

SECTION III—THE TECHNICAL SPECIALTIES

INTRODUCTION

UNTIL the modern era military medicine was surgery and military medical officers were first, foremost and all the time surgeons. In the army the "official" history of internal medicine can hardly be said to date beyond the 17th century, and in particular to the creation of the British regular standing army of 1660. Thereafter (until the eclipse of the "apothecary" in the 18th century) surgeons, physicians and apothecaries were concerned in the direction of the Medical Department of the Army. In the middle of the 19th century Miss Florence Nightingale and Sir Sidney Herbert forced preventive medicine on a subservient and discredited service, and in 1857 as we have seen the "Army Hospital Corps", forerunner of the Royal Army Medical Corps, was created. A "professional" Army Nursing Service was the inevitable outcome of the Crimea and the Nightingale system of nursing.

It was left for the Great War of 1914 with its inexhaustible demands for effectives and the apotheosis of "return to duty" to compel a more complete and exact differentiation of specialties within the service itself and the Medical Corps. Already pharmacy had found its level as a service subsidiary to internal medicine, and its personnel had been "put in their place" in the high-handed and unpleasant fashion traditional of the orthodox official medical profession. Together with dentistry, and physio-therapy, pharmacy claimed "a place in the sun" within the medical department of the Army—it required social as well as a technical recognition.

In any army—but particularly in the older European ones—social status for a profession may be achieved in one way and one only—by inclusion of a proportion of "officers"¹ within

¹ In the British and dominion forces "officers" were those whose rank was held in virtue of a "commission" from the King and not of an Army Warrant.

the technical establishment laid down for its personnel. It is impossible for anyone outside the British Army to understand the fierce jealousy with which in that army and nation the commissioned class guards this social privilege, nor the utter and complete social distinction which before this war, and even during it, was conferred thereby. Nor was the British Army unique.

**"Officer"
status**

Rightly, therefore, to understand the evolution of the auxiliary medical services, it would be necessary to traverse the history of "commissioning" in the British Army. Fortunately, it is not necessary to undertake this invidious task.² But it is necessary, since the future structure of the medical service in a great measure depends on the spirit in which the problem is faced, that the facts be recorded as they influenced developments in the A.I.F. in the war of 1914-18.

The question of granting commissions in the Australian Army Medical Corps to members of the civil community, outside the medical "profession"—instead of practically restricting it by law to qualified medical practitioners—was, in the war of 1914-18, a cause of dispute and disaffection so considerable as to interfere, if not with the actual efficiency of the service, at least with its harmonious working. The main questions arising were (1) the criteria which should be held to justify the promotion of any particular group of technical experts

**The special
services**

² For the uninitiated it is necessary to any understanding of the Army system that the significance of "commissioned" and of "non-commissioned" rank should be made clear. To generalise, it can be said that commissioned rank allocates the right of initiative and direction in matters of policy—whether these be concerned with the tactics of battle or with methods of maintenance. And as an outward and visible sign of the principle of command and obedience, by which alone battles or Test Matches may be won, it is obvious that gradation of rank is a *sine qua non* to effective execution.

But while this must be recognised it is necessary to an understanding of the practical problem of British Army organisation to appreciate the fact that the distinction between commissioned and non-commissioned rank in the services is not inherent in or necessarily created by the absolute or relative importance of the executive duties associated with the two types of "rank". As interpreted in the past in the British Army the distinction between the two is absolute and fundamental; there is no real gradation that bridges the gap. Each type of rank—commissioned, and "warrant" or non-commissioned—has its own gradation, and between the two there is "a great gulf fixed" and the gulf is essentially a "social" one. The distinction is a heritage from the feudal system, the relation is a reflection of social conditions (already obsolete in some nations) exemplified by position "above and below the salt" or of the social distinction into "gentlefolk"—and others. With the industrial era, wealth and in some degree, education, partly replaced "hereditary" right to military command. The only justification for the system is that "it works" as no other system as yet devised has done. Whether or not "democracy" can find a better, depends, like many other problems of social relations, on whether we are really resolved to do so.

or "specialists" to such a privilege and (2) if the right to receive a "commission" was accepted, what ranks were appropriate to the particular specialty? Should it be given an independent "gradation list" for promotion? Should it be represented in the administration?

A closely allied question arose within the medical profession in itself. Entry into that profession is controlled by the University "faculties" or the professional "Colleges", "Associations", or "Societies" which are entitled by law to grant "licences" to practise medicine—such as the "Royal College of Physicians of London", the "Royal College of Surgeons of England" or the "Society of Apothecaries of London"; in Australia in 1914 by the Universities of Melbourne, Sydney and Adelaide.³ This legal "licence" to practise was accepted in the British and apparently in all modern armies as entitling to commissioned rank in the Army Medical Service. In addition, however, to this primary qualification various "specialties" have, in the course of medical evolution become differentiated. The primitive, and almost elemental differentiation is into internal medicine, surgery, and obstetrics and gynaecology. Of the rest the most essential may be listed as the practice of anaesthetics, ophthalmology and otorhinology, dermatology (including venereal disease), neurology and psychiatry, orthopaedics (clinical specialties); pathology, bacteriology, biochemistry and radiology (technical specialties); and hygiene and public health (preventive medicine). The war itself added the specialist in aviation. Here too the question arose—what rank and status were appropriate for this host of specialists. It was, however, much less urgent inasmuch as all were already officers by reason of their medical qualification being accepted as entitling them to a commission. The issue was essentially different. The only question that need be examined here⁴ is that of what may be termed the democratisation of the medical service by the admission to commissioned rank in the A.A.M.C. of elements from social groups other than, and hitherto regarded as socially inferior to, the qualified medical practitioners.

³ The University of Queensland now grants medical degrees.

⁴ For the position of specialists see pp. 431-32.

The social groups and callings in relation to which, in the late war, the problem of status and rank came into special prominence were dentists, pharmacists, registered nurses, and physical therapists (chiefly masseurs and masseuses) together with the personnel, voluntary and paid, of the "International Red Cross" represented by the Australian Branch of the British Red Cross Society. The last named, as we have seen, claims and is accorded a place of its own in relation to the mandate given by the Geneva convention to the medical service. The question of the status of the female nursing service is also *sui generis* by reason of the fact that a woman could not then⁵ be an officer or soldier of the British Army and can only be absorbed into or attached to it in a relation closely akin to that of the first "hospital corps".⁶

Pharmacy. The place of the apothecary and the pharmacist at the outbreak of war had in a great measure been fixed by tradition which reached back throughout the military history of Australia; the wartime developments were the result of the trend to a more democratic adjustment.

Dentistry. It is scarcely credible, certainly far from creditable to the medical service, that when the war began in 1914 dentistry as a science and art was not recognised as necessary in the wartime structure of the Australian Army. The early stages in the evolution of a dental specialty within the Army Medical Service and Corps have been recorded in the earlier chapters of this work.⁷ During the war this specialty developed a "Corps" complex which, following the tradition of the dental profession in civil life, found expression in an increasing demand for administrative and professional independence of the medical service, for the formation of a dental "corps" for independent administration as a "department" under the

⁵ This matter is discussed in *Chap. xi.*

⁶ Optometry as an organised technical calling did not enter into the picture, by reason chiefly of the fact that the medical profession was able more or less effectively to supply the requirements, and that the filling of optical prescriptions could be done outside the Army. The same may be said and with greater assurance of radiology since the medical radiologist had command of the technique as well as the clinical application of radiography, while at the outbreak of war only a modicum of medical men were capable of estimating an error of refraction. The employment of men who practised the art of "bone setting" did not come within the field experience of the Australian Medical Service, as is well known British experience in this matter was considerable—and was both chastening and salutary.

⁷ See *Index to Vols I and II under Dental Service.*

Adjutant-General, and for the right to independent bargaining regarding its status, ranking and military responsibilities.

Physical Therapy. In this occupation, as in that of pharmacy the question of commissioned rank and special "establishments" gave rise to a violent divergence of views, as between the Director of Medical Services in the A.I.F. (Howse) and the Director-General in Australia (Fetherston). The position achieved at the end of the war served as a "jumping off" point not only in a quest for still wider military recognition, but also in constructive peacetime work in defining the technical sphere of this group and in consolidating its social status.

The problem relating to each of these is examined in the chapters dealing with them; but the experience of 1914-18 suggests the lines of solution, at least in the democratic Australian Army.

(1) Gradual integration of the privileges and responsibilities of "commissioned" and "non-commissioned" rank respectively so that the distinction between them becomes one of *responsibility* rather than of *privilege*.

(2) That "rank" should be determined by the intellectual quality of the service required. The determination of "value" in this service may perhaps most readily—though still only crudely—be based on the social recognition of the "professions". It may be argued that the significance of the term profession is too indefinite to be used as a social yard-stick. But however vaguely defined, the term connotes a clear recognition of the essential factors involved in the scientific grouping of social service and hence of social groups. The chief distinguishing characteristic of a profession has been defined as

the application of an intellectual technique to the ordinary business of life, acquired as the result of prolonged and specialised training.⁸

The criteria determining the social status of a professional group may be postulated as—(1) the primary and independent character, or otherwise of the social services to be rendered; (2) whether or not its operations relate directly to human life

⁸ *The Professions*, by A. M. Carr-Saunders and P. A. Wilson, (Oxford; At the Clarendon Press, 1933, p. 491).

or activities; (3) the scientific quality of the service, and the technical skill required in its performance; **The "professions"** (4) the degree to which the body of the calling recognises its obligations to the community and controls its members for the protection and advantage of the public. Most of these criteria have formed bases for claims made by the several special services for recognition of rank, commissioned and non-commissioned.

Applying these criteria to the services concerned, it may be observed that the medical profession itself performs a subsidiary service, a service of maintenance, and the various services that compose it necessarily have this character. Moreover only two of the callings concerned can be regarded as of independent significance—the medical and the dental. The pharmaceutical, massage, and nursing services exist to serve the requirements of these two. And of these dentistry is—or at least was—confined to one local and clearly defined anatomical field of treatment; for the exercise of the higher functions of prevention and general treatment it has to call in the medical profession.⁹ It is indeed technically a specialty of medicine.

These are not, of course, the only factors in the question. The nature of the service rendered, or how intimately it is concerned in the essential duties of a military medical service, its "humanitarian" value, and even the tradition of social life, will have their place. But since the ascent of man is universally accepted as due to the evolution of a creative intellect, it cannot be doubted that a general acceptance of what may be called "intellectuality" as a main criterion in these matters would greatly promote a stable equilibrium in them.

The problem can justly be solved only on a basis of liberal common sense and democratic realism. It seems certain that the interests of the Army Medical Service, and of the special services will best be served by building up a self-contained medical service, with or without internal division into specialist corps, and gradation lists.¹⁰

⁹ See in connection with the future of dentistry, Prof. W. H. Gilmour (Royal London School of Dentistry), *Brit. Med. Jour* 3 Dec, 1932, p. 1032.

¹⁰ It is interesting to note that after the war the position of Director-General at the British War Office was held by a specialist in Bacteriology and Tropical Diseases, Sir William Leishman.

The first volume of this work, which dealt with the evolution of the Australian Army Medical Service and Corps, and with the problems that faced the service with the A.I.F. in what is now called the "Middle East"—in Gallipoli, Palestine, Syria and at the Base in Egypt—incidentally described the problems of the dental, pharmaceutical, nursing and massage services, and of the part played by the various professions of Australia in meeting these. The account was, however, written strictly from the point of view of the medical service as an element in the fighting forces and in particular of the Australian troops which had a part in the several campaigns.

The purpose of this series of chapters is so far as possible to present the history of each of the specialist services from its own standpoint. It is obvious that this could best be done by a member of the special arm, service and profession itself. That this was not found possible is deplored by no one more sincerely than by the writer, and in fairness he must put on record the fact that in each of the special arms and specialist services, excepting only massage—dental, pharmaceutical, nursing—special endeavours were made to arrange for this. The accounts have, however, been based largely on material supplied by members of the services. In particular the work of the dental service is taken almost wholly from memoranda and narratives compiled by its senior members for this specific purpose.

It has unfortunately not been found possible to include as had been proposed in this Section some account of the work of what are known as the medical specialties and which for the purpose of military medicine may be held to include diseases of the eye, ear, nose and throat, together with pathology, bacteriology, radiology and dermatology. Specialists in all these held commissions in the A.I.F. and as in civil life they played an important part in the work of the service.¹¹

¹¹ An account of ophthalmological work done at Lemnos by the ophthalmic specialist in No. 3 A.G.H. (Maj. Lockhart Gibson)—which unit was made responsible for all wounds to the eye during the August operations—was published in the *Guy's Hospital Reports*, Vol. LXX, 1919, as part of an article by the Consulting Ophthalmic Surgeon to the M.E.F., Lieut.-Col. H. L. Eason.

Observations on eye-sight and military efficiency made by Sir James Barrett while acting as ophthalmic specialist to the M.E.F. in 1915 and subsequently in the R.A.M.C. and published by him in his book *A Vision of the Possible* are original and valuable.

The question of the status and rank of medical specialists was a difficult and thorny one. The fact that administration and command carried much higher rank than the technical specialties made the position of many men of high professional standing very unsatisfactory since they must either give up their specialist work and compete for administrative positions in command, or remain at their special work with a low rank. The position has since that war been materially improved.¹²

¹² The involvements of this problem in the Royal Army Medical Corps are examined in *Chap v. See p. 231-2*, note by Maj. S. F. McDonald, R.A.M.C.(T.).