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Patients: The Other Ranks

The other ranks and the Army Medical Service

The disciplinary and analytic models of shell shock treatment at Queen Square and Maghull give some indication of how soldiers encountered military medicine and hospitals during the Great War. In this and the following chapter, by exploring both soldiers’ and doctors’ perspectives on treatment in practice, a more detailed picture emerges of how institutions and individuals were involved in making shell shock; of how the condition emerged in the interaction between doctor and patient, in the implementation of institutional rules and treatment techniques, in the antagonistic friction between doctor, patient and military authority. One instance of the way traumatic neurosis was marked by social interaction is in its definition and treatment according to rank. Within the Army, and therefore within the Army Medical Service, rank decisively influenced the opportunities and rights of the individual soldier. In combat rank shaped life-chances, in social encounter rank defined peer group reaction and self-perception, and in sickness too, rank fashioned attitude and expectation, which then guided the formation and presentation of symptoms as well as sanctioning the type and extent of treatment. The collective, popular memory of shell shock treatment is also influenced by rank. United by upbringing, education and social status, officers have been better able to describe their experiences of combat, and these accounts are more widely known in both the medical literature and memoirs of the Great War. Most shell shock casualties were not officers though, but members of the other ranks.

The physical conditions and administrative framework of treatment are also important to understand fully shell shock’s social context, because they too influenced, however subtly, soldiers’ self-perception.

P. Leese, Shell Shock
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Writing of the British Army Medical Services for the treatment of injured and disabled soldiers in 1917, Sir Alfred Keogh, Director, stressed that all soldiers were treated within a system that was stretched almost to breaking point. The facilities and treatments in the Military and Auxiliary Hospitals of England, Ireland and Scotland were limited, he observed, by the need to maintain the armies in the field:

Questions of accommodation, equipment and staff soon become embarrassing. The necessity for not disturbing civil conditions and for maintaining, as far as may be in peacetime, the great philanthropic institutions and educational establishments, at once limits the possibilities of providing sufficient hospitals and appropriate staffs for a sufficiently long period for all cases of injured and disease... ¹

For both social and economic reasons therefore, hospitalization was minimized. Nevertheless, a range of treatment was available in British hospitals. For instance, Dr E. Bramwell at the Royal Edinburgh Infirmary was one of many medics who in cases of ‘neurasthenia’ combined the traditional rest cure regime with non-punitive faradization, employed to persuade the patient that his condition was mental, not organic, and therefore curable.² Elsewhere, some doctors used intimidating behaviour and equipment to ‘convince’ patients that they were not beyond cure, but many of their colleagues rejected such procedures as unethical. Numerous physicians also used hydrotherapy, to relax; harmless drugs, to give the impression of medicine in action; perhaps most common of all, bromides to reduce restlessness or nervous irritability. Yet as the war progressed, and cases of hysterical conversion gave way to nervous exhaustion and chronic fatigue, new treatments were widely adopted, including suggestion and persuasion as practised, for instance, by J.A. Hadfield at the Ashurst Hospital, Oxford.³ Authority and expectation were essential in these later treatments, which included both waking suggestion and hypnotic suggestion, but as happened very often in cases of all ranks, even where such techniques were judiciously applied, the incidence of postwar neurosis shows that they alleviated symptoms without eradicating the underlying cause. Unusually, Hadfield also recommended collective [group] hypnosis because it saved time, adding that respect for the patient, expressed through ‘reassurance, elucidation, demonstration, re-education’, was essential to effect a proper cure.⁴ These conditions were, though, often entirely absent.