MORALE AT THE BASE

BY

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MORALE, that fleeting quality which is the constant care of all who take up arms, is a measure of the attitudes and ideals of individual soldiers. It exists from the firing line to the remotest convalescent depot, but derives, as it must always do, from personal emotions. It is conditioned by many circumstances, such as the efficiency of individual units, confidence in the higher commands, and indeed the over-all progress of a war. These are the factors that govern, in the long run, the spirit with which individuals set about their duties whatever they may be, and morale, if it is to serve an army well, must be a bond uniting all ranks in a common endeavour.

Writing as one who is called upon to serve only in times of national emergency and whose overseas experience in war time is limited to three and a half years in base hospitals in the Middle East, I am in no position to pass judgment upon morale in forward areas, nor am I able to overlook the incompleteness of my military experience. However, constant contact with troops who have occupied positions of danger can hardly have failed to leave an impression that morale at the front and the base, although basically the same, has important differences. Perhaps I might be allowed to indicate where the differences lie and to consider some of the difficulties which face the staffs of general hospitals, as seen against the limited background of service in the Middle East, if a high morale is to be maintained.
"Morale up in front is terrific. At the base it is dreadful." This was said by a combatant officer on arrival at our base hospital in Palestine. After weeks of preparation, his unit had moved into position at El Alamein and then, a few days before the battle, he had the misfortune to develop jaundice. He spent the next two days and nights in various types of transport and eventually reached us in the hours of darkness. Obviously, he had many reasons for feeling resentful. Perhaps his reactions during evacuation can be surmised. When he reached a field ambulance, he probably found the general atmosphere to be much as he expected. Being still within the brigade area, the personal factor persisted. Indeed, he may well have had friends in the unit, or at least have known its number and reputation, and the principles of quick recovery or evacuation were in keeping with the tempo of warfare. On arrival at a casualty clearing station, and seeing nursing sisters for the first time, he probably realised that he was becoming less of a soldier and more of a patient. He may have begun to wonder not so much when but whether he would be able to regain his unit. Then, after surviving the rigours of an ambulance train, he is admitted to a general hospital far away from the zone of active engagement. Having been deprived of his local loyalties, he finds himself in an entirely new environment, peopled for the most part by those who, by reason of age, infirmity or special qualifications, are best employed there.

This incident, which refers to a lull between conflicts when the lines of communication were unimpeded, illustrates the changes in outlook that a casualty may undergo when passing through the standard medical units in their classical forms. If the commitments of our Corps were always as simple as this, doubtless the factors influencing morale could be enumerated in an orderly sequence. Unfortunately, warfare is often much more complicated, with units moving to and fro and having no clear demarcation between front and rear. General hospitals, with which we are primarily concerned in this context, can rarely be erected in ideal sites and may well be flooded with casualties before they are fully established. In addition, the staff may be under strength or substantially reinforced from non-British sources. Whether of 200, 600 or 1,200 beds, they are designed to function with their proper number of beds fully staffed. If the number is exceeded or the staff depleted, efficiency suffers. All these variables are bound to influence morale.

Reverting to the officer with jaundice, we should constantly ask ourselves what he expects from a military hospital. Perhaps kindness and efficiency are his greatest needs; kindness because he is ill and efficiency to restore his health and confidence. There is little room for discipline in the accepted sense in hospitals. Instead, if a high standard of efficiency be maintained, the rules have a habit of looking after themselves. This, of course, applies to all good army units, in that enforced discipline is necessary only when efficiency fails. Regimentation, which is by no means the same as discipline, is a function of the medical services. It is ordinarily initiated in convalescent depots, but may be started in the convalescent wings of hospitals. We may assume that our officer patient was quick in forming impressions of our unit. His remarks about morale suggest that he did not approve our arrangements in the reception department, but it is more likely
that they reflected the state of his own. Nevertheless, impressions are made rapidly, and I well remember our feelings when his convoy came in. We had arrived from Britain a few months before and had immediately been distributed among various established military hospitals in Palestine. We had then been given our own hospital and were thrilled to be carrying out the purpose for which we existed. Our main anxiety was that we might fall short of the standards set by neighbouring hospitals with longer experience, so that our morale, which I cannot believe was other than high, was tinged with brittleness. Our shortcomings were soon recognised by the casualties in the first convoys, but, somewhat to our surprise, we were treated as long-lost friends rather than as the greenhorns we knew ourselves to be. Our tents, many of which were flattened by a sudden sandstorm, were quickly secured with the assistance of the more able-bodied casualties. In return, we were held responsible for maintaining an efficient service, especially in the distribution of hot meals and in medical care.

The proper relationships between medical officers and combatant troops, whether within hospitals or without, are a most important determinant of morale. It is made no easier in time of war when civilians comprise the bulk of the army. Most civilian doctors live within the environment of their practices and take people as they find them. Any authority they may have to exercise involves individuals, with whom they deal one at a time. Within limits, they have a wide responsibility and their decisions are rarely questioned. Amongst their many early reactions to army life, they are likely to remember that they possess a specialised and essential skill and, coming from a hardy stock as exemplified by many illustrious names in the more rugged forms of sport and endeavour, they feel that they are as good as the next man. Both reactions are natural and true, but armies exist to win battles and the man who counts is the man with the gun. Medical officers, for all their worth, can never play more than a subsidiary part, but any frustration they may feel at times is more than offset by the opportunities they are given when they are called upon to act. They must learn the lessons of organisation and delegation. When casualties arrive, their medical skill will be quickly, and probably accurately, assessed. They may have to learn almost overnight the routine management of diseases they have not previously encountered, and individual patients will not be slow to detect and comment upon any deviation from standard treatment. A rush of casualties may easily militate against a high standard of treatment, in which case good organisation is essential. In the last weeks of 1942 we regularly had three or four convoys of one hundred to three hundred men in and out each week. There was a waiting list of about four days for the convalescent depot and about a week for the local transit camp. In common with the other general hospitals, we had to anticipate discharge dates for the lightly disabled and ensure that the more seriously ill were retained and cared for by those best qualified to do so. If a happy compromise between organisation and medical skill can be achieved, the morale of our patients will be well served.

Hardly less exacting than the morale of the patients is that of the hospital staff. Medical officers tend to be individualists and are notoriously difficult to
control. Their skills derive principally from civilian experience and their powers of organisation, both natural and acquired, are not always related very closely to their ranks, but, in common with others, they are happiest when they are fully occupied and faced with adversity. The morale of nursing officers also varies with the extent of their nursing commitments. The responsibility of taking eighty sisters, of whom fifty were under the age of thirty, on a two months’ voyage around the Cape and then distributing them among four hospitals in Palestine is one that cannot be easily forgotten. Perhaps the outstanding recollections are that above all the matron must be properly accommodated and cared for, and that the most imperturbable sister will be reduced to a state of despondency if she is separated from her more intimate possessions.

In considering the morale of other ranks, the static nature of general hospitals must be remembered. They may move from time to time, and often have to operate in inconvenient places. Sometimes they receive their early casualties within days of arrival, but they are likely to require at least six weeks before they are able to function smoothly and frequent moves should not be lightly undertaken. The problem is not so much the conditions of work, which are dictated by medical commitments, but the facilities when off duty. Places of entertainment, bathing beaches and travelling concert parties may or may not be available. If they are not, and they are by no means essential, that remarkable invention the “regimental institute” is able to provide most of the needs. The selection of a suitable P.R.I., often the second-in-command, is a matter of great importance, for he controls, or should control, sport, entertainment and extra messing. These three are of roughly equal importance, and such funds as are available can equitably be distributed among them in equal amounts. By a process of trial and error, we found that our purposes were best served by holding a meeting of the whole unit three-monthly, at which the P.R.I. presided over a free discussion and the committees for sport, entertainment and extra messing were elected or re-elected. The composition of these committees, which represent all ranks for the purpose of benefiting other ranks, would seem ideally to be an officer, a member of the sergeants’ mess, a corporal and two privates, in order that a fair balance in voting may be maintained. Properly run, the committees can go a long way towards ensuring a happy unit.

No account of morale can be complete without mention of the Chaplains’ department. Many tragedies are enacted in hospitals and the guidance and assistance of sympathetic parsons can be of inestimable benefit to both patients and staff.

Reminiscences are inclined to be boring, and any major conflict in the future is likely to bear little resemblance to the last war, but basic problems of morale will remain unchanged. Others will be added—for example, fear of the unknown in the event of nuclear explosions. To combat these, reliance must be placed upon the spirit with which individuals carry out the duties they have been taught and of which they are capable, upon unit efficiency and, in the last resort, enforced discipline. The motivating spirit is the complex of all the elements already discussed, but efficiency derives principally from training. The proper
distribution of trained personnel will raise very great difficulties during the first vital six months. At present we have a vast army of young and youngish men who have served for not less than two years with the colours, but the only soldiers who are properly trained are regulars. In field medical units, whether at the front or rear, there are four vital posts, namely the commanding officer, the company officer, the quartermaster and the regimental sergeant-major. We should ensure that not less than two of these posts are held by regulars in every unit, and must not allow units to fend for themselves as they had to do in 1939. Morale is so dependent upon training and efficiency that an untrained unit, if it becomes a rabble under pressure, soon becomes a liability.

I cannot close without mentioning morale in the Territorial Army. Although we have our parachutists and front line volunteers, many of us, by sheer weight of years, gravitate towards the base where, in middle age, we tend to occupy the higher ranks, both commissioned and non-commissioned. Our morale is always high, for as long as we attend our parades. We know our colleagues, we have our equipment and within limits we are trained, but we cannot match full-time soldiers for experience. If we are to become efficient rapidly in an emergency, we need a stiffening of regulars. Alternatively, we are useful nuclei from which fresh units can be formed. I think we are worth retaining.

SOME PRACTICAL ASPECTS OF A COMMAND TRANSFUSION SERVICE

BY

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Previous articles in this Journal have described some of the practical aspects of transfusion work in a station hospital (King, 1956) and the organisation of an Army Blood Bank (Lunn & Turk, 1957). A number of official directives are in existence covering the administrative and technical details concerning transfusion. This article is designed to describe how these may be translated into practice, particularly overseas, under peace-time conditions, in such a way as to satisfy the clinician, with his often urgent demand for blood, and the pathologist whose duty it is to ensure that blood issued is safe to give.

ORGANISATION

In the United Kingdom the National Blood Transfusion Service provides hospitals with bottles of grouped blood, banks being replenished at stated intervals or as necessary, and the hospital transfusion service need only be