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IT'S DRAINING MEN: PUBLIC OPINION, MILITARY NECESSITY AND THE BRITISH RESPONSE TO SHELL SHOCK DURING THE FIRST WORLD WAR

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SUMMARY: The First World War introduced many new challenges for medical practitioners. Prominent among these were psychiatric conditions, commonly termed as shell shock. This paper will investigate the Royal Army Medical Corps' (RAMC) treatment of shell shock by incorporating public advocacy as a significant factor for consideration. It will be shown that public activism for shell shock patients was as important to the RAMC as pressure from the British military in implementing a course of action for treating psychiatric casualties on the western front. This paper will examine the RAMC's status within the British Army and the effect this status had on its submission to a military system. The psychiatric expertise within the RAMC will be assessed as a factor in its ability to generate a workable solution to the problem of shell shock. The British public's awareness of shell shock will be discussed, as well as their level of activism on the matter. Lastly, the effects of public opinion and advocacy will be assessed as a consideration in the RAMC's implementation of treatment methods for psychiatric casualties.

KEYWORDS: Shell Shock, Military Medicine, First World War, Great Britain, History of Psychiatry

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Introduction

New psychiatric diseases and conditions, such as the phenomena commonly known as "shell shock" became a major challenge that medical practitioners faced during the First World War. This topic has received much attention in the study of medical history. Numerous monographs survey the research and treatment of psychiatric casualties by military

psychiatrists during the war.¹ Modern historical analysis of the British experience has concentrated mainly on capturing the impact of shell shock on the popular memory of the war. Jay Winter has written extensively on this topic.² Another well-explored theme is the British Army's unprepared or indifferent response to the problem, as exemplified by Fiona Reid's article "Playing the Game to the Army".³ Although shell shock has been explored in these contexts, it has not been studied in relation to the contemporary British public's response to shell shock.

The Early Days of the Royal Army Medical Corps

The state of pre-war medical services in the British Army played an important role in determining how the *Royal Army Medical Corps* (RAMC) would react to military pressure in wartime. As a functioning branch of the army, the RAMC prior to 1914 was held in very low regard amongst the other branches of the British Army. Formed in 1898, the RAMC's first test was the Second Boer War (1899-1902) in South Africa. The service's insignificance was quickly demonstrated by the War Office's indifference to the RAMC's recommendations to deploy sanitary officers to reduce non-battle casualties.⁴ However, the creation of a Director-General of the Army Medical Services to sit in as an equal to the heads of other departments on the Army Board, along with reforms to the RAMC's system of promotions, improved the status of the RAMC in the years leading up to 1914.⁵ Problems like inequities in wages between Medical Officers and their counterparts in the combat arms and exclusion from the Army Council served to remind the RAMC of its marginalized importance within the Army.⁶

¹ Ben Shephard, *War of Nerves: Soldiers and Psychiatry in the Twentieth Century* (Harvard: University Press, 2000); Peter Leese, *Shell Shock: Traumatic Neuroses and the British Soldiers of the First World War* (Houndmills, England: Palgrave, 2002).

² Jay Winter, *Remembering War: the Great War Between Memory and History in the Twentieth History* (New Haven: Yale University Press, 2006), Chapter 5; Jay Winter, "Shell Shock and the Cultural History of the Great War," *Journal of Contemporary History* 35 (2000), pp. 7-11.

³ Fiona Reid, "'Playing the Game to the Army': The Royal Army Medical Corps, Shell Shock and the Great War," *War & Society* 13 (2005), pp. 61-86.

⁴ Ian R. Whitehead, *Doctors in the Great War* (London: Leo Cooper, 1999), p. 14.

⁵ Whitehead, *Doctors*, p. 18.

⁶ *Ibid.*, p. 19.

The RAMC's low standing fostered a state of inherent conservatism and submissiveness amongst its senior medical professionals. The hard victories won by the RAMC in its fight for recognition as a legitimate service within the army cultivated a need to impress military values such as order and discipline onto its new doctors. This sentiment became especially reactionary as its ranks swelled with enthusiastic recruits on the outbreak of the First World War.⁷ In the years leading up to the war the RAMC faithfully adhered to its role in sustaining the army's manpower by developing a strong tradition of weeding out "scrimshankers" and maintaining discipline in its centers.⁸ Scrimshanking, or malingering (also known by a number of other terms), was seen by some as a rising problem within the contemporary British working class, though only a few civilian practitioners were overly concerned about excesses in malingering.⁹ Increasing fatalities on the front lines placed tremendous pressure on the RAMC doctors to reduce the amount of soldiers excused from duty as a result of "wasteful sentimentality".¹⁰ The desperate need for soldiers on the front lines coupled with the desire for the RAMC to "fit in" to the British Armed Forces made its vital role of returning soldiers ever so important.

It is very evident from the personal recollections of medical officers that doubt and suspicions were cast upon soldiers presenting for the sick parade. One Canadian medical officer described the challenge of determining if his patient was "really ill, or [...] just suffering from ennui. Finally he has at last become so 'fed up' with it all that he has decided to go sick, running the gauntlet of an irate M. O. with the hope of receiving a few hours or days of rest at the transport or in the hospital?"¹¹ His memoir went on at length recounting anecdotes from his colleagues and the clever manner in which they unmasked feigned illness.

Psychological Casualties of the War

With regards to psychological matters, the RAMC was woefully indifferent of these conditions prior to 1914. The lack of concern within

⁷ *Ibid.*, p. 68.

⁸ *Ibid.*, p. 70.

⁹ Roger Cooter, "Malingering and Modernity," in: *War, Medicine and Modernity*, Roger Cooter, Mark Harrison and Steve Sturdy, eds., (Gloustershire, Stroud Sutton, 1998), p. 126.

¹⁰ Whitehead, *Doctors*, p. 155.

¹¹ Robert James Manion, *A Surgeon in Arms* (Toronto: McClelland, Goodchild & Stewart, 1918), p. 104.

the army for mental disorders was evident in the RAMC's talent pool. There were neither psychiatrists nor neurologists within its ranks as late as 1913.¹² British medical students were required to complete only a minimum of studies in psychiatry before qualifying as doctors. This resulted in the shortage of psychiatric or neurological expertise, leaving the vast majority of Medical Officers in the RAMC very ignorant of any matter related to mental disorders.¹³ In 1914, the RAMC did not have the necessary specialists to address psychiatric casualties. This severely challenged the organization's ability to diagnose and treat these conditions.

The appearance or the lack of psychiatric casualties in 1914 is reflected in casualty statistics. The official medical history only reports nine psychiatric casualties for the campaigns of 1914, but admits this figure only counted psychiatric casualties that could be recognized as physically "wounded".¹⁴ This is largely because senior medical authorities refused to recognize any diagnosis for neurological casualties that could not be attributed to physical trauma.¹⁵ The marginalization of psychiatric casualties during the opening stages of the war indicated the senior RAMC leadership's insistence on its military duty to reduce illegitimate casualties.

Without sufficient expertise in the RAMC, the psychiatric casualties that were evacuated to Britain in 1914 and 1915 were treated in various hospitals and produced a variety of experimental treatments for the diverse conditions that were diagnosed. For example, Captain E.T.C. Milligan (1887-1972) advocated for the use of chloroform as a method of inducing suggestions to overcome physical debilitation.¹⁶ Wilfred Garton (1886-1948) based his treatments "on the assumption that neurasthenia is an organic disorder" and published an article in October 1916 which recommended cerebrospinal galvanism, or electropuncture therapy, as a preferred method of treatment.¹⁷ In an address to the Malta Medical

¹² Shephard, *War of Nerves*, p. 17; Mathew Thomson, "Status, Manpower and Mental Fitness: Mental Deficiencies in the First World War," in: *War, Medicine and Modernity*, Roger Cooter, Mark Harrison and Steve Sturdy, eds., (Somerset: Sutton Publishing Ltd., 1998), p. 150.

¹³ Reid, *Playing the Game to the Army*, p. 77.

¹⁴ William Grant Macpherson, *The Medical Services: Diseases of the War*, Vol. 2 (London: Her Majesty's Stationary Office, 1923), p. 4.

¹⁵ Leese, *Shell Shock*, p. 32.

¹⁶ E.T.C. Milligan, "A method of Treatment of 'Shell Shock'," *British Medical Journal* 2 (1916), pp. 73-74.

¹⁷ Wilfrid Garton, "Shell Shock and its Treatment by Cerebro-Spinal Galvanism," *British Medical Journal* 2 (1916), pp. 584-586.

Conference in April 1916, Captain Montague David Eder (1866-1936) explored the psychological side of the illness and presented psychic hypnosis for an ideal form of treatment.¹⁸ A variety of diagnoses and treatments for psychiatric conditions continued to be presented into 1916. As a result, the British military medical service's experts did not have a singular set of conventions with which to base treatment for shell shock.

The turning point for the perception of shell shock in Britain was the Battle of the Somme, which greatly increased the amount of psychiatric casualties. Although the statistics are admittedly incomplete, the prevalence of shell shock casualties in 1915 totalled roughly 400 recorded cases.¹⁹ After July 1916, the number of recorded shell shock casualties increased tenfold.²⁰ Such an influx raised concerns for both the RAMC and the British public.²¹ The increased publicity of the diseases was seen as contributing to the incidence of shell shock casualties, as growing awareness of the disease within the ranks of the British Expeditionary Force led to an increasing number of patients directly stating they were suffering from the condition.²² The RAMC was forced to find a solution that could be applied on a large scale to deal with this influx of shell shock.

Establishment of Shell Shock Centers

The solution that the RAMC implemented in France mid-1917 was the establishment of centres specific to treating shell shock patients behind the front lines in the early stages of the condition to increase the chance of recovery. Capt. Charles Samuel Myers (1873-1946), a leading psychologist in the RAMC, had lobbied his superiors in the RAMC for the establishment of such centres for over a year without success.²³ The rationale amongst the senior officers was that these centres could not be established because of their "impractical methods of treatment."²⁴ The amount of shell shock cases that materialized during the Battle of the

¹⁸ Montague David Eder, "The Psycho-Pathology of the War Neuroses," *Lancet* 2 (1916), pp. 264-268.

²⁰³ Macpherson, *Diseases*, p. 4; Thomas John Mitchell, ed., *Medical Services: Casualties and Medical Statistics of the Great War* (Nashville: Battery Press, 1997), p. 144.

²⁰ Macpherson, *Diseases*, p. 4.

²¹ *Ibid.*, p. 8.

²² *Ibid.*, p. 9.

²³ Shepard, *War of Nerves*, p. 27.

²⁴ Macpherson, *Diseases*, p. 10.

Somme forced the RAMC to revise its attitudes and Myers was appointed Consulting Psychologist to the Army in France. His recommendations for the establishment of special shell shock centres were taken to heart by the RAMC.²⁵ The treatment offered at these centres prescribed periods of rest and minor psychotherapy to allow the patient to regain composure and self-confidence.²⁶ Once the patient had sufficiently recovered, he was placed in a more structured environment and gainfully employed until all symptoms were overcome and the patient was fit to return to duty.²⁷ These treatments were nothing like what medical experts were recommending in the medical journals of 1916 as described above.

By 1917 and into 1918, a consensus began to develop amongst British medical authorities on the proper treatment for shell shock casualties which, like the special centres established in France, were based on the idea of rest, exercise and employment during convalescence. In April 1917, Honorary Lieutenant Colonel Ernest White (1876-1940) published an article outlining his findings as an inspector of various shell shock facilities in England.²⁸ His findings were that the current state of convalescent care was ineffective in treating patients suffering from shell shock. He found treatment regimens that offered patients "the tenderest [*sic!*] care, surrounded by luxury" to be "bad for the patient."²⁹ Rather than coddle the patient and reduce any motivation for recovery, White prescribed light exercise and fresh air.³⁰ Major Fred W. Mott (1853-1926), an experienced pathologist who had spent years dissecting brains in London asylums, also came to advocate manual labour in open air and recommended that a program be established to arrange agricultural work for fit patients recovering from shell shock.³¹ Speaking at a medical conference in October 1917, Dr. Frederick C. Forster (1827-1919) raised the justification for employment as a form of treatment due to the moral value of working as a means "to restore self-confidence and to prove to [the patient] that he was capable of some sort of work and [...] so make

²⁵ Shepard, *War of Nerves*, p. 47.

²⁶ *Ibid.*, p. 34.

²⁷ *Ibid.*, p. 38.

²⁸ Ernest W. White, "Observation on Shell Shock and Neurasthenia in the Hospitals in the Western Command," *British Medical Journal* 1 (1918), pp. 421-422.

²⁹ *Ibid.*, p. 422.

³⁰ *Ibid.*

³¹ Fred W. Mott, "(The Chadwick Lecture) Mental Hygiene and Shell Shock During and After the War," *British Medical Journal* 2 (1917), pp. 39-42.

him increasingly dependent on his own efforts.”³² Dr. Richard Thomas Williamson (1862-1937) also argued the value of these distractions for the rehabilitation of shell shock patients.³³ In 1917, a significant body of British experts were developing a consensus towards these treatment methods.

The consensus was by no means universal. Two doctors working at Connaught Hospital and Queen Square, both major shell shock facilities, supported the use of psychological suggestion reinforced by electroshock for those patients “who prefer not to recover.”³⁴ It was noted by Major Arthur Frederick Hurst (1879-1944), during a meeting for the Royal Society of Medicine, which hypnotism and electroshock were declining in use. However, during the discussion subsequent to his presentation, the feasibility of light work as a universal treatment was both supported and challenged. Although other forms of treatment were still practiced, the findings of contemporary medical experts concurred with the treatment principles of the regimen being implemented by the RAMC for psychiatric casualties in France.³⁵

Contributions from the Public

Despite the growing consensus for treatment between the medical community and the military, the ability to return soldiers to the front was confounded by the dichotomy between the military’s goal in conserving manpower and public opinion on the treatment of shell shock casualties. The treatments for shell shock patients in hospitals in Britain were proving inconsistent in restoring patients to functional capacity. Between October 1917 and February 1918, the hospital at Golders Green was able to discharge 186 patients, 143 of which were fit for employment. During the discussion mentioned above, Major Hurst had claimed that half of his discharges have returned to military duty, while the other half was fit for civilian employment.³⁶ As encouraging as these claims were to the promise of conserving military manpower, it was generally found that

³² Frederick C. Forster, “Neurasthenia and Allied Conditions,” *British Medical Journal* 2 (1917), pp. 618-620.

³³ Richard Thomas Williamson, “The Treatment of Neurasthenia and Psychasthenia Following Shell Shock,” *British Medical Journal* 2 (1917), pp. 713-715.

³⁴ Edgar Douglas Adrian and Lewis Yealland, “The Treatment of Some Common War Neuroses,” *Lancet* 1 (1917), pp. 867-872.

³⁵ Author Unknown, “Reports of Societies,” *British Medical Journal* 1 (1918), pp. 354-355.

³⁶ *Ibid.*, p. 355.

once shell shock cases left France, it was unlikely they would be returned to the front. Part of the reason for this can be attributed to the influence of public efforts to promote the convalescence of shell shock patients above all else.³⁷

The views of the public were reflected in the contemporary parliamentary debates. In November 1917, the Under-Secretary for State for War Ian Macpherson was questioned on the length of time before shell shocked patients will be returned to the front.³⁸ Macpherson's reply was that setting pre-determined terms of recovery was ill-advised, though to be considered.³⁹ When asked two weeks later on the outcome of these considerations, Macpherson reported that shell shock patients once deemed recovered, would be reclassified according to the conditions of their return to duty.⁴⁰ Some other queries raised in Parliament in December 1917 questioned the impartiality of medical boards in awarding pensions to shell shock cases, while others questioned the possibility of relapses for shell shock soldiers that had been returned to duty. These questions all addressed the caution with which shell shock patients recovering in England were returned to duty. This reflected the underlying sentiment criticizing the practice of callously returning patients to active duty and advocating more lenient treatment for psychiatric casualties. Although one could argue that inquiries such as these were probing the faults of an organization too eager to return recovering patients to the front. The fact that recovered soldiers seldom returned to the battlefields of France refutes the notion that the RAMC was overly aggressive in returning psychiatric patients to duty. It does show that British public interest promoted slow, restful recovery for shell shock patients.⁴¹

The degree of public interest in this matter was demonstrated by the groundswell of private initiatives to improve accommodations for recovering shell shock patients. One example presented itself in May 1916, when Mary E. Mitchison (1897-1999) requested access to the nearby Chelsea Physic Garden for the use of the shell shock patients recovering in her small convalescent home.⁴² What is notable about this incident is that the denial of access to the gardens "aroused considerable interest in the locality" which culminated in the circulation of a petition

³⁷ Macpherson, *Diseases*, p. 55.

³⁸ Great Britain. H.M. Stationary Offices, *The Parliamentary Debates: Official Report (Fifth Series)*. Vol. XCIX (1917), p. 232.

³⁹ HMSO, *Parliamentary Debates* (13. Nov. 1917), p. 233.

⁴⁰ *Ibid.* (26. Nov. 1917), p. 1658.

⁴¹ *Ibid.* (17. Dec. 1917), p. 1500; *ibid.*, p. 2162.

⁴² Mary E. Mitchison, "A Debt to the Wounded," *The Times* (23. May 1916), p. 9.

supporting Mrs. Mitchison's original request.⁴³ Another example of the public's efforts to ameliorate the convalescence of shell shock patients in England was Dr Thomas W. Lumsden's (1875-1953) scheme to allow these to recover in the country estates of willing proprietors, which he advertised in a letter to the editor of *The Times* in August 1917.⁴⁴ Less than a week after proposing his plan, he submitted another letter to the editor claiming the responses were so enthusiastic that he found it "impossible to answer without delay the many kind letters offering hospitality."⁴⁵ Another extraordinary example of public efforts from August 1917 was the praise given to Sir John Leigh's (1884-1959) offer of one of his country homes to operate as a recovering hospital for shell-shocked non-commissioned officers and other ranks. This act of charity was especially remarkable since he previously donated the use of another of his estates to house a similar establishment for officers.⁴⁶ The amount and the nature of contributions made by the public to increase the comfort of shell shock patients' recovery is evident of the level of interest which shell shock had attained in the minds of the public.

Reduction of Shell Patients Evacuated to England

The impact of popular sentiments on reducing the number of shell shock patients in England that were returned to the front is evident in certain public announcements. One such announcement was made by the Minister of Pensions John Hodges (1855-1939) who spoke at the Cowen Training School for Maimed Soldiers and Sailors. He publicly pledged that no one suffering from shell shock shall be returned to the front.⁴⁷ The impact of such a claim was demonstrated by the need to clarify that statement a few days later, explaining that it only applied to soldiers who had been discharged and were under the care of the pension department, and not to recovering soldiers who were otherwise still enlisted.⁴⁸ More

⁴³ Author Unknown, "Rest Gardens for the Wounded: Householders' Approval," *The Times* (24. May 1916), p. 11.

⁴⁴ Thomas W. Lumsden, "Nerve Shattered Pensioners: A Scheme of Treatment," *The Times* (22. Aug. 1917), p. 9.

⁴⁵ *Ibid.*, *The Times* (27. Aug. 1917), p. 8.

⁴⁶ Author unknown, "A Shell Shock Hospital: Generous Gift to the Nation," *The Times* (21. Aug. 1917), p. 3.

⁴⁷ John Hodge, "Mr Hodge's Promise to Sick and Disabled Men: No More Fighting After Shell Shock," *The Times* (1. Oct. 1917), p. 5.

⁴⁸ John Hodge: "Shell Shock Sufferers: Scope of Mr. Hodge's Statement", *The Times* (3. Oct. 1917), p. 3.

public support for allowing recovering shell shock patients to remain in England was gained in the December 1917 letter of Sir John Collie (1861-1935), later Chief Medical Officer of the Metropolitan Water Board, to the editor of *The Times* in response to an article outlining the Military Service Act. On the issue of returning shell-shocked soldiers to duty, the act specified that these cases could be given exemption from returning to duty by a medical board, to which Collie, as president of a medical board, proudly advertised that it was his “practice to issue certificates of exemption to officers and men suffering from these diseases” and stated his intention to “continue to do so,”⁴⁹ These public announcements that deliberately advertised policies against returning shell shocked soldiers to the front demonstrate the popular appeal of such a stance.

To ensure that shell shock cases were returned to duty after their recovery, the army had to control the amount of shell shock casualties being evacuated to England. In order to accomplish this, the army enforced rigid but functional guidelines. An order came down from the Adjutant-General of the *British Expedition Forces* (BEF) that no casualty “without any visible wound” could not be evacuated anywhere but to one of the special shell shock centres.⁵⁰ This prevented shell shock patients from being swept back to England without being examined at one of these centres. Furthermore, the designation for shell shock casualties was changed to “*Not Yet Diagnosed Nervous*”, and cases that used to qualify as Shell Shock “wounded” needed to be substantiated in writing by the patient’s regiment.⁵¹ These measures were heavily criticized for creating a backlog in patients awaiting treatment in the special shell shock centres.⁵² However, No. 3 *Canadian Stationary Field Hospital*, one of the units designated as a special centre, reported that after initial delays, “the military evidence upon which a definite diagnosis of this class of case is made is coming more quickly.”⁵³ Whether these measures were effective in providing appropriate treatment for shell shock patients is debatable, but the effect these policies had on retaining these patients in France were very evident.

⁴⁹ “Special Medical Board: To the Editor of the Times,” *The Times* (5. Sept. 1917), p. 7.

⁵⁰ Macpherson, *Diseases*, p. 11.

⁵¹ Shepard, *War of Nerves*, p. 54.

⁵² *Ibid.*, p. 54.

⁵³ National Archives of Canada (NAC), Record Group (RG) 9, Militia and Defence, Series III-D-3, Volume 5033, ReelT-10923 File: 844, War Diary, No. 3 Canadian Stationary Hospital (2. Jun. 1917).

Although statistical data on the subject are not reliable, anecdotal evidence also indicates that the new policies towards shell shock patients significantly reduced the number of these cases being evacuated to England. The statistics presented in the official histories of both the medical services and the war are inconsistent in recording cases of shell shock returned to duty during the years 1917 and 1918. The statistics do show that in 1917 roughly 36 percent of these patients were returned to duty, while in 1918 roughly 70 percent were returned to duty.⁵⁴ The official history of the medical services also indicates that after the implementation of special centers for shell shock only 10 percent of shell shock cases were evacuated out of France.⁵⁵ The official history goes on to quote that one designated shell shock facility, the 62nd Casualty Clearing Station was able to reduce its number of casualties evacuated to England to as low as 4 percent of cases admitted.⁵⁶ The war diary of No. 3 *Canadian Stationary Field Hospital* did not distinguish between cases evacuated and cases returned to duty. Though in August 1917, it reported “good results being obtained” from its rehabilitation program.⁵⁷ The war diary consistently reported a high ratio of patients being returned to duty in August, September and October 1917.⁵⁸ Despite the unreliability of statistical data, anecdotal evidence further substantiates that the measures implemented to deal with shell shock cases were highly effective in treating patients in France and returning them to active duty.

Conclusions

The treatment protocol that the RAMC finally implemented for British shell shock patients in 1917 was partly a product of its *institutional history*. At the outbreak of war, the RAMC was still a very young branch of the British Army. In their efforts to prove themselves as a credible professional military organization, the RAMC’s senior leadership was adamant in fulfilling its role of conserving manpower in the British Army. Psychiatric expertise in the RAMC prior to the war was nearly non-existent. As a result of its conservative attitudes and its lack of experts, the RAMC marginalized shell shock patients and evacuated them to

⁵⁴ Mitchell, *Medical Services*, pp. 115-116.

⁵⁵ Macpherson, *Diseases*, p. 44.

⁵⁶ *Ibid.*, p. 14.

⁵⁷ NAC, WD, No. 3 Canadian Stationary Hospital (16. Aug. 1917).

⁵⁸ *Ibid.*, (24. Aug.; 3. Sept.; 7. Oct. 1917).

Britain for treatment in specialized civilian hospitals. Few patients returned to duty once evacuated to *Blighty*.

In 1916, the sharp increase in the incidence of psychiatric casualties during the Battle of the Somme raised awareness of shell shock in the British public sphere. Public activism mobilized to relieve the plight of these sufferers. Questions raised in Parliament reflected the popular sentiment that the army was too callous in its drive to return shell shock patients to duty. These sentiments were reflexive of – if not actively condoning – public announcements like John Collie's on his policy never to find shell shock patients fit to return to duty. Meanwhile, public initiatives intending to establish relaxing convalescent facilities proliferated and reinforced the practice of allowing shell shock patients to recover in comfortable surroundings. These not only demonstrated the extent to which the British public was interested in easing the suffering of shell shock patients, but as contemporary research was beginning to show, were undermining their recovery. Public pressure and activism in Britain made it nearly impossible to return psychiatric casualties to active duty.

By 1917, the RAMC was ready to implement a universal treatment regimen for psychiatric casualties in France. Special centres were created to provide a structured environment and promote physical activity in order to encourage psychiatric casualties towards recovery by rebuilding their confidence. The establishment of these centers was partly a product of the RAMC's traditionalist attitudes to conserve manpower by treating and returning as many of these patients to duty. The RAMC created its system of psychiatric facilities in France, because public activism in Britain undermined the effectiveness of civilian facilities in Britain and raised opposition against the return of shell shock casualties to active duty. Thus, public activism in Britain was an important catalyst in influencing the RAMC's decisions in establishing a treatment protocol for psychiatric casualties.