed forces in the light of their disheartening experiences in South Africa. After Lord Haldane had been appointed War Secretary in the new Liberal government in 1905, Esher persuaded him to bring Haig back to London, first as director of military training and then as director of staff duties. From 1906, Haig took a leading role in preparing Britain for participation in a continental war through his involvement in reforming the General Staff, his formation of a small but highly efficient and well-equipped expeditionary force, and also a second line 'territorial' army, consisting of civilians who regularly undertook part-time military training. After a brief sojourn in India in 1909, Haig returned to Britain in 1911 to take command at Aldershot, where he directed army training. The post was important as, in the event of overseas conflict, it carried with it command of the 1st Army Troops. Consequently, when Britain went to war in August 1914, the expanding forces of the BEF in France and Belgium were divided into two armies and Haig was appointed commander of the 1st Army with the rank of General. He assumed overall command of the BEF in December 1915.

Haig's leadership of the BEF was characterised by a number of distinctive features. These included his 'hands-off' approach to command(6), his belief in the doctrine of mobile warfare(7,8), his promotion of technological advance(9,10,11) and his ethos of rigid discipline(12). Haig's 'hands-off' approach to command, for example, allowed subordinates such as Sloggett, Director-General Medical Services (DGMS), considerable freedom to deal with medical conditions as they saw fit. Harrison notes that the British army was quick to adopt the latest developments in the medical sciences and harness them to all areas of military life, reflecting the wish to protect its limited source of manpower(13). Reading his war diary, Haig seems to have had a healthy pre-occupation with the medical care of his troops and may well have personally encouraged innovation in this area. For example, he regularly visited casualty clearing stations (CCSs)(14) and commented on their medical arrangements for infectious disease(15). Sloggett, his chief medical advisor, was also open to new ideas. For example, after a tour of inspection of the French services in 1915, he secured the introduction of steel helmets in the British forces(16).

Sir Arthur Sloggett, born in 1857, entered the army as a surgeon in 1881(17). He next saw service in India, in the Sudan and in the Boer War. His career advanced rapidly, becoming Director Medical Services (DMS) in India in 1911 and DGMS in 1914. In October 1914, he went to France as DGMS on the Western Front, while Sir Alfred Keogh returned to his old post as Director-General Army Medical Services (DGAMS) in London. According to Harrison, this occurred because the task of organising military medical provisions for a fast-growing army was proving too much for one person and a decision was made to split the responsibility(18). Bosanquet adds that Keogh's health precluded his service in France(19). However, May gives a different explanation, stating that Keogh was summoned to the WO in October 1914 by Kitchener, who wanted him to take over in France as DMS of the BEF(20). However, Keogh stated that it would be essential for him to be at the WO, where he had direct access to the Minister of War and if necessary, the Prime Minister. Sloggett arrived in France in November 1914(21), forming an effective team with his subordinates(22). A Director of Medical Services (DMS) was appointed to each of the armies, to the Lines of Communication (L of C) and the Cavalry, a Deputy-Director of Medical Services (DDMS) to each of the corps, and an Assistant Director of Medical Services (ADMS) to each of the divisions and the principal bases. Sloggett supported a new role for leading civil specialists as consultants on the Western Front. In summary, Bosanquet writes: 'Sloggett provided the leadership and drive to meet the new challenges of trench warfare'(23). Keogh is also regarded as having a good war record. In fact, Harrison notes that his wartime work was generally regarded as outstanding(24).



*Figure courtesy of Canadian War Museum (CWM 19930012-475)*

### **Recruitment of MOs**

Soon after its foundation in 1898, the RAMC had faced problems in recruiting MOs. The Army Advisory Board noted in 1904 that the number of MOs in the organisation had fallen below the requirements of an expeditionary force in the case of war. It, therefore, recommended an immediate increase of 179 MOs. In addition, it decided that shortfalls

during wartime would be met by the recruitment of civilian practitioners and the proportion of regular RAMC and civilian practitioners was fixed at 55% and 45% respectively(25). From 1909-14 there was a sustained campaign in the medical schools to persuade students to join a Special Reserve of officers upon qualifying. However, an army career remained unpopular amongst medical graduates and there was difficulty in filling vacancies. The best young graduates normally set their sights on a prestigious position in one of the teaching hospitals or a lucrative private practice, and the RAMC was neither particularly respected nor well paid(26). Sir Wilmot Herringham agreed: 'None of our best students ever thought of going into the Army, and we teachers always discouraged it, for the Army offered no career to a man who cared about the knowledge or status of his profession'(27). In order to redress this deficiency, medical companies of the Officer Training Corps were established in the universities. Approximately 1,900 medical students passed through this organisation before 1914.

At the outbreak of the War, army planners estimated the total requirements of the BEF at 800 MOs. However, in spite of a pre-war recruitment drive, the number of MOs on the active list fell well short of this number. There were only 406 regular officers, 119 officers on the reserve list and 248 officers in the Special Reserve. As had been envisaged, civilian medical practitioners, responding to advertisements placed in the national press, made up this shortfall. They were employed as temporary officers and contracted for 12 months or the length of the war, whichever was shorter. They were then allowed to return to civilian practice. This was a different approach to that taken by the other combatant countries:

*"...in the matter of medical administration for the war the French, like the Germans, mobilised all their physicians for the service of the country, those too old for field duty continuing at their posts as practitioners and teachers, at the same time managing, on occasions, difficult cases from the front at their special clinics"(28).*

The Central Medical War Committee, the organisation tasked with recruiting MOs, enrolled 5,253 civilian medical practitioners for call up. However, casualties among MOs proved very high (over 1,000 were killed during the conflict). Coupled with the fact that the pre-war BEF had been almost 'chewed to pieces' by Christmas 1914(29), this led to a great shortage, especially of younger men, for service with regimental and field service units(30). Fortunately, Keogh proved skilful in securing medical manpower for the services in negotiations with the government(31). In response to the shortages, the State implemented measures to increase the pool of MOs, for example, the Military Service Act was passed in 1916, making doctors liable for

compulsory service once their temporary contract finished. In spite of this, in August 1917, the Central Medical War Committee informed the WO that no more civilian medical practitioners could be recruited without endangering the health of the civilian population(32). By this time, over half of the home medical profession had been enlisted, with 12,363 MOs in the Army. This prompted the setting up in April 1917 of a Commission on Medical Establishments (CME), which travelled to France in August that year to assess whether MOs could be used more efficiently(33). Harrison notes that Keogh came in for some criticism on medical provisions in France for his 'allegedly profligate use of resources'(34). In spite of this, he enjoyed the support of many senior army officers and was able to oppose cuts in the medical services, although there still remained medical manpower shortages on the ground. In March 1918, for example, Major-General Thompson, DMS 5th Army, wrote that the supply of MOs was so low that 'unqualified' officers needed to be brought in to fill posts as the Bearer Officers of Field Ambulances(35). Fortunately, these deficiencies were relieved by an appeal to the Americans, and, by 1918, 1,000 of their MOs were serving with the BEF(36).

### Training of Civilian MOs

The urgent need for qualified medical personnel meant that there was little time for formal training(37). The authorities initially assumed that civilian doctors would require little formal instruction. However, a number of MOs felt that their civilian practice was poor education for military service(38). For example, Captain E.S.B. Hamilton wrote in his diary: '*On landing in France we naturally felt at a great disadvantage from not having any previous training in England*'(39). The provision was inadequate, since, in 1914, there was only one depot at Aldershot for the training of RAMC personnel. In response to this problem, a number of centres were established around the country. Colonel A.H. Hapgood, for example, was sent to one at Colchester to instruct newly enlisted doctors. He wrote: '*Part of my duties was to initiate the temporary medical officers, general practitioners of all ages and shapes, in elementary drill and army routine of which they knew nothing. This was amusing to me, if not to the MOs*'(40). At the end of 1916, these centres were combined within a central school at Blackpool. Apart from the training institutions, MOs were also taught at military hospitals. The London sanitary companies of the Territorial Force RAMC also helped to school recruits in sanitation(41). These were paralleled in the combatant force, where a range of training schools sprang up, designed to bring all ranks up to the high standards demanded by modern warfare(42). In spite of these developments, the necessity for a more systematic

programme of training was highlighted by the CME(43). It recommended that newly enlisted MOs should be sent to front line training centres. As a result of this, the 1st Army established its own school of instruction in 1917, but these improvements were cut short by the great offensives of 1918(44).

### Work of RMOs

The Regimental Medical Officer (RMO) was the doctor on the Front, caring for the men in the trenches. In training, RMOs were taught to perform diverse roles, which included:

*“...the professional supervision of sanitary measures, the collection of sick and wounded, the compilation of records regarding them, arrangements for their transportation from the front, the discipline and maintenance of combatants under their care, the replenishment of medical and surgical supplies, the provision of food, clothing and other requirements of their men...”(45)*

As the stalemate of high mortality and morbidity in trench warfare dragged on, the military authorities became progressively occupied with maintaining their supply of manpower. The ‘relatively unskilled’ nature of such combat made the quantity, rather than the quality of the troops, the over-riding concern. Consequently, the RMOs principal role became the maximisation of personnel: *‘...he had a key role in facing the developing problems of long-term siege. The primary care of the R.M.O. was the crucial factor for maintaining manpower...’(46)*. One task was the promotion of trench hygiene, designed to minimise loss of manpower due to sickness. The RMO acted as the health education officer for the unit, teaching the basic elements of public health practice. For example, J.W. Wayte, RMO of the 14th Hampshire Regiment, frequently mentioned the state of the unit’s latrines in his war diary(47). Much of this work was neither taxing nor exciting. Consequently, a number of RMOs complained that they had insufficient work or that it involved little more than basic first aid(48). This led to criticisms that medical manpower was being wasted, as experts were employed to perform menial jobs. Many doctors became frustrated: they felt detached from professional developments and dreamt of more challenging work(49).

### Casualty Evacuation

The RAMC casualty handling system was based on the treatment of soldiers at the Regimental Aid Post, manned by the RMO. The organisation of a typical RAMC unit, from the front line to the base, can be examined by following the course of a hypothetical soldier struck down with disease. The soldier would be hoisted onto a stretcher by an orderly and carried to the dugout of the RMO. This officer would take a history, examine the patient and make a provisional

diagnosis. A label was then attached. The writer Siegfried Sassoon, himself a war casualty, described this process:

*“A label was attached to me... It was stamped Lying Train and Ship in blue letters, with sick P.U.O on the other side. On the boat, my idle brain wondered what P.U.O. meant...I devised several feebly funny solutions, such as ‘perfectly undamaged officer.’ But my final choice was ‘poorly until October’”(50)*

The sick soldier would then be ferried to the relay post of the Field Ambulance (FA) at the rear of the trench system. The FA was composed of nursing orderlies, equipped with horse ambulance wagons early in the War, but from September 1914 with convoys of motor ambulances. These were provided by the War Office (WO) and by private sponsors; for example, the Maharaja of Gwalior paid for the No.7 Convoy. In total, 48 were sent to France, each consisting of 50 vehicles under the direction of a motor convoy MO.

The FA transported the patient to the casualty clearing station (CCS), a new addition to the medical organisation. All the sick and wounded from the front were collected in this unit before being sent to base hospitals(51). It was designed originally to be highly mobile and to accommodate 200 patients. However, as the conflict developed into trench warfare with a static front, the CCSs mushroomed until they could treat 2,000 patients and they became, in essence, semi-permanent hospitals. CCSs were usually positioned near railways or good roads to ensure speedy transport. On arrival at the CCS, the patient was admitted to a receiving ward where a definitive diagnosis was made and further treatment administered. There was an operating theatre on site to handle the surgical cases.

From the CCS, the patient was conveyed by train or motor ambulance to a base or general hospital in France, or to Britain in a hospital ship, depending on the nature and severity of the condition(52). Base hospitals were stationary hospitals equipped with 200 beds whereas general hospitals had 500 beds. The beds provided in these institutions increased from 10,000 in 1914 to 95,000 at the close of the war. A few hospitals occupied large municipal buildings, but most lay outside towns, occupying huts and marquees. In Britain, war casualties were transferred to one of the 150 military hospitals, 23 Territorial Force hospitals, which had been opened near medical schools, ‘war’ hospitals, ‘hatted’ hospitals, civil hospitals or auxiliary hospitals run by voluntary aid detachments. Approximately 400,000 beds were provided in these institutions by 1918(53). Once treated, the soldier would be discharged as either, fit for duty, fit for a command depot or fit for employment in home garrisons or labour companies. Command depots performed functions similar to military convalescent hospitals. By 1918, they had housed more

than 75,000 soldiers. Those discharged to a command depot were usually available for front line service after about six months. If his condition warranted it, the man could be transferred to a specialist hospital for further treatment or pensioned off by the Medical Board as 'unfit for further service.' Men classified as 'fit for duty' or 'fit for employment' were discharged to their reserve units, where they were physically hardened.

## Conclusions

It can be seen that the RAMC during the Great War was a highly structured organisation, geared towards disease prevention, as well as returning sick men to the Front line. In fact, the RAMC was described throughout the war as an 'efficient' organisation: 'The resources of every branch of medicine and surgery were enlisted in the task of maintaining the greatest efficiency in the greatest part of the available manpower'(54). However, it faced recruitment difficulties, as well as problems with training civil practitioners needed to fill its ranks.

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