

## The art of medicine

### Doctors at war

Service in the military can be a testing experience for doctors. A particularly jaundiced account of a clinical and managerial posting in World War I was provided by Lt Colonel Charles Myers, consultant medical psychologist to the British army in France. Prompted by the outbreak of war, in 1939, he sought to warn others about the pitfalls of military medicine in a book entitled *Shell Shock in France 1914–1918*. "On the 31 March 1919", Myers recalled, "I was demobilised, not altogether unwillingly. For I was by now tired of the many difficulties and frustrations which had beset me in my four and half years' work. Before leaving the army, I appealed to the Director-General of Medical Services for some recognition on behalf of certain junior medical officers of the neurological service who to my knowledge had done brilliant and strenuous work in a most unostentatious manner [no distinctions were forthcoming]... With this farewell visit ended my medical work in the Army of the last Great War." What was it about the military that left Myers so disillusioned and what, if anything, can be generalised from his experience?

When a doctor agrees, or is told, to enlist, the context in which he practises medicine is transformed. As a civilian, he is taught to serve the interest of his patient with the proviso that he does no harm. By contrast, the army doctor is presented with a very different set of priorities. Major Dugmore Hunter, a World War II veteran, observed of the military psychiatrist: "his patient is the army rather

than the individual". Indeed, the motto of the US Army Medical Corps is "to conserve the fighting strength". This priority may require the doctor to act as a gatekeeper controlling the flow of injured or sick from the front line. Alternatively, he might have to decide who will go back to combatant duty and possible death and who will be downgraded to a safer posting in the rear. On the surface, this military agenda may seem to simplify matters for the clinician. The task of being a national leader, Churchill believed, was far simpler in wartime than in peace because everything could be subjugated to a single over-riding goal: victory on the battlefield. Although a doctor might also adopt this strategy, it inevitably brings him into conflict with his civilian training and ethical system. For the natural wish of the individual soldier to preserve his life might be incompatible with the military aim of recapturing territory or defeating an enemy. A doctor might fudge a diagnosis to excuse a soldier from battle, but he will do it at the expense of the war effort and the possible sacrifice of others.

Educated in a profession designed to save life and relieve suffering, it might seem strange to join an organisation that routinely trains its members to kill or at least inflict harm on others. And with a hierarchical structure and a culture of overt toughness, the armed forces may not be the first career that a newly qualified doctor considers. Despite any reluctance to enlist, doctors in general have proved remarkably successful once in uniform. The Royal Army Medical Corps is the most decorated unit in the British army, with 31 Victoria Crosses; two of the three soldiers awarded the medal twice were doctors: Captain Noel Chavasse and Captain-Surgeon Arthur Martin-Leake.

The dramatic expansion required of the armed forces during the two World Wars resulted in the rapid recruitment of most young or recently qualified doctors. Regular army doctors often found themselves seconded to administrative duties, leaving large numbers of clinical posts to be filled by recent recruits. Distinguished consultants were drafted into the military at a higher rank to provide supervision and advice. Philip Gosse, who served with 69 Field Ambulance during World War I, observed that temporary commissioned officers were often "better qualified and more experienced in the technical side of medicine, surgery or public health than the regular officers under whom they served", allowing them a certain latitude in the observance of orders. Indeed, those who found it difficult or were unwilling to assimilate military culture were often categorised as "civilians in uniform". By contrast, other doctors wholly committed to the war effort declined to enter the armed forces themselves. Sir Archibald McIndoe, who effectively ran plastic surgery

**The printed journal  
includes an image merely  
for illustration**

for the Royal Air Force at East Grinstead, remained a civilian throughout World War II. Nicknamed "The Boss", he was an inspirational but autocratic leader and doubtless felt that formal membership of a hierarchical organisation might have limited his freedom of action.

Edward Mapother, a surgeon and psychiatrist in the British army, described military doctors in safe jobs as the "fire-eaters of the field ambulances" because of their inappropriate, overt aggression. Tom Main, a psychiatrist in World War II, believed that this behaviour was a by-product of "bitterness and impotence, anger, and—if one's own job is not heroic or important enough—[leading] to defensive swashbuckling or a guilt-ridden compassion for others who have to undertake risks of death in battle". Having been invalided from France, Siegfried Sassoon attended a medical board in London to assess his fitness for duty. There he encountered a temporary Captain who tormented military patients with threats of a rapid return to action. "I was told afterwards", Sassoon recalled, "that officers had been known to leave the doctor's room in tears... [T]hough his power over the visiting patients was brief and episodic, he must have derived extraordinary (and perhaps sadistic) satisfaction from the spectacle of young officers sobbing and begging not to be sent back to the front."

To address the cultural gap that existed between the military and civilians, some nations set up medical schools for their armed forces. In 1707, for example, Peter the Great founded the Moscow Military Hospital, which included a medical school for 50 students. Graduates from the Military Medical Academy included Nikolai Pirogov, who developed methods of general anaesthesia for the battlefield and a triage system for the evacuation of the wounded from the Crimea, and Ivan Pavlov, who developed the nervous reflex theory. In 1926, the Greek army opened a dedicated military medical school in Athens, which transferred to Thessaloniki 20 years later and widened its remit to include the training of dentists, pharmacists, veterinary surgeons, and even lawyers. As recently as 1972, the US government opened the F Hébert School of Medicine at the Uniformed Services University of the Health Sciences in Bethesda, MD. With an entry of 165 students a year, the curriculum is 700 h longer than that of most civilian medical schools and includes tropical medicine, disease prevention, and field exercises.

By contrast, the British army recruited newly qualified doctors from civilian medical schools and then sent them for training at its own postgraduate college, established in 1863 at the Royal Victoria Hospital, Netley. However, deficiencies revealed by the Boer War prompted its removal in 1902 to dedicated lecture facilities and laboratories at Millbank where it was hoped that proximity to prominent teaching hospitals, such as St Thomas's Hospital, would raise standards of clinical practice and research.

Military medical schools had the advantage that specialist topics, such as hygiene, tropical medicine,



Kashmiri earthquake survivor at US mobile army surgical hospital, Muzaffarabad, Pakistan, Oct 31, 2005

and logistics were included in the core curriculum and the student introduced to military culture from the outset. However, by forcing potential recruits to make an early career decision, they limited the range of doctors who might be attracted to this path. There was also a danger that their relative isolation divorced them from mainstream developments in medicine and from the wider medical community.

Although any ethical dilemma that a doctor might feel about joining the forces can more easily be over-ridden in times of national crisis such as the threat of invasion, an era of relative peace punctuated by foreign wars and peacekeeping operations can also present practical problems for medical recruits. Today, the British army has a shortage of doctors in general practice and some specialties despite financial incentives. It has become an issue of both recruitment and retention as military doctors are hit by the growing tempo of tours to Iraq and Afghanistan. Not only have the demands on the armed forces increased, but cuts in numbers are such that those who remain are forced to rotate more frequently with consequent disruption to families. However, "command" appointments—postings to operational units rather than base hospitals—appeal to doctors seeking challenge and adventure. Yet the younger doctor with fewer family ties who seeks an overseas posting to a combat zone inevitably lacks the clinical experience of his older colleagues. The issue for the military remains, as in the past, how to establish links with the civilian world to encourage entry but also to devise ways of keeping their practitioners once the encumbrances of domestic life exert an influence.

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#### Further reading

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