Casualties: On the Western Front

Army medical practice

The front line relationship between war-traumatized soldier and medical officer vexed both parties throughout the war. Many soldiers avoided their medical officer because they knew they would be judged by the requirements of discipline and fighting fitness more than their personal welfare; some found that social background and rank meant their sickness claims were taken more seriously. Many doctors were practically-oriented and empirically-minded, favouring organic, not psychological explanations and treatments for mental disorders; they took less notice of changing medical opinion and research than the strategic requirements of the Army. When patient and doctor met, the medical gaze could soften or harden. These gradations of judgement decisively influenced how the casualty was diagnosed, how quickly his sickness claim was given official validation by the Army bureaucracy, as well as how and where he was treated. So while it is necessary to refer to the Army's changing administrative policy and its administrative reorganization of treatment to explain how shell shock came into being, it is in the confrontation between soldier and doctor serving on the Western Front, and in the relationship of medical officer to commanding officer, soldier to soldier, and soldier to friend and family, that the medical and social discovery of shell shock took place.

There was little agreement between Army authorities and front line soldiers on the nature of ‘shell shock’ or how to treat it on the Western Front in the early months of the war. The Army flatly rejected any medical diagnosis at first, and took a military, disciplinary view of the condition; soldiers in turn resented the apparent callous disregard of the military authorities.¹ Personal testimony shows that military medics
Casualties: On the Western Front 33

and higher-ranking officers were usually sceptical about the diagnosis of shell shock, and that they turned this disbelief into official policy. The mass of articles and full-length studies on shell shock show too that specialists and professional Army doctors accepted and enforced Army medical policy. There were, therefore, well-defined limits to the medicalization of traumatic neurosis. Front line soldiers for their part often recognized intuitively the psychological injuries of combat, but at the same time they could not help viewing shell shock as a shameful condition, a threat to reputation and peer group status. This shame has meant that very few have spoken about shell shock; what testimony there is indicates that fear of letting down comrades was the greatest anxiety. Many psychological casualties rightly believed too that comrades-in-arms, friends and family saw traumatic neurosis as either cowardice or madness. The guilt was not relieved, perhaps it was even increased, by the knowledge that this was a war-related condition. Consequently some combatants were irrevocably shattered by the war, they suffered guilt and shame in silence, they were either too little or too much aware of their own traumatic neurosis.

The social dynamics of the doctor-patient relationship that often fostered this guilty silence were set in the institutional framework of Army Medical Services. Faced with the harsh conditions of trench warfare the organization of both the hospital network and the methods of military medicine went through a series of alterations between 1914 and 1918. In large part these reforms proved ineffectual, and cure rates were not much improved. While both French and American Army medical services managed to develop a policy of positive expectancy towards traumatic neurosis, which assisted quick, full recovery, the British did not. This reflects a wider failure of the British, a breakdown of military medicine that began with the retreat from Mons, when the RAMC was unable to collect injured soldiers efficiently as the British Army withdrew, and which led thereafter to the abject failure of shell shock treatment. While British soldiers increasingly stayed in France as the war went on and could therefore be treated quickly and efficiently, and while there were extensive reforms in 1916 that made the forward Casualty Clearing Station vital to the whole system on the Western Front, both before and after reforms of 1916, the decisive role remained with the regimental medical officer. He undertook basic health care, acted as the immediate face of military medicine in the front line, and made the first critical diagnosis, and his view of the condition strongly influenced the patient’s later fortunes. A soldier just off the battlefield went first to the regimental medical officer at the Regimental Aid Post,