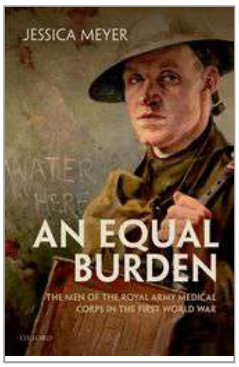

An Equal Burden: The Men of the Royal Army Medical Corps in the First World War
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Bandage Wallahs and St John’s Men

British military medicine before the First World War

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Abstract and Keywords

This chapter surveys the formation and reformation of the British Army Medical Services in the period from the Crimean War to the outbreak of the First World War. It locates the social and political debates around the nature and make-up of the unit in the context of wider reforms to the military and the medical profession. It further identifies the ways in which these debates were shaped by the development of the humanitarian voluntary-aid movement in Europe. It argues that the reforms to both the military and medicine as gender-demarcated professions constructed medical caregiving in the context of military conflict as a socially and culturally ambiguous role for men to undertake.

Keywords: professional reform, medicine, military, voluntary aid, Crimean War, Second Anglo-Boer War, first aid

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 **(p.23)** 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 **(p.24)** 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 **(p.25)** 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 overworked 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.

(p.26) 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 **(p.27)** 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, demarcationary 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 **(p.28)** 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 **(p.29)** 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 **(p.30)** 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 **(p.31)** 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 ninteenth century would remain strictly limited for both officers and men, with the persistence of class-based demarcationary practices of exclusion outweighing attempts to introduce more credentialist systems of professional definition.

(p.32) 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, **(p.33)** 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, workhouses, asylums, and even military hospitals provided an obvious counterargument 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.

(p.34) 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 **(p.35)** 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 **(p.36)** 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.

(p.37) 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 **(p.38)** 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 **(p.39)** 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 **(p.40)** 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.

(p.41) 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 **(p.42)** 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 **(p.43)** 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.

(p.44) 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] **(p.45)** 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 **(p.46)** 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 **(p.47)** 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 2*s.* 4*d.*, or 6*d.* 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 **(p.48)** 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 had 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 **(p.49)** 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. **(p.50)** 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 **(p.51)** 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 **(p.52)** 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.

Notes:

([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.

([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 Stationary Office, 1858), pp.lxxvi–lxxxi.

([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.

([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.

([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.scarletfinders.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.

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