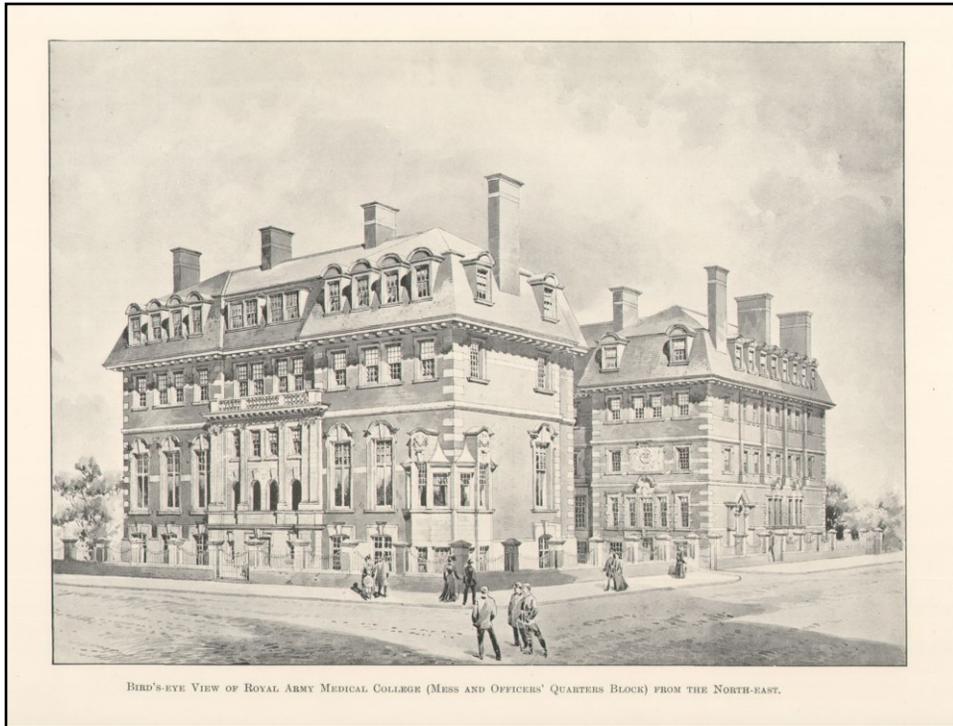


THE RAMC IN 1914

Centenary Talk to Friends of Millbank, 21 February 2014

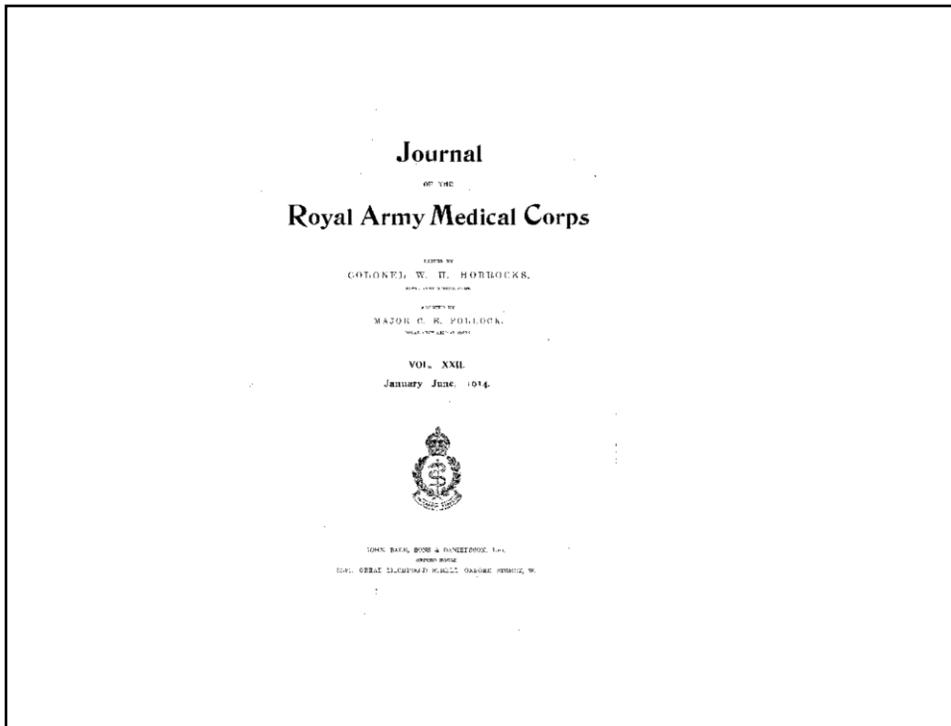
Brig (Retd) Alistair Macmillan DL

It is a great privilege to be asked along this evening to talk to the Friends of Millbank and thus start off consideration of the Great War.



I was first in this building in the summer of 1970 when I came down from Glasgow University Medical School for an interview concerning my application for a cadetship in the RAMC. The Selection Board was chaired by the then Director General, Sir Norman Talbot, and a certain Robert Sidney Blewett acted as Secretary being the Assistant Commandant here at the time. Having bluffed the examiners, I was duly processed through the paper-heavy administrative process of becoming a probationary Second Lieutenant and met a few of those who would become my cohort subsequently through basic training and on to initial RMO-ship.

Anyway, let us turn to the subject at hand. Frank asked me to talk about the RAMC in 1914.



I have based my approach through the eyes of the Journal of the RAMC that year, Regulations for the Army Medical Service, the RAMC Training Pamphlet and the Field Service Manuals. There was vivid commentary on RAMC matters every week in the British Medical Journal and I have dipped into some of that. I want to paint a picture of who were in the Corps and where they were at the time, what the norms of service and training were and then move on to our mobilization and deployment overseas.

We started a tremendous build up of forces and the Territorial Force became operative, not least the RAMC's component, and the creation of Kitchener's Army had far reaching impact on the RAMC. Before 1914 had ended we were already learning significant lessons about military medicine and so I hope to finish with setting the scene for others to tell you about all the facets of the RAMC which emerged thereafter through 1915 until 1918. My focus is firmly on organisation and control and this is not to dismiss the individual contributions of each and every clinician and medical soldier, and who, of course, form collectively the RAMC, but it was these wider matters with which the Great War was ultimately about and our initial steps in 1914 paved the way for employment, adaptation and ultimate success over the next four years.



Let me start though with this piece of music. Does anybody know what it is? it is the Corps March of 1914, newly adopted that year and already we were into our second march, the first being Souza's Washington Post adopted in 1898.



So in 1914 this was a Corps which was only 16 years old and which had been born after decades if not centuries of controversy over the place of medicine in the Army and its governance. It was born during the British Expedition to avenge the death of Gordon at Khartoum and its first battle honour was the Battle of Omdurman. I use the term battle honour advisedly as, of course, the Corps and its antecedents, was like the artillery and engineers, being everywhere or 'Ubique' but was not engaged in combat, merely confronting the consequences of it and the local environment. However it was the following three years which provided the Corps baptism and what a one of fire that was – through the Boer War. This exposed the paucity of RAMC personnel, their training limitations, unit organisational mismatches, hygiene ignorance and clinical ante-deluvianism. After Parliamentary enquiry great lessons were learned and these were put into practice very successfully so that the RAMC entered the Great War in 1914 in a quite reasonable state. It was not perfect but it rapidly learned the current lessons and adapted successfully to rapid expansion, organisational change, clinical and scientific advance and to react to an equally evolving Army it was supporting with the doctrine, tactics and weapon development changes implicit in the conduct of the War. There was to be no Royal Commission or enquiry into the failures of the medical services associated with the War, possibly a first in history but there was one post-war commission into shell shock but that was a matter for the Army at large and not just the RAMC. Equally the Dardanelles and Mesopotamia had their problems but again these were far from merely medical.

Medical Officer 1914



Let us turn to the people of the Corps in 1914. It was essentially a Corps of medical officers though there were some Quartermasters holding honorary commissions. These Quartermasters were all commissioned from warrant rank in the Corps. Most medical officers were at general duties having graduated from medical schools around the United Kingdom before applying for commissions. A sizeable proportion of them came from Scotland and Ireland. Some specialised in Medicine or Surgery and a few had gone into Pathology and fewer into Obstetrics. There were no Anaesthetists, Orthopaedic Surgeons, Burns and Plastics Surgeons, Maxillo-facial Surgeons or Neurosurgeons. There were no Accident and Emergency Specialists nor Psychiatrists. But, of course, this reflected the civilian medical services situation broadly. There was hardly a dentist, the Army Dental Corps was not formed until 1921. Whilst the RAMC gave young doctors a good grounding in military medicine, hygiene and medical organisation (initially and then for returning officers at its new 'staff college' in London – the Royal Army Medical College), the challenge remained of giving its medical officers sufficient clinical experience to keep them professionally challenged and content, clinically useful and up-to-date in an organisation that was spread all around the Empire. The inevitable consequence of working in a bureaucratic and seniority driven organisation was that success and promotion stemmed from understanding all this and that the leadership of the Corps was engaged in

management and administration whilst it was the juniors who provided the clinical service.

Essentially, despite its flaws, the system survived and served the Army pretty well throughout the War but it was leavened by senior eminent civilian clinical expertise and with a large influx of young volunteers and an expanding field medical organisation which had to deliver prodigious feats on the battlefield.

RAMC Soldier 1914



The basic RAMC soldier was the Nursing Orderly, now today's Combat Medical Technician, and this was the predominant branch of employment for other ranks. This cadre beget masseurs (now physiotherapists), mental attendants, skiagraphers (now radiographers), electrotherapists and operating room attendants. Selected nursing orderlies were further trained in nursing to become honorary members of the Queen Alexandra's Imperial Military Nursing Service or QAIMNS. The rest of the RAMC soldiers were part of the General Duties cadre from which were found cooks, laboratory assistants, sanitary orderlies, dispensers and storemen. There was a discrete sub-cadre of medical clerks. The training of all these happened initially at the Depot housed in McGrigor Barracks Aldershot (located in front of the Cambridge Military Hospital) and thereafter at trade schools spread around the major UK military hospitals and the College at Millbank. I have mentioned the College a couple of times but will not stray much further in that direction as I know you are going to get a more detailed story from Peter Starling later this year and I must not steal his thunder. It is important to stress that the RAMC took this development of its soldiers very seriously and additional pay was awarded to successful dispensers, laboratory attendants, operating room attendants, mental attendants and skiagraphers. Nursing specialism was rewarded as were those who developed further nursing expertise in managing sexually transmitted and infectious diseases.

RAMC CAP BADGE 1914



In the last two slides you have seen both characters dressed in Khaki. This is how they were to be dressed for war in 1914, it was the dress for peace as well since 1902. This is the cap badge we wore in 1914, note the King's Crown and the subscription RAMC. The Corps motto wasn't adopted on the cap badge until 1950.

REGULAR AND TF SHOULDER TITLES



The other significant regimental identifier was shoulder titles for the soldiers, worn on their epaulettes, the Regulars with a simple RAMC badge and the Territorial Force showed its regional identifiers. You will hear more of these identities later.



At the top of the RAMC family tree was the Director General – a position which had been in existence since 1810. He was, however, ranked as a Surgeon General. For all that the Army had granted normal ranks and powers to the medical officers in 1898 when the Corps was formed it had bridled to do this for general officers. So medical generals were Surgeon Generals and classified as equivalent to Major Generals. A lesson from the Boer War was that medical needed better access to the chain of command and that medical, especially prevention and sanitation, needed to be involved more closely with higher military governance. As a consequence in 1902, the DG, Sir William Taylor, was granted equivalent status to a Lieutenant General, whilst remaining a Surgeon General and became a member of the Army Council. With the formation of the General Staff in 1906 though, the DG was suborned to the Adjutant General and it would be he who sat on the new Army Board and represented medical matters at that level – a situation which remains to this day. It was felt that hygiene was a matter of discipline and thus this was properly under the aegis of AG. In 1917 a letter on this subject was published in the BMJ from Lord Esher, the architect of the creation of the General Staff and thus the Army Board, which regretted this positioning and that medical should have remained on the Army Board. This was the lesson of the Great War in his view and that events on the battlefield had amply illustrated this. The issue was, and I might add, it remains to this day, that there are two components to medical in the Army, healthcare on the one hand and prevention on the other. AG sees prevention firmly within his bailiwick as the levers of the determinants of health are in the hands of the chain of command. He has never really been successful in dealing with healthcare, particularly on the battlefield and medical has interacted directly with the chain of command over this or through logisticians and the Quartermaster General, given that transport, equipment and communication resources are vital to a successful casualty treatment and evacuation schematic. Of course, prevention and healthcare are inexorably intertwined and this is what Army powerbrokers have found difficult to reconcile since the end of the Second World War.

So I have covered in a short sweep the three branches of the staff, G, A and Q. Certainly A and Q were to work well during mobilization and in the field, Britain's challenge was with the effectiveness of the G.

Sir Alfred Keogh



William Taylor was followed by this man Alfred Keogh, a Galway graduate. He was very young when appointed following a successful Boer War commanding a general hospital and was pivotal in the process of reform following that war. Whilst membership of the Army Board may have been ripped from his grasp he had a profound impact through a whole range of changes to the AMS. The College here opened on his watch, he started the School of Hygiene in Aldershot and revolutionised sanitation training for line and medical officers as well as for the sanitary attendants. He reorganised the field medical organisation to create field ambulances in 1905. He set up appointments of eminent civilian medical advisors to himself and to military hospitals in UK. He was the architect of the medical component of the Territorial Force which came into being in 1908 and later, from observations from the Russo-Japanese War of 1905, devised the role and concept of the clearing hospital. He did a double tour as DG and still was a relatively young man when he retired in 1910. He was later involved with the Voluntary Aid Society's activities in France at the beginning of the War but was recalled to take over as DGAMS in October 1914. The work in preparing the Medical Services at home was to be a massive and prolonged undertaking. His previous experience, his civilian and military networking and his understanding of the War Office were to be of especial benefit to the country at large and to the Army for the rest of the war.

Sir Arthur Sloggett



What wonderful names our leaders had then, today I think the Royal Navy still selects the 1st Sea Lord on the strength of exotic or alliterative names, Keogh was followed by Sir Launcelotte Gubbins but in July 1914 the role passed onto Sir Arthur Sloggett. He certainly got a swift baptism by fire the following month as Britain went to war. Sloggett was a most decorated and campaign experienced medical officer. He served during most of the later Victorian small wars and was seriously wounded at the Battle of Omdurman in 1898. He had a good Boer War and had just come from being the Principal Medical Officer of the Indian Medical Service. Sloggett was a bit of a rogue and a lady's man, indeed in many circles he was known as Naughty Arthur but he had a great sense of humour and got on well with the staff. He also recognised his own strengths and weaknesses and was able to encompass and encourage others more expert than himself. He simply couldn't both see to home expansion of the Army Medical Services and reception of casualties back into UK as well as oversee the medical support to the BEF. After a period of ill-health he went out to GHQ as the Director General. He was also appointed Commissioner for the Voluntary Aid Societies in theatre and was able to bring all the diverse medical inputs together. Like Keogh, he served on successfully until 1918 when they both reached retirement age. Both men had big boots to fill.



The DG was supported by a small staff, the Army Medical Directorate and mobilization in August 1914 was, like all the branches of the War Office, an exercise in emptying the offices as officers were appointed to the British Expeditionary Force. The workload of the Directorate was to expand massively and in a short period of time after 4 August 1914 when Britain declared war on Germany following the invasion of Belgium. It had been perceived that the war would be short and that everybody would be back home for Christmas. Just as was planned across the Army, and particularly in the RAMC, retired officers were expected to step in to back fill posts when the AMS mobilised. Known as 'dug-outs' they quickly had to get involved with primary and secondary care services in the UK and confront the sudden large demand for medical examinations for the myriad of volunteers for the Army. And in this they would be assisted by the Voluntary Aid Societies, the Red Cross and St John.

RAMC Companies 1914

1, 2, 3	Aldershot	18, 35	London
4, 5, 21	Netley	19	Chester
6	Cosham	20	Tidworth
7	Devonport	22, 23, 24	S Africa
8	York	25	Bermuda
9	Colchester	26	Ceylon
10	Chatham	27	Hong Kong/S China
11	Shorncliffe	28	Gibraltar
12, 34	Woolwich	29	Jamaica
13	Edinburgh	30	Malta
14, 17	Dublin/Curragh	31	India (Deolali)
15	Belfast	32	Singapore
16	Cork	33	Cairo
		A, B, C	RAMC Depot

The RAMC was not organised for war in peace, quite the opposite. Both in UK and overseas around the empire, the RAMC was formed into peacetime Companies. The screen shows you the 38 companies that existed in 1914 and their locations, 35 numbered ones and three lettered ones for the Depot at Aldershot. So all RAMC personnel were managed by these Companies and they were employed in garrison hospitals and medical centres. On mobilization, the men were allocated to the field medical units which were to support the BEF or be shipped overseas to other theatres. The Company was the essential administrative base for the men of the Corps. The peace establishment of the RAMC was dictated by peacetime needs and funded accordingly. However, this was somewhat more generous than that which applied at the beginning of the Boer War. It was from the Companies that ad hoc field medical units would be temporarily brought together to do field training and support formation training, mainly around Aldershot or on Salisbury Plain. So, in reality, the mobilization process was being practised in peace as a consequence and when the balloon went up in 1914, the process worked reasonably smoothly. So the manpower came from the Companies RAMC and the stores had to be picked up from Woolwich, both general and medical. It was only in 1905 that the Army Medical Store was properly established and that these stores were removed from the damp cellars of the Royal Herbert Hospital in that Garrison. Horse drawn wagons were collected and horses garnered for mobile units – to be handled by detachments of the Army Service Corps. Horses were taken up from trade so to speak from local owners under shadow leasing contracts.

RAMC Personnel Numbers 1914

Officers		Other ranks		TOTAL
Regular	1090	Regular	3797	
Reserve	29	Reserve	4937	
Special Reserve	248	Special Reserve	1435	
Total	1467		10169	11636
However:				
India	333		0	
Elsewhere	229		1300	
Home	83		0	
Total	645		1300	1945
BALANCE AVAILABLE FOR BEF			9691	

So what was our strength in 1914? On 31 July that year we had on the active list 1048 medical officers and 42 Quartermasters with 3797 other ranks. However, 333 of these officers were on the Indian establishment and with 229 officers and 1300 other ranks stationed elsewhere abroad. 83 officers were also required by the War Office and home appointments in order to see to the mobilization process. However there was a small reserve, the Special Reserve, which had previously been the Militia; this provided 248 medical officers and 1435 other ranks. Retired officers and those with a reserve liability for call-up amounted to 119 medical officers and 19 Quartermasters. Terms and conditions of service for Regular soldiers meant they spent about 6 years with the colours and another years with a reserve liability; there were thus 4937 other ranks liable for call-up on mobilization.



The prospect of Britain fighting on the continent as opposed to troops being used for home defence or reinforcement around the Empire, and notably to go to the aid of the jewel in the crown India, and despite the size of the Indian Army, was not really acknowledged by the Government though there had been informal staff talks between the French and the War Office over the potential for the British to return to the continent for the first time in over 90 years. One of the consequences though of lessons from the Boer War and pressed by Haldane, the Secretary of State for War, who saw through so much military reorganisation, including the formation of the Territorial Force, meant that an Expeditionary Force of six Regular Infantry Divisions and One Regular Cavalry Division was set up in peace, and trained together, so was available for deployment to the continent if necessary. The main medical units, as laid out in Field Manuals, were:

Field Ambulance

Marriage of Bearer Company and Brigade Field Hospital

3 per Infantry Division (ratio 1 per Brigade)

9 MOs, 1 QM and 224 ORs

A,B,C Sections, each with bearer and tented elements

10 Horse drawn Ambulances

Cavalry Field Ambulance (ratio 1 per Brigade)

5 MOs, 1 QM and 118 ORs in A, B Sections

6 Light Horse drawn Ambulances

The field ambulance. These were scaled as three per infantry division, which is a ratio of one per brigade although they were controlled at divisional level. The field ambulance was born of reflections of how things had gone in South Africa. There each brigade had a bearer company and a 50 bed field hospital. There was a field hospital for divisional troops as well. The problem was that there was an imbalance of troops between the two types of unit and manpower from both was required at both ends of the battlefield. There was not a simple mechanism to synchronise their use and the interface between them. Our colonial cousins had melded the two together and in 1905, the RAMC followed suit. Each field ambulance was divided into three sections, each with a bearer division and a tented division – the treatment element. The cavalry field ambulance was smaller and only had two sections.

17 Field Ambulance on Parade



The field ambulance thus dealt with both casualty evacuation and treatment. Its sections could act independently or together. The unit was to clear regimental aid posts of their casualties and set up advanced or main dressing stations for treatment prior to be cleared of casualties and thus allowing the field ambulance to remain mobile in support of the battle. It was entirely horse drawn at the outbreak of war but that was to change quickly after battle was joined.

Clearing Hospital 1914

Created in 1909

Lesson from Russo-Japanese War

Ratio of 1 per Division

7 MOs, 1 QM, 86 Other Ranks

Light and Heavy Divisions

No Transport

200 Beds

No QAIMNS until 1915

1915 becomes Casualty Clearing Station (CCS)

The clearing hospital was scaled on the basis of one per division but was to be controlled by higher formation. This was the point to which the field ambulance would have its casualties cleared. Ideally it was to be placed at a railhead and thus at the front of the Lines of Communication back to the Base. The creation of this unit happened in 1909 and clearing hospitals were not established for the territorial force until 1913. The problem in the field would turn out to be the transport linkage between dressing station and clearing hospital as there was initially no dedicated resource and a reliance on a combination of returning empty supply wagons and trucks with double-hatting of field ambulance transport. Its change of name, change of role and reinforcement after the lessons of 1914 were to have a profound impact on the delivery of healthcare on the battlefield.

Stationary Hospital 1914

200 Beds

Ratio 2 per Division

7 MOs, 1 QM, 86 ORs

Initially no QAIMNS

No Transport

On the Lines of Communication, staging facilities

The stationary hospital was designed to deliver intermediate care on a long Line of Communications as well as support directly troops operating on those lines. After the initial deployments they hardly featured on the Western Front and ended up be used as general hospitals.

Stationary Hospital



Their utility in other theatres was to remain throughout the war.

General Hospital 1914

520 Beds

Ratio 2 per division

20 MOs, 1 QM, 143 ORs, 43 QAIMNS

No transport

Later doubled in size and some beyond that

Located at the Base

The general hospital was the point of main clinical effort and maximum numbers of beds. Here were found the surgical and medical specialists, diagnostic technology as there was of the time and nursing, female nursing. The General Hospital was located at the Base or rear of the Lines of Communication and patients would either be treated and nursed to recovery here or further transported by sea to the UK.

Ambulance Train

2 MOs, 45 ORs, 4 QAIMNS

33 Casualty Coaches each four stretcher frames
which could accommodate 3 stretchers

Other coaches for staff, restaurant, supplies and
'walking wounded'

The ambulance train linked the two ends of the Lines of Communication and was meant to be pretty well self contained. The essential plan was for the equipment to be transported overseas as an entity and then fitted into locally procured rolling stock.

Ambulance Train



Despite the lessons of the 1882 Anglo-Egyptian War and the Boer War, the initial equipping of ambulance trains was problematic in the early stages of the war.



Up at the sharp end, of course, with units was the regimental medical officer and he was supported by 5 RAMC soldiers who were mobilised for water and sanitary duties. However in battle these soldiers would be heavily involved in treatment. Units provide their own stretcher bearers. There would be over a hundred RMOs in the BEF and their presence and role would stimulate much debate and examination during the war.

New Staff Nomenclature 1909

DMS	Army	Surgeon General
DDMS	Corps/LofC	Colonel
ADMS	Division/HQs	Colonel
DADMS	All HQs	Major
October 1914		
DGMS	GHQ	Surgeon General (3*)

With the advent of the General Staff and plans for a BEF evolving, in 1909 the British staff structures were revised. It was acknowledged that there was a medical component to this and the following positions were allotted. Beforehand the senior medical officer in a formation had been alluded to as the Principal Medical Officer. So there was to be a Director of Medical Services at GHQ, and a Deputy Director at a Corps Headquarters and the Lines of Communication with an Assistant Director at the Divisional Headquarters. Supporting staff officers of similar titles worked below the principals at headquarters. The system was sound and worked when properly populated but it got off to a very shaky start when the BEF was first committed, and the general staff must bear the blame for this. Surgeon General Woodhouse, the DMS, was shunted off to the Lines of Communication and Corps Commanders didn't want a DDMS at first. As events unfolded, the proper arrangements came into being but not before there were distinct troubles in the field medical system. As the Army expanded, we ended up with DGAMS going to GHQ as DGMS and another DGAMS being appointed back at home as you have already heard.



So on 4 August 1914, Britain declared war and in accordance with long prepared plans it mobilized and proceeded to deploy an expeditionary force, the BEF, of six infantry divisions, one cavalry division and an independent cavalry brigade. Initially only four infantry divisions were deployed to France, the remaining two kept in reserve for home defence but soon after battle was commenced, the fifth division was sent out and by the time the scene had shifted to the Marne, the sixth division was engaged. There were to be more reinforcements as Regular units returned from overseas duty around the Empire.

BEF Medical Order of Battle Aug 1914

1 Division	1, 2, 3 Field Ambulance
2 Division	4, 5, 6 Field Ambulance
3 Division	7, 8, 9 Field Ambulance
4 Division	10, 11, 12 Field Ambulance
5 Division	13, 14, 15 Field Ambulance
6 Division	16, 17, 18 Field Ambulance

This was the medical order of battle for the BEF. In support of each infantry division were three field ambulances. In support of the cavalry division were four cavalry field ambulances.

BEF Medical Order of Battle Aug 1914

1 Cavalry Division 1, 2, 3, 4 Cavalry Field Ambulance

5 Cavalry Brigade 5 Cavalry Field Ambulance

Army Troops

19, 20 Field Ambulance

Lines of Communication

1, 2, 3, 4, 5, 6 Clearing Hospital

1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12 Stationary Hospital

1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12 General Hospital

1, 2, 3, 4, 5, 6 Ambulance Train, 2 x sanitary sections

Convalescent Depot, 3 x hospital ships

There were two additional field ambulances for Army troops, 19 Field Ambulance was quickly re-roled within a newly created 19 Infantry Brigade formed from the Regular infantry battalions that had secured the Lines of Communication initially. There was a clearing hospital for each of the divisions of the force albeit that they would be controlled at a higher formation level. There were twelve stationary hospitals and twelve general hospitals plus six ambulance trains and three hospital ships and two sanitary sections.

BEF Medical Personnel Requirement

Medical Officers	800
Quartermasters	56
Other Ranks	9000
Total	9856
QAIMNS	528

The total manpower required for these units is here - nearly 10,000 men and from the figures I showed you earlier, short of a couple of hundred medical officers. Well, volunteers for temporary commissions in the RAMC came quickly from near and far. After a quick interview with the DG or his deputy it was off to your tailors for fitting out with uniform, off to your gunsmith for a pistol if you were so inclined (the RAMC was not armed during this war) and processing to your new unit as quickly as possible. There was no training, as, after all, they were medical men recruited to do a medical job. However, later on proper medical training for temporary medical officers was devised but in a somewhat abridged version of the pre-war model. Such officers were sent to the hospitals and the more experienced medical officers were then used to fill up the RAPs and field ambulances. And, unsurprisingly, they replaced battle casualties amongst them also. But there were also some highly experienced volunteers such as Ronald Ross, the identifier of the cause of malaria and who had previously served in the Indian Medical Service. It is also germane to point out that the Special Reserve fully populated 18 Field Ambulance in 6 Division.

Later Medical Order of Battle Additions 1914

7 Division	21, 22, 23 Field Ambulance
8 Division	24, 25, 26 Field Ambulance (1/1, 1/2, 1/3 Wessex Field Ambulance)
27 Division	81, 82, 83 Field Ambulance (1/1, 1/2, 1/3 Home Counties Field Ambulance)
2, 3 Cavalry Division	6, 7, 8 Cavalry Field Ambulance (6, 7 from TF volunteers, 8 from Yorkshire Mounted)

There were to be more medical reinforcements to the BEF during 1914 and these are shown here. Three more infantry and two more cavalry divisions were deployed and required their own medical units. You should notice here that the RAMC ran out of Regular and Reserve personnel by the time 7 Division was deployed and the territorial force stepped into the breach to fill the gaps. Territorial divisions sent to India to relieve infantry battalions over there hadn't taken their field ambulances with them and this provided the first couple of tranches. So the initial lot were in action by November 1914 in parallel with territorial battalions such as the Glasgow Highlanders and the London Scottish in order to cover losses within the BEF's Regular Divisions.

Later Medical Order of Battle Additions 1914

7, 8, 9 Clearing Hospital
(7 from 1/1 West Riding Clearing Hospital)
13 Stationary Hospital
13, 14 General Hospital
7, 8 Ambulance Train
Mobile Hygiene Laboratory
Mobile Bacteriological Laboratory
1, 2, 3 Motor Ambulance Convoy
Divisional Sanitary Squads

There was some additional hospital cover deployed to bring up the bed total in theatre to about 10,000. Note the Territorial Force played its part with a clearing hospital but the really big advance was the creation of the first three Motor Ambulance Convoys and in addition to the motor ambulances which were deployed to the field ambulances, these provided vital enhancements to casualty evacuation. The divisions got their own sanitary squads and as the situation developed with wounds, mobile laboratories were built and deployed. In their wake came Sir William Leishman to investigate the pathology of the new wounds. Sir William, of course, was the discoverer of Leishmaniasis and a future Director General.

Territorial Force

Fourteen Infantry Divisions

Each three field ambulances

Fourteen Mounted Brigades

Each one Mounted Brigade Field Ambulance

Twenty three General Hospitals

24th formed August 1914

Fourteen Clearing Hospitals

Two Sanitary Companies

The 1908 Territorial Force was designed for home defence primarily but there were putative plans for its use as a second echelon to an expeditionary force. The problem it had was with the terms and conditions of service where individuals could opt for or decline overseas service in the event of an emergency. When 1914 came along this opting in was sporadic across all arms.

14 Territorial Divisions

Highland	1 st London (City)
Lowland	2 nd London (County)
Northumbrian	Home Counties
East Lancashire	East Anglian
West Lancashire	Wessex
North Midlands	Welsh
South Midlands	West Riding

Later numbered in the order they were deployed overseas 42 Div onwards

The Territorial Force was composed of fourteen regional infantry divisions and had sundry medical elements.

TF Field Ambulances

Three per division

Identical, at war, to Regular equivalent

Named after Division

eg 1st, 2nd, 3rd Highland Field Ambulance

Second and third echelon

eg 2nd/1st, 3rd/2nd Home Counties Field Ambulance

Retained these titles when parent division and constituent brigades numbered

Each division was established for three field ambulances of identical design to their Regular counterparts and named after the region so you see first, second and third highland field ambulances. When war came the territorial force was instructed to create and train its own second, and sometimes third, echelon units and the impact on the RAMC is shown. These titles were retained on deployment despite the parent divisions being numbered eg East Lancashire Division became 42nd (East Lancashire) Division on deployment to Egypt in 1914. The Territorial Force was administered by County Associations and had its own Regular RAMC manned training schools.

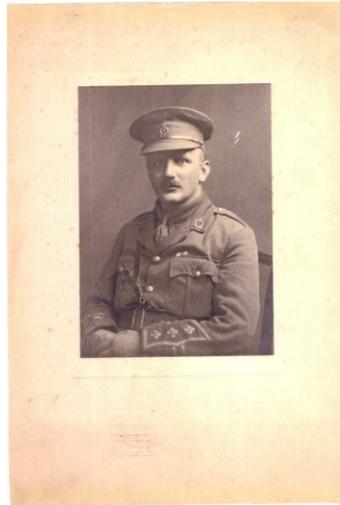
Extract from the Journal of the RAMC

November 1914

John Macmillan:

To be Lieutenant
28 September 1914

5th London Field Ambulance



I have slipped into view a picture of my great uncle John, a typical territorial! Joined the 5th London Field Ambulance at Woolwich in 1914 as a Lieutenant – this was the standard rank for a newly joining medical officer, Regular or Territorial, at that time. He deployed to the Western Front with his unit and its parent division, 47th (2nd London) Division, in March 1915, later being awarded an MC and by the end of the war was commanding his unit as a temporary lieutenant colonel and finally awarded a DSO for his leadership before returning to civilian life in 1919.

14 Territorial Mounted Brigades

Highland	Welsh Border
Lowland	South Wales
Yorkshire	1 st South Western
Notts & Derby	2 nd South Western
North Midland	Eastern
1 st South Midland	South Eastern
2 nd South Midland	London

Each supported by their own Mounted Brigade Field Ambulance modelled on the Cavalry Field Ambulance

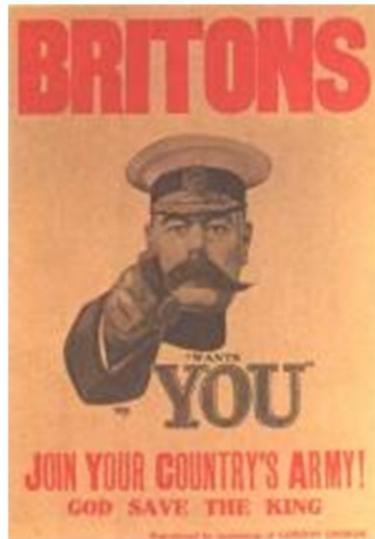
The old yeomanry had become fourteen mounted brigades and each of these had a mounted brigade field ambulance, constructed as per a Regular cavalry field ambulance. Much happened to these units, initially used for home defence and some converting to cyclist units whilst most ended up overseas where they were in some cases dismounted or otherwise reformed.

TF General Hospitals 1914

1 st Eastern	Cambridge	1 st Scottish	Aberdeen
2 nd Eastern	Brighton	2 nd Scottish	Edinburgh
1 st London	Camberwell	3 rd Scottish	Glasgow
2 nd London	Chelsea	4 th Scottish	Glasgow
3 rd London	Wandsworth	1 st Southern	Birmingham
4 th London	Denmark Hill	2 nd Southern	Bristol
5 th London	Lambeth	3 rd Southern	Oxford
1 st Northern	Newcastle	4 th Southern	Plymouth
2 nd Northern	Leeds	5 th Southern	Portsmouth
3 rd Northern	Sheffield	1 st Western	Liverpool
4 th Northern	Lincoln	2 nd Western	Manchester
5 th Northern	Leicester	3 rd Western	Cardiff

Around the country were also twenty-four general hospitals as shown. On mobilization, they set up hospitals nearby and these endured to the end of the war. Another two were formed in 1915. They were an important part of the matrix of new hospitals which sprang up in UK to sustain the mass of war wounded which had come back from the front. They also provided hospital care for Kitchener's New Army and those troops used for home defence. Eventually, in April 1917, elements of seven of them were deployed to the Western Front as general hospitals. Finally the Territorial Force had only been charged with raising clearing hospitals in 1913. All fourteen were named after their parent regional division for example the Northumbrian Clearing Hospital. They were all deployed as Casualty Clearing Stations from 1915.

Kitchener's New Army



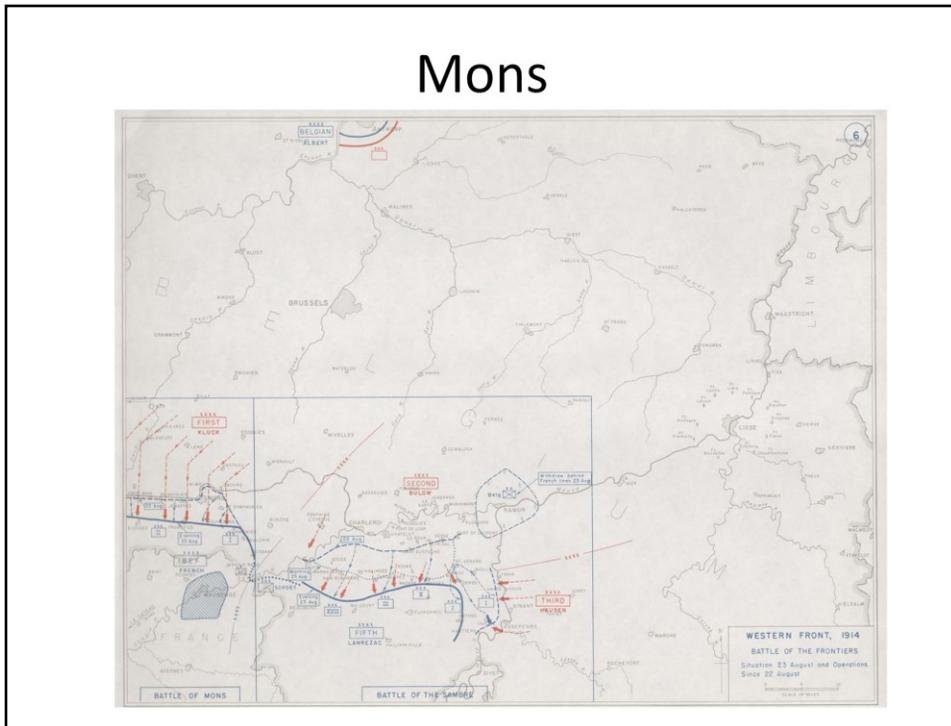
Lord Kitchener had become Secretary of State for War the day after War was declared. He foresaw a long war and the requirement to raise an Army to continental standards. He had just returned from Egypt where he was based and had previously been in charge in India. He knew little of the Territorial Force and was dismayed by the low incidence of commitment for overseas duty within the Territorial Force. So he devised a new volunteer army which would be raised directly by the War Office – the New Army. The tide of volunteers was massive and sustained. There were brought together as a number of mirror images of the BEF that is in tranches of six infantry divisions, which became known as K1, K2, K3, K4 and K5. Each division was to have three field ambulances and, of course, the combat units were to have their RMOs. All around Britain camps were created to house these new armies and these would pose their share of sanitary problems which had to be dealt with and there were to be countless medical examinations of recruits. The Kitchener divisions were numbered 9 through to 41, less 27, 28 and 29 which were the later Regular ones created from units returning from abroad. Thus a total of 90 field ambulances would be created. Six of these came from the territorial force mainly in West Lancashire. The training of the medical volunteers was a large challenge to the RAMC Depot and it was massively expanded to meet this with personnel quartered and camped all around Church Crookham and Tweezledown race course. When the New Army divisions started to be deployed in 1915 and 1916, frequently they didn't meet their field ambulances until just prior to deployment.

Field Ambulance marching off to War



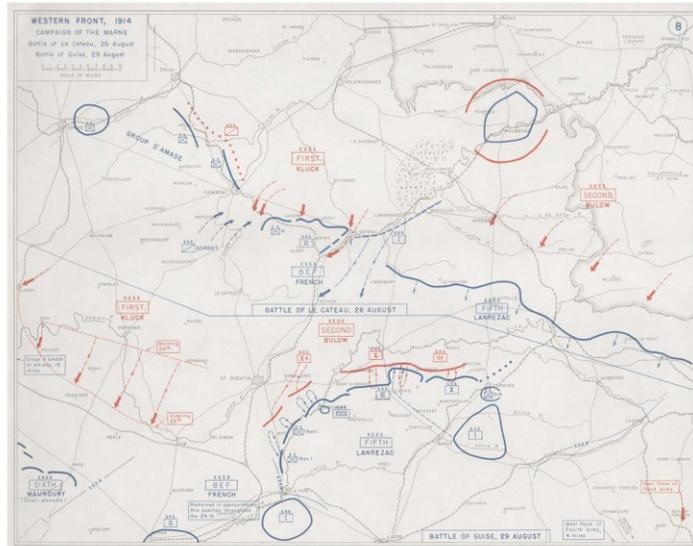
Let us turn now to the battlefield. The Base and its hospitals were set up at Rouen, Le Havre and Boulogne. An advanced base was established at Amiens. The whole deployment from UK garrisons to France went without a hitch. The BEF set off smartly to its concentration area near Mauberge and from there began its advance in Belgium

Mons



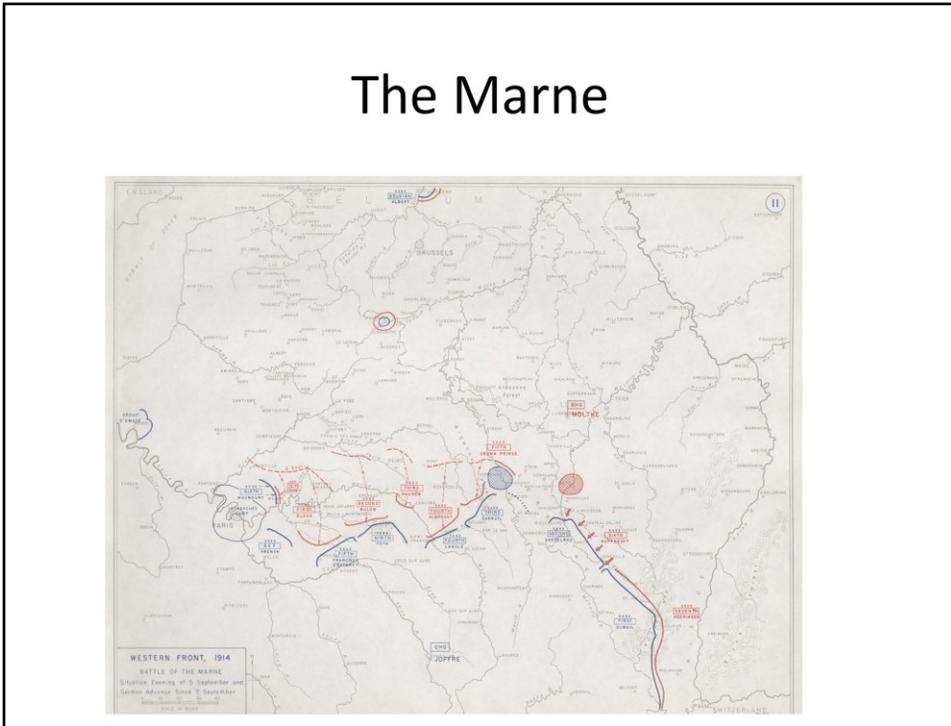
towards Mons where, on 23 August, it stumbled into the advancing German Army. Sir John French, the commander, had no idea the Germans were there nor at what strength. The second Corps bore the brunt of a defensive fight at Mons and it should be noted that each of its two divisions, the 3rd and 5th, only had one of their three field ambulances up with them. The remainder were en route. The more lightly challenged first Corps, on the right flank had all its six field ambulances in place but there was no DMS in place at GHQ, located at Le Cateau, to finesse mutual support. The battle lasted a couple of days and when it became apparent the degree to which the BEF was outnumbered, and that flanking French formations were moving back, a decision was made to withdraw.

Le Cateau



This should have been a big step backwards but General Smith-Dorien, commanding the second corps made a stand at Le Cateau which slowed down the Germans and eventually the BEF broke clean and made its way down to the River Marne, east of Paris where the great stand, side by side with the French Army, was made on 6 September and which repulsed the German attack.

The Marne



By the time of Le Cateau the second Corps had all its field ambulances in place but behind them, all was certainly not going to plan. There had been difficulties in setting up the ambulance trains and the setting up of the clearing hospitals was not done effectively, then they were withdrawn prematurely. Ad hoc French trains had to be employed. Communications on the battlefield and the challenges of a fighting withdrawal also impaired casualty evacuation.

Ambulance Train

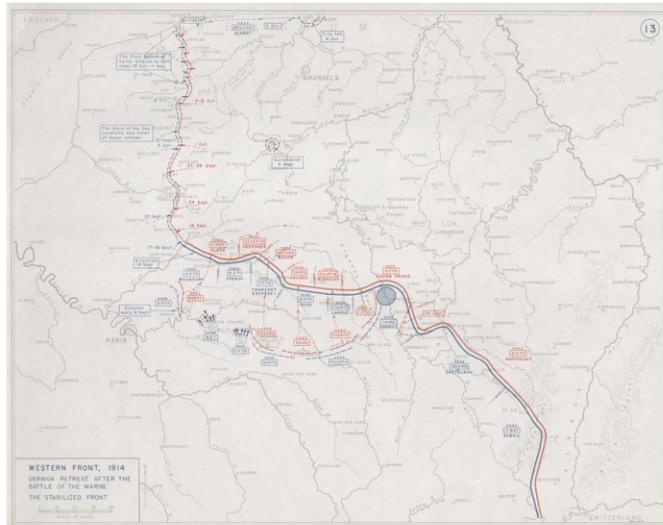


Everything was further confounded by a decision to move the base around to the Atlantic ports such as St Nazaire and the forward base to Le Mans. This was due to a worry that the Germans might break through right to the channel and it made better sense, given the direction of the BEF's withdrawal, to reset the lines of communication around the south of Paris. This managed to kick in by the battle of the Marne and the ambulance trains started to roll. The closure and redeployment of the general hospitals did little to support the BEF as a consequence during the withdrawal.



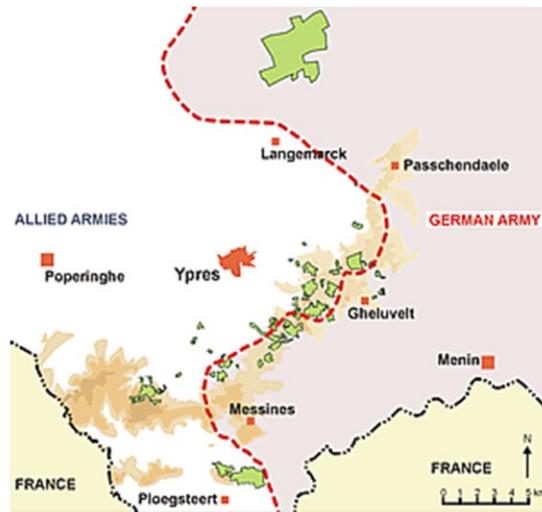
Many early casualties were placed with local French hospitals and became prisoners of war. There were long delays in getting casualties back to the general hospitals and then many of those were transferred back to UK before surgery took place. These were not the bullet wounds of the open dry veldt in the Boer War which could be managed by conservative treatment, these were fragment wounds from high explosive artillery munitions and mired with the heavily manured soil of the area. The BEF was reinforced by Leishman as I said earlier and also by a couple of experienced and eminent surgeons, George Makin and Anthony Bowlby, territorials both and Boer war veterans, who arrived as consultant advisers to the DMS. The lessons were quickly learned about earlier surgery, about debridement of wounds, delayed primary suture and the avoidance of gas gangrene. Tetanus anti-toxin became a short supply item quickly and alternative sources of it had to be found.

Aisne



On 12 September, the great counter attack against the Germans took place up to the River Aisne and here we see the start of siege or trench warfare and its consequences. The Germans defended the Aisne stoutly and effectively so this triggered off flanking movements which became the race to the sea in the north.

1ST Ypres



Some British Troops marched there, others went by train, but the end result was a mighty contest for the town of Ypres on 14 October and which lasted well into November. Here the BEF fought itself almost to destruction but saw off the Germans. It would need the territorials and the new armies to fight the rest of the war but an awful lot of expertise in staff work, potential leaders of the new formations and tactical nous was lost with its inevitable knock on effects on future years on the Western Front.

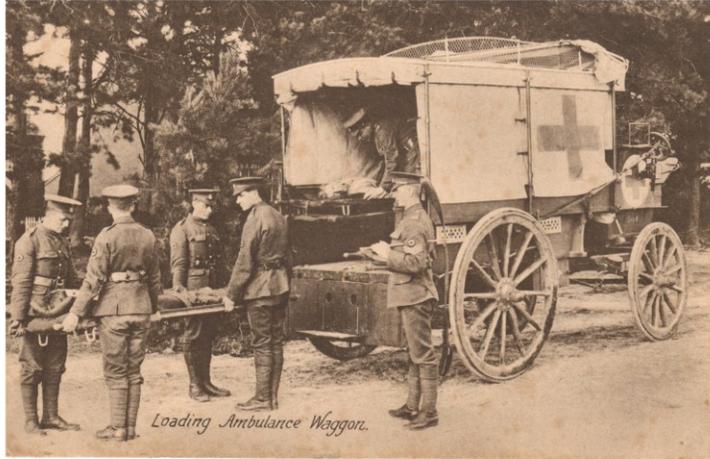
Stretcher Bearer (SB) Parties



THE WORK OF THE ROYAL ARMY MEDICAL CORPS ON THE BATTLEFIELD.
R.A.M.C. orderlies gathering the wounded from a trench after a severe engagement.

The Base was brought back to Rouen and its environs for the battle of Ypres and the lines of communication shortened as a consequence. The clearing hospitals started to make their contribution and the ambulance trains became effective.

Mk 5 Ambulance Wagon



The link between dressing station and clearing hospital was established and resourced through the motor ambulance convoys and this was to remain the case throughout the rest of the campaign.

Motor Ambulance



Makin and Bowlby had spotted also that the Clearing Hospital was the real pivot of surgical care in this battlefield and plans were afoot to reinforce them with more surgical teams and nurses. They would become casualty clearing stations early in 1915 and be a vital part of the medical services during the next period of trench warfare. There is an irony here as the name change was deliberate to avoid criticism of the clearing hospital as it didn't function as one that did more than provide an interim holding facility yet as soon as that occurred, the units became genuine hospitals with surgeons, nurses and diagnostic equipment as the necessary response to trench warfare kicked in.



Before I finish, and sadly I haven't enough time to pay tribute to both the Indian Corps which arrived during the race to the sea, and which contained a number of RAMC officers, or the home structure and the development of additional hospitals or hygiene, I must say a couple of words about two of our heroes.

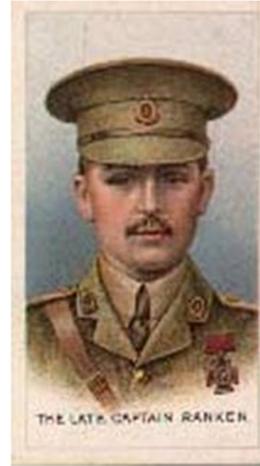
Capt Harry Ranken VC RAMC

RMO 1st King's Royal Rifle Corps

Hautvesnes, Belgium

19-20 September 1914

Died of his wounds



The first RAMC VC of the war was awarded to Harry Ranken who died earning his award. He was regimental officer to a regular battalion of the King's Royal Rifle Corps and during the race to the sea he met his fate.

Lt Arthur Martin-Leake VC and Bar RAMC

His first VC in S Africa 1902

With 5 Field Ambulance

Zonnebecke, Belgium

29 October–3 November 1914



Our second awardee was serving with 5 Field Ambulance of the second division during the first battle of Ypres. This was quite historic. Arthur Martin-Leake was awarded his second VC, the first time ever this had happened, and to this day there are only two others, one of whom was RAMC as well, to whom this had happened. He survived this and many other ordeals during the war and left the RAMC at the end of his contract in 1917 to live to a ripe old age and be buried in his native Hertfordshire. Martin-Leake had earned his first VC in the Boer War in 1902 as medical officer with the South African Constabulary. He only joined the RAMC when the Great War was declared and he was passing through Paris on his way home from India.



So I think I have taken you as far as is possible tonight and will close with a look to 1915.

I mentioned earlier that changes were afoot with the clearing hospitals. In March 1915 shell shock was first described in an article in the Lancet by Captain Myers RAMC. Ill-health through trench life became prevalent such as Trench Fever, Trench Foot and Nephritis. Blood transfusion developed and the introduction of the Thomas Splint started to reduce the subsequent deaths of casualties with fractured femurs, indeed acute orthopaedic surgery emerged as a speciality. You should have a talk on all aspects of trench life at some stage. The helmet wasn't adopted until 1916 but by then many territorial and new army divisions had literally been blooded in combat. And we can't ignore the first use of gas in the spring of 1915 by the Germans and the subsequent use by ourselves. Countering gas was ably led by Colonel Horrocks, also editor of the Journal of the RAMC. And, of course, adventures in the Dardanelles, Mesopotamia, East Africa, Egypt, Palestine, Salonika and Italy were all to come.

Postscript

The world wasn't built in a day,
And Eve didn't ride on a bus,
But most of the world's in a sandbag
The rest of it's plastered on us.

So I hope now that this postscript will set the tone for the rest of your WW1 deliberations,

most certainly it was to apply to the Western Front and for a shorter period of time at Gallipoli. It is from the Wipers Times:

The world wasn't built in a day,
And Eve didn't ride on a bus,
But most of the world's in a sandbag
The rest of it's plastered on us.



So to finish where I started, that was is Her Bright Smile Haunts Me Still again but in slow time as it was recycled as our Slow March in 1950 after we had adopted our current Quick March, Here's a Health unto his Majesty, in 1948. For completion of this little bit of our Corps history, our third march, a breezy Bonnie Nell was adopted in 1923, replacing Her Bright Smile Haunts Me Still and this lasted, of course, until 1948.

Questions?

I am happy to take your questions.

Delivered: 21 February 2014 at Millbank. 1 Hour.