REORGANIZATION—MEDICAL SERVICES.

By

Major E. A. R. BERKLEY,
Royal Army Medical Corps.

[Received July 24, 1946.]

INTRODUCTION.

In making the following comments and suggestions the writer is handicapped by being unaware of the intentions of H.M. Government with regard to defence in general and the Territorial Army in particular. However, it is clear that apart from the Regular Army and the Regular Army Reserve a “part-time” force is essential to the National Security. It is also clear that the best foundation for such a force, whatever its title may be, is the old Territorial Army whose units have played such a prominent part in the recent war. There is no doubt that the majority of Territorial Officers and Other Ranks who have survived the war, and who are still medically fit, are willing to continue service in a reorganized Territorial Army. There is no need to emphasize their active service experience as a valuable asset when the problems of reorganization and subsequent training come up for consideration.

STAFF.

(A) Formation.—While many of the observations and suggestions which follow would apply with equal force to other branches of the Army, the writer will confine himself to the Medical Services.

It is considered that there are a number of Territorial Officers, Royal Army Medical Corps, with administrative and staff experience in the recent war who would be willing to engage on a permanent basis under the same conditions of service as Regular Officers. The Director-General Army Medical Services should be empowered to sift this material and by careful selection appoint a
number of officers to form a staff under the Director Medical Services, Territorial Army. It is not suggested that these officers, although holding permanent full-time appointments, should be granted Regular Commissions. They should preserve their status as Territorial Officers but the Royal Warrant should be suitably amended so that a form of pension or gratuity would be available for the officer on his reaching the retiring age. The main qualifications of such officers should be:

(a) Mental alertness.
(b) Varied administrative and Staff experience on active service, preferably in more than one theatre of war.
(c) Keenness on military service.

The main advantage of forming a Staff from such officers would be that, having shared the problems and experiences of war in common with their regular colleagues, they are also aware of the problems peculiar to part-time service on a voluntary basis.

(B) Duties.—The duties would fall into two main groups:

(i) Planning and policy.
(ii) Implementation of final plans.

In the early stages, planning and policy would occupy almost the entire working time of the Staff. The Staff should be in a position to assist the Director Medical Services, Territorial Army, in the reorganization plans put forward and be able to report and advise on conditions and problems peculiar to various localities. It is assumed that the County Territorial Associations would be retained and it is essential that efficient liaison by personal contact be maintained with these bodies and the Territorial Army Staff, especially throughout the period of planning. To enable this liaison to be effective it is suggested that a Territorial Medical Staff Officer be appointed to work in each Army Command Area in the United Kingdom. He would visit each County Territorial Association in his area and assess the medical man-power potential within the orbit of each County Association. From the information thus acquired a reasonably accurate estimate of the number of General Hospitals, Field Medical Units and Regimental Medical Officers in each case could be given. To keep these units up to strength it is suggested that, while conscription remains in force, all officers and other ranks shall be directed into the Territorial Army for a minimum period of four years at the termination of their tour of service with the Regular Army. They should be allowed to sign on as volunteers, if they so desire, at the conclusion of their compulsory Territorial Army service provided their service during these four years has been satisfactory. It would be the task of the Command Territorial Medical Staff Officer to keep in constant touch with all medical unit commanders in his area and to assist them in the problems arising out of personnel, equipment and training. By such personal contact much time can be saved and much red tape avoided as the Command Territorial Army Staff would be in direct contact with the Director Medical Services, Territorial Army.
If the United Kingdom is to maintain its place among the nations it is vital that the Army never again becomes the Cinderella of the Services and it is equally vital that the Territorial Army never again assumes the role of poor relation to the Regular Army. To that end it is imperative that the conditions of service, standard of equipment, facilities for training and social functions shall all be of the highest order for the medical services as for the rest of the Territorial Army; otherwise the response to the call for volunteers will be negligible and achievements nil.

The implementation of final plans must of necessity be left until the final plans are completed but it is not inappropriate to indicate here a few pointers from the training and selection of personnel angles.

**Training and Selection—Officers.**

It was most noticeable, especially during the latter stages of the war, that newly commissioned medical officers of the Royal Army Medical Corps were posted to units with very inadequate knowledge of regimental procedure and general military information.

A few examples are given below:

(i) Ignorance of the existence and purport of Part I and Part II Orders.
(ii) Ignorance of Orderly Room procedure.
(iii) Ignorance of their powers and responsibilities as military officers apart from purely medical duties.
(iv) Ignorance of elementary military law and King’s Regulations.
(v) Ignorance of how to salute and whom to salute.
(vi) Ignorance of Mess etiquette.

These and other gaps in military knowledge placed the newly commissioned medical officers at a grave disadvantage when compared with Bearer Officers, Quartermasters and Regimental Officers who had, perforce, to have served in the ranks or had Officer Cadet Training Unit experience before gaining commissions. Consequently, solecisms were frequently committed and efficiency suffered.

Another criticism lies in the selection of officers for duties with various types of units. Every field ambulance commander has had posted to his unit officers temperamentally unsuited for service in the field but who would have done well as G.D.O.s in hospitals. Conversely, many officers ideal for regimental or field ambulance duties dwelt within the comparatively comfortable shelter of hospitals. As a field ambulance commander and as a staff officer the writer experienced many examples of these types of mis-posting and, on one occasion, when commanding an Ambulance Transport in the Bay of Bengal, had two of his seven officers incapable of duty the moment the ship put to sea on account of violent and intractable seasickness. Doctors are, above all men, individualists and each one should be carefully studied before being assigned to special duties if the maximum is to be obtained from available man-power. Any fighting unit commander will confirm that a regimental medical officer who is tempera-
mentally unsuited to regimental life and the handling of men soon loses the confidence of all ranks, however good a clinician he may be, and the efficiency of the unit suffers.

It may be claimed with some justification that with the rapid and vast expansion of the armed forces, widely scattered in many parts of the world, that time did not allow for adequate elementary training and painstaking selection. That is appreciated as far as the conditions prevailing during the recent war is concerned. Now, during the period of reorganization and reconstruction, is the time when machinery can be constructed to obviate the pitfalls mentioned above.

It is suggested, therefore, that a medical officers' Officer Cadet Training Unit be formed and that fresh intakes of medical men should go through a four months' course with the status of Officer Cadets prior to receiving their commission and appearing before selection boards. The objection is of course the time lag, but it is the writer's contention that this would be "ironed out" within two years and the resulting efficiency would more than offset such a temporary disadvantage. With the cessation of conscription a modified course for volunteer Territorial Officers could be developed, but that is not of immediate concern. Even specialists should not be exempt from the Officer Cadet Training Unit as the wider the knowledge of all branches of military activity the less narrow their view when dealing with casualties from front-line units.

Training and Selection—Other Ranks.

A large number of men, having been found unsuitable for various branches of the Army seem to drift into the Royal Army Medical Corps. Men of low medical category and imperfect mental development are all too frequently found among intakes and reinforcements. Many of these unfortunate individuals are posted from unit to unit unwanted and untrainable. They are invariably relegated to menial duties which they perform with marked lack of success. The Royal Army Medical Corps is, or should be, a corps of specialist tradesmen just as much as the Royal Electrical Mechanical Engineers, or any other technical corps. It is true that useful work can be done by men of low medical category provided that they are mentally suited to medical and surgical tasks. It is essential, however, that other ranks for service with field medical units should be of tough fibre, physically and mentally, in addition to having aptitude for, and interest in, their work. Personal and painstaking selection is the only solution to this problem. On the other hand there are many men in Infantry and Royal Artillery Regiments ideal in every way, including inclination, for service with the Royal Army Medical Corps. The machinery for transferring a man from one branch of the Service to another is far too cumbersome and is in urgent need of overhaul. To give one example of many which might be quoted is that of a highly qualified St. John Ambulance man who found himself a gunner and it required fifteen months of persistent and untiring effort to secure his transfer to the Royal Army Medical Corps in which he received rapid and well-deserved promotion.
It will be realized that the criticisms detailed above are not made in a destructive spirit. To summarize, criticisms based on personal experience during the recent war are made on the training and selection of personnel of the Royal Army Medical Corps and the remedies suggested are:

(a) The formation of a Staff of Territorial Army Officers in a permanent engagement.

(b) The formation of an Officer Cadet Training Unit for potential medical officers.

(c) An overhaul of the machinery for the selection of personnel for the Royal Army Medical Corps.

(d) An overhaul of the machinery for the posting of all ranks of the Royal Army Medical Corps to the various types of units in the Army.
Reorganization—Medical Services

E. A. R. Berkley

*J R Army Med Corps* 1946 87: 151-155
doi: 10.1136/jramc-87-04-01

Updated information and services can be found at:
http://jramc.bmj.com/content/87/4/151.citation

**Email alerting service**

Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

**Notes**

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/