Unjustly accused? Medical authorities and army recruitment in Australia 1914-1918

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Abstract

Throughout World One, army recruiting in Australia was subject to wartime demands, demographic constraints and political interference. Australia's small medical establishment became better in dealing with these issues, helped by the greater combat experience of the Australian Army Medical Corps. Within the political and military constraints of the day it generally responded well to changing Government and military policies at home and abroad. This was despite serious differences in opinion within the senior command of the Corps.

Key words: recruiting, World War One, Australian military, medical officers, physical standards, enlistment standards

Introduction

A comparison of these two following statements, written a generation apart, is an interesting one.

> "It may be doubted whether any feature of medical responsibility in connection with the war did more to intensify the popular contempt for a supposed lack of efficiency and alertness in the medical profession than the circumstances associated with the medical examination of recruits. The same blistering criticism has occurred in Great Britain."[1]

> "…it is fair criticism to state that the primary recruiting medical examinations were carried out under very unfavourable conditions, in pursuance of a policy that was penny wise and pound foolish."[2]

These comments invite reflection and speculation should Australia ever commit large numbers of servicemen and women to a future large scale conflict. Strategies and weapons have changed, but for the foreseeable future there will still be a requirement for recruits to be screened and made fit to deploy. To quote the official medical historian of World War One again: "It is a truism, but one of which Australia [took] account only since the second world war was imminent, that the physical standard of the soldier reflects exactly that of the community."[3] This observation brings us back to the 21st century.

This article reviews the role of Australia's military medical profession in recruiting, how it dealt with recruiting during World War One; and its response to changing policies. We also explore the tensions between the two senior medical commanders responsible for policy as they strove to maintain standards and respond to military and political pressure at home and abroad.

The Role of the army medical establishment and civilian doctors in recruiting

In the early stages of the war, medical officers on the Active List of the Australian Army Medical Corps (AAMC) were available to examine recruits. It was not long however before many of these officers themselves volunteered for active service. Their duties, as far as examining recruits were concerned, were then filled by reservists and civilian doctors, many of whom later joined the AAMC. Once the Principal Medical Officers (PMOs) of all six military districts enlisted shortly after mobilisation in 1914, this left a gap in experienced administrators in the Corps, which soon lost its most experienced officers and non-commissioned officers for service abroad.

When the original PMOs were replaced by less experienced officers, they were assisted by an advisory body which was also established in each military district to liaise between military and civilian hospitals. However most of these men were not familiar with medical examinations nor with army requirements. Consequently numbers of recruits who should not have been passed fit were accepted for service, went into training camps and were deployed.

By May 1915, army Standing Orders made it clear

that recruits from the country were to be examined by local medical officers; that recruits were not to be enlisted at rural centres but would be given rail warrants to travel to the cities or Military District HQs where all recruits, including those previously vetted in regional centres, would be medically examined and, if fit, attested. In a separate circular, "it was made clear that medical officers were entirely responsible for checking all questions on the attestation paper concerning a recruit's medical history".[4]

Until May 1916, the main role of the AAMC in Australia was associated with recruiting and providing health support to numerous training camps and facilities and (from mid 1915) of managing battle casualties when the first batch of 1,325 convalescents returned from the front. The Corps also had to recruit and train its own staff and reinforcements.

Recruiting between 1914 and 1918

It all started simply enough. In 1914 there were three army physical entry standards: for the permanent force, militia and the volunteers. In 1915 there were three medical categories applied to all recruits: A – fit for service, B – for service on the Lines of Communication only; and C – invalids for home.[5] These standards were laid down in Commonwealth Military Regulation 165. In comparison with most other countries directly involved in the fighting in France and the Middle East, Australia's population (see Table 1) was a small one, whose health was not, despite later myths, as robust as to allow slipshod standards of recruit screening. Venereal disease and poor dentition were notable features across the male civilian demographic.

As Butler pointed out, a comparatively large and quite unexpected proportion of the adult male population was unfit for military service. The fact that it was undetected and unexpected in 1914-15 would add to the immediate burden on screening recruits. Therefore recruiting during the first 18 months of the war was marked by "a progressive lowering of the physical standards (in height, weight, and chest measurement) and by increasing difficulty in complying with the reiterated demands from the Australian Imperial Force (AIF) for adherence to a high standard of fitness."[6]

In 1914 men up to 50 years old (most of whom should never have been recruited) deployed with the Australian Naval and Military Expeditionary Force to New Guinea. As medical authorities pointed out with increasing alacrity over the next five years, the long term cost to Australia by way of ongoing medical treatment, invalid compensations and pensions from poor recruit screening would be considerable (see table 2).

Table: 2 Percentage of men pensioned on medical grounds WWI

	No. men in combatant service	% of men pensioned
USA	1,390,000	55
UK	4,970,902	10
Italy	5,600,000	4
France	7,932,000	14
Germany	12,000,000	7
Australia	416,809	18

Source: Medical History War of 1914-1918, Vol II statistics. AWM 41/778.

When the 1st Australian Imperial Force (AIF) was formed in August 1914 the standards were lowered – height was reduced to 5'4" (although medical officers had discretionary powers of half an inch in a healthy recruit) and the chest measurement to 33 inches (fully expanded). Recruits with false teeth had to be able to eat without them.

In a circular of August 1914, General William Bridges (then Inspector-General of the army) issued instructions that the qualifications for enlistment of recruits in the AIF should be those laid down in Australian Military Regulations for the militia (see table 3) and that recruits must be "physically fit on medical examination." What to a soldier seemed a straight forward direction was open to wide interpretation by doctors. It was from this document that much of the subsequent confusion among and criticism of, army doctors occurred.

Table: 1 Adult Australian Population as at 3 April 1911, according to age (MD = Military District)

Age	NSW	Vic	Qld	SA	WA	Tas	NT	ACT	Total
	MD 2	MD 3	MD 1	MD 4	MD 5	MD 6	MD 1	MD 2	
15 ≤ 21	100,551	81,223	39,532	25,861	14,533	11,744	107	119	273,670
21≤ 45	316,463	229,179	121,711	75,059	72,569	32,779	1,002	358	849,120
45 ≤ 65	133,550	106,201	51,706	32,067	25,090	14,659	1,221	181	364,685

Adapted from: Official Year Book of the Commonwealth of Australia, 1901-1915, No. 9 -1916, Melbourne: McCarron, Bird & Co; 1916: 125.

Table: 3 Army Recruit requirements, 1914

	Age Limit	Height Minimum	Chest Measurement Minimum
Permanent			
Royal Australian Garrison Artillery	18 - 30	5'7"	35
Royal Australian Field Artillery – gunners	18 - 30	5'7" to 5'10"	35
Royal Australian Field Artillery – drivers	18 - 30	5'4" to 5'7"	34
Royal Australian Engineers	18 - 30	5'7"	35
Army Service Corps	18 - 30	5'7"	35
Australian Army Medical Corps	18 - 30	5'7"	35
Army Ordnance Corps	18 - 30	5'7"	35
Militia			
Australian Light Horse	18 - 35	5'6"	34
Australian Field Artillery - gunners	18 - 35	5'6"	34
Australian Field Artillery - drivers	18 - 35	5'4"	33
Australian Garrison Artillery	18 - 35	5'7"	35
Corps of Australian Engineers	18 - 35	5'6"	34
Infantry	18 - 35	5'6"	34
Australian Corps of Signallers	18 - 35	5'6"	34
Army Service Corps	18 - 35	5'6"	34
Australian Army Medical Corps	18 - 35	5'6"	34
Australian Army Veterinary Corps	18 - 45	5'4"	33
Army Ordnance Corps	18 - 45	5'6"	34
Volunteers			
Infantry	18 - 45	5'4"	33
Departmental	18 - 45	5'4"	33

Source: Enlistment and Examination of Recruits. AWM 32/91.

During the first year of the war approximately thirty-three per cent of all volunteers were rejected. The demands of war soon superseded doctrinaire standards and long established regulations and there were further easing of physical standards. "As a result of reports from ophthalmic specialists, the eyesight tests were slightly relaxed and the use of spectacles was permitted. Venereal disease was put on the same basis as dental unfitness. The age limit was increased to forty-five."[7]

This created a challenge for the army medical services and one partly of their own making. This may be explained by the absence overseas in early 1915 of its two most senior and experienced officers (General William Williams and Colonel Neville Howse VC). But there was at that time no precise procedure for medical examination, certainly not for the number of enlistees coming forward. In general, the policy was adopted of making the examining medical officer personally responsible, and of seeking his co-operation in overcoming problems detecting (and rejecting) unfit men among the recruits.

The numbers of men flocking to enlist in 1914 had exceeded the requirements for the first two contingents and for their reinforcements (3,227 men per month). After negotiations with the War Office on 20 January, 1915 Australia agreed to provide a monthly quota of reinforcements which reached 5,263. Toward the end of that year 'standing medical boards' were appointed to pass or reject all recruits about whose fitness there was doubt. As an additional precaution and to stop impersonation, repeated re-examination was ordered before soldiers deployed.

As an aside, in 1915 the procedure for medical boards for serving soldiers (i.e. not recruits) involved two medical officers, nominated by the PMO in each state. They constituted a board for medical review purposes. One Medical Officer (MO) had to belong to the hospital in which the soldier was being treated. Physicians would review medical cases and surgeons surgical cases. Where four or more soldiers were boarded at a time, MOs were paid £2/2/- .8 They were to report against three criteria:

- Whether or not they concurred with the report of the medical officer who presented the case and in how far they concurred.
- What it actually found on examining the patient, stating briefly the actual lesion or pathological condition present.
- Its *recommendations* based on its findings.

The standard reference for medical officers conducting recruit examinations in 1916 was a little eight page booklet. The categories listed were: height, chest measurement, vision, general examination, examination of limbs, general physical development; and teeth (bad teeth were no longer a reason for immediate rejection, unless the recruit presented with a chronic oral or dental condition).

General practitioners were dropped from the recruiting examination system in 1916 and in their place came a properly constituted medical board.

As the Director General of Medical Services (DGMS) General Richard Fetherston pointed out to the Defence Minister, Senator George Pearce:

> For economic working, medical boarding must be done by men who understand military routine, and who are conversant with the latest Military Orders; this knowledge cannot be acquired in a few weeks.[9]

But even with the strictest regulations there were abuses in the system. In one instance three AAMC officers had rejected a recruit whose would-be commanding officer wanted him in his unit. Therefore, the recruit obtained a private medical certificate and was officially enlisted. Subsequently he later had an epileptic fit at Broadmeadows camp in Victoria and repeated fits when he got to Egypt. The soldier had apparently suffered from this disability since infancy and had a trephine scar the size of a man's palm.[10]

During 1916 the small military dental establishment in Australia was also overwhelmed while trying to make recruits and soldiers dentally fit. It was therefore suggested in mid-April that one dental officer be attached to every infantry battalion deploying overseas. Unfortunately Fetherston had to decline the suggestion as there was not enough dental equipment in Australia; and even if there had been, the navy prohibited the use of "any form of spirit or gas flame" on ships.[11]

On 4 April 1917 a conference of representatives of all State Recruiting Committees was held at Victoria Barracks Melbourne. They discussed age limits and there was some disagreement as to the limit of 45, with military doctors arguing for the retention of the 45 year limit. This view later softened, especially for soldiers serving on the home front.

In the following year, attempts to rehabilitate recruits with sub-standard chest measurements in a trial 'deferred battalion' in Queensland were not very successful. Even support staff were unimpressed. The senior physical training instructor there noted in November 1918 that most recruits were "habitual cigarette smokers…" which had "a tendency to contract the chest and bring about improper breathing."[12]

Political and other pressures on the medical establishment

In Australia there was incredible political pressure to ease recruiting standards as the war dragged on. Even at an individual level a politician's relative, who was too short, too fat, too flat-footed or myopic to make the grade, felt himself badly done by. They wrote letters: to friends, newspapers and their local MP. Consequently, hardly a day did not go by when some self-important dignitary walked into the Melbourne office of the embattled Surgeon-General and demanded an audience.

After news of Gallipoli fiasco and the ensuing casualties reached Australia, recruiting campaigns were organised in every State. The subsequent rush (in Victoria 21,698 men turned up at recruiting centres in July 1915 alone) resulted in large numbers of troops concentrated in camps at the beginning of winter.[13] The impact on army medical staff can be imagined. In order to make good the losses of the early weeks on Gallipoli, the Commonwealth offered the War Office on 9 July double the previously agreed reinforcements for October and November, in addition to providing another infantry brigade (the 8th).

Although recruiting fell again after July 1915, the Commonwealth promised the War Office a further 50,000 men 'for active service'. The balance of troops in camp supplied the first reinforcements for these; but the commitments for future reinforcements of 11,000 per month "taxed the utmost resources of Australia (under voluntary enlistment) for the rest of the war and necessitated a series of special recruiting campaigns."[14]

In a memo of 2 July 1915, Lieutenant General Thomas Dodds, the Adjutant General, advised the Secretary of the Defence Department that the recruitment conditions "are generally known and men who do not conform to the standards are nearly always aware of the fact before applying, but feign innocence, many in fact after rejection turning up elsewhere and making the percentage of rejections greater than it would otherwise be."[15] This had affected deploying forces, and later, reinforcements. A spot check of the troopship *Euripedes*, which had stopped at Albany in November 1915 *en route* to France revealed four cases of pneumonia, seven of mumps, one tuberculosis, one malaria, one hernia and 12 men with venereal disease.[16] How was it that men with such obvious medical conditions had slipped through the net? Clearly policy and regulation were not as effective as they should have been, nor perhaps was there appropriate oversight being provided at a senior level in overworked and understaffed Military District headquarters.

As solutions were sought to maximise the effectiveness of medical assets, it was decided in 1916 to place recruits who required medical, dental or other treatment in special companies (much like our current 'rehab platoons') in recruit camps. While they were in these units they were to receive the necessary attention and would be available 24 hours a day for any medical (but not surgical) treatment

or intervention. Once medically and dentally fit they would then rejoin other units in training. But the reinforcements for the army were still constrained by physical standards (see table 4).

Table: 4 Number Medically Examined, Rejected, Passed, etc in the Call Up of October 1916

Number reported	191,610
Medically Examined	180,715
Found fit	114,322
Found Unfit	49,138

Source: A.G. Butler, The official history of the Australian Army Medical Services in the War of 1914-1918. Vol. III. Canberra: Australian War Memorial; 1943: 888.

Until the end of 1917 reinforcements for all corps and branches of the army other than the medical service arrived from Australia earmarked for particular units. After the heavy casualties of Third Ypres and the failure to send full quotas from Australia they were pooled and deployed where most required. The recruiting standard was now lowered to five feet and consideration was being given by senior medical officers in Australia to lower that height for recruits 'as long as they are strong and well built'. This approach was an option favoured by Fetherston, but not accepted by his counterpart in London, General Howse.

It was becoming clear that not all doctors were using the same procedure to examine recruits and that some medicos were using outdated protocols. [17] In that year it became an offence under the *War Precautions Regulations* for a recruit to make a false statement while undergoing a medical examination.

Unsuccessful applicants were still trying to circumvent the system by appearing at multiple recruiting centres for medicals. Fetherston, apparently acting on Government advice, therefore asked all examining officers to take the applicant's thumb prints on the attestation papers to try to stop this fraud. This was a public relations disaster for the Government as there was widespread resistance to implementing such a measure, due to its association with criminal activity.

Colonel William Giblin, Tasmania's PMO, spoke for his inter-state colleagues when he reported on 30 June 1917 that it had "been found very difficult to obtain a uniform standard of examination by the many primary examiners [GPs], few of whom have had any previous medical experience. This uniformity can only be obtained at the secondary examination. As a result, the number of recruits secondarily rejected has been large."[18] A cable from AIF HQ, London three months later explains concerns there about the physical profile of newly arrived soldiers (see table 5) about to be sent to the front.

Table: 5 Examination of AIF Reinforcements arriving in UK, 1917

	Under Age	Dentall unfit	Medically unfit
1st Military District	87	602	129
2nd Military District	105	676	39
3rd Military District	45	356	14
4th Military District	46	410	20
5th Military District	78	446	52

Source: A cable AIF HQ to Defence department, 30 September 1917. Official Historian, Enlistment and Examination of recruits. AWM 41/768.

At this time complaints were being received from England that many reinforcements had deployed from Australia without being inoculated or without any record of inoculation in their pay books. At home the situation warranted instructions from July that all recruits whose age was suspect were required to produce a birth certificate. Medical officers and civilian doctors were urged to be vigilant:

> In the past it has been found that many youths have overstated their age in order to enlist and draw pay, but when about to embark their parents have approached the department and demanded their discharge as being under age. Careful attention is also to be paid to elderly men who apply to enlist, and who represent that they are under 45 years of age, as it has been found that many such men have understated their age in the past and on joining their unit at the front have been found to be quite unfitted for service, thereby necessitating their return to Australia, without giving their country any return for the money expended on them.[19]

Following the heavy losses at the Battle of Pozieres on 29 July 1916 both the Imperial and Australian governments were concerned about how the AIF was to be kept up to fighting strength. If future casualties were on the same scale as those sustained at Pozieres (over 20,000 men), the number of volunteers coming forward would have to meet demand. It was because of this concern that Australian Prime Minister William Hughes wanted to introduce conscription.20

According to Lieutenant Colonel McIntosh the most arduous medical work arose from the 1916 War Service Proclamation, which compelled eligible men to attend a mandatory training camp and thus be part of the Citizen Military Forces. In each of the subdistricts a medical officer was assigned who acted in conjunction with a regional military registrar. Most recruits (see table 6) were examined by the Area

Table: 6 Medical Examinations in the call up by Military Districts, 1916

Mil. District	Reported	Examined	Fit	Unfit	Doubtful	Temp. unfit	% fit for Active Service
1	33,925	32,876	21,836	8,335	1,676	1,029	66
2	69,210	59,837	36,860	17,066	2,347	3,564	61
3	54,846	54,678	33,805	14,955	3,631	2,287	60
4	18,687	18,416	13,118	3,832	659	807	71
5	8,631	8,601	4,589	3,121	480	411	53
6	6,311	6,307	4,114	1,829	203	162	65

Source: A.G. Butler, The official history of the Australian Army Medical Services in the War of 1914-1918, (Vol. III), Australian War Memorial, Canberra, 1943, p. 889

Medical Officer. To eliminate any local favouritism, medicals were not conducted by local GPs or reservist medical officers but by referee medical boards. Within one week in October 1916 106,579 men were examined.21 This was despite the fact that the legality of the proclamation was questionable. Once the conscription referendum was defeated on the 28th of that month the proclamation's legality was challenged, with the result that training camps were closed down.22 Not only had this been a huge waste of medical resources but it still left the Hughes Government with the problem of how to meet the insatiable demand for men at the Western Front.

In March 1917 a senior British officer (Surgeon-General Birrell) and the Consulting Physician and Consulting Surgeon of the AIF (Colonels Harold Maudsley and Charles Ryan), advised Howse that large numbers of Australian reinforcements arriving in the depots were overage, and of very poor physique.

Howse now recommended that every new arrival be examined seven days before embarkation by competent medical officers, who should personally certify such soldier was physically and mentally sound and appeared to be within the age limit. The district commandant was held responsible for ensuring that no soldier left for deployment as a reinforcement unless he was properly classified.

Men who failed their initial board because of 'minor defects' could, at the discretion of the MO, be admitted to a military hospital for surgical intervention.23 The War Office was keen for Australia to recruit men up to 50 years, with those not fit for combat being identified for employment in logistic and other units in the rear or along the Lines of Communication. However General Birdwood and Australian army medical authorities stood firm and left the ceiling for overseas service at 45 years.24 It was believed that older Australians did not tolerate the cold European climate well and were therefore prone to contact lung and bronchial disease as well as rheumatism. There may have been some truth in this view (see table 7).

Table: 7 Percentage of recruits discharged for medical reasons 1916-17

Month	No. examined	No. Discharged	Percentage
1916			
July	870	61	7.0
August	762	52	6.8
September	2054	82	3.9
October	1925	69	3.5
November	1751	61	3.4
December	1307	36	2.7
1917			
January	663	18	2.6
February	720	25	3.4
March	738	25	3.3
April	599	19	3.1
May	607	23	3.7
June	449	19	4.2
	12,445	490	3.9

Source: Enlistment and Examination of Recruits – reports of PMOs upon medical examination of recruits, AWM 32/100

On 1 November 1917 Surgeon General Richard Fetherston advised the Secretary of the Defence Department that the practice of deploying men overseas after only a few weeks in training camps be discontinued. He suggested that all men should be kept in camp for four months before embarkation, and no one be allowed to deploy within that period. It would also provide an opportunity for medical staff to observe the men and those likely to break down would present with tell-tale signs of physical disability before they embarked. They could then be referred for discharge. However the Adjutant-General, Brigadier-General Victor Sellheim and the Minister (Senator George Pearce) disagreed with keeping men in Australia for such a long period, although they approved the need for intending recruits to provide their birth certificate. In London, much closer to the fighting, Howse estimated that 34 per 1,000 of all reinforcements arriving in England during 1917 were totally unfit for front line service in France.

The extra load being thrown onto administrative, health and logistics assets by unfit men being deployed overseas drove senior commanders to

exasperation. Referring to the additional burden, HQ AIF spelled it out for Defence officials in Melbourne:

> This means a scandalous waste of public money amounting in all to £100,000, a waste of valuable space on transports both ways, needless work on staffs here which are already working at full pressure and a taxing of the dental staff here beyond the powers of the largest staff available. The waste is almost wholly preventable by proper action in Australia.[25]

There was an obvious disconnect between the Government's priorities in meeting its obligations to Britain, the capacity of the AAMC to properly scrutinise recruits and the unwillingness of AIF HQ in London to use these 'sub-standard' recruits for combat service.

If we take the 1st Military District (Queensland) as typical of the other states, its PMO, Lieutenant Colonel A.M. McIntosh wrote in 1917 that:

> It was apparent at an early date that the medical examinations were of very uneven quality, and numbers of men were being sent to camp who were by no means fit for active service. This was checked at first by the institution of a second medical examination on arrival in camp, and further by the establishment in Brisbane of a board of medical officers who re-examined all men before they appeared in camp.[26]

He also pointed to the long journeys many men took from remote areas, once they had been vetted by their local GP, only to be rejected at the army medical. This was the cause of some financial hardship for these recruits. So it was decided to establish army medical examination centres in twenty regional towns around the State to reduce the travel time for recruits. Despite this a number of unfit recruits still found their way into army camps. At the top of the list of causes were: heart disease, hernia, poor vision, poor dentition and varicose veins.

On 4 April 1917 at Senator Pearce's request, a conference of representatives of state recruiting committees was held in Melbourne. Among the proposals was one to raise the age limit of recruits from 45 to 50 years. Fetherston opposed the idea but agreed to give 'special consideration' to older men. Bypassing Fetherston, Pearce went direct to the War Office, which gave its approval on 25 May, although the British Cabinet disapproved. Army HQ was not obliged to heed its technical advisors, so Major General James Legge, the Chief of the General Staff (in Melbourne), agreed to the scheme and opened recruiting to men whose standard had until then been unacceptable. Fetherston and Howse were aghast and expressed their concern in unequivocal terms, but not before a number of over-age men and under-age boys had been dispatched to England.[27] On arrival, many were found to be senile or physically immature.[28]

Pearce's decision in July 1917 to maintain the age limit for recruiting to 45 years was probably in response to strenuous opposition from the General Officer Commanding, AIF, on the advice of his chief-of-staff (General Brudenell White) and with the general approval of the corps commander (General John Monash) that in the matter of physical standards, he would be guided by the advice of his technical expert – General Howse.[29] This group continued their campaign against the recruitment of youths under 18 years of age and of men over 40 years for combat deployment.

On 16 September, 1917, in response to repeated complaints from the training battalions, Colonel Douglas McWhae, the Assistant Deputy Director of Medical Services, AIF Depots in the United Kingdom, drew the attention of General Howse to "the large number of soldiers" who had arrived in August "quite unfit for any military service." The chief reason for these enlistments he found in the fact that the men had been encouraged by recruiting officials to understate their correct age, or had done so "to encourage the young men to enlist."[30] Of 4,400 reinforcements who arrived during September and October 1917, 1,700 soldiers were found dentally unfit for inclusion in drafts. They sapped resources because of the immense amount of treatment required.

By the beginning of 1918 the debate on the question of "unfit" recruits had developed into a major dispute between AIF commanders (including Howse) in London and those in Melbourne. By October Fetherston informed Howse that Prime Minister Hughes was furious because the Army Medical Corps was rejecting so many recruits in Australia. Howse remained unmoved, sure of support from HQ AIF.

In 1918 political imperatives were not helping matters, as Brigadier General George Lee, Commanding 2nd Military District (no doubt advised by Fetherston) informed the Secretary of the Defence Department:

> When a strenuous campaign is being carried on to obtain recruits it is unfortunately impossible to prevent some loss to the Department by impositions and over-keenness of people to obtain recruits, but the fact

> remains that if too stringent [medical] methods are adopted to prevent this class of thing, it is immediately stated that the efforts of the various recruiting agents are being handicapped and cold water thrown on the recruiting campaign.[31]

By 1918 recruiting standards had become such a vexed issue that the Government sought public submissions on the matter. In one such response a Mr. Edwin Spragg wrote to the Minister, Senator Pearce on 16 April, drawing to his attention the New Zealand military system then in place – special camps in which recruits were gradually brought to meet entry standards, through graduated training, swimming etc.[32] Senior Australian army doctors were unenthusiastic, mainly because of the lack of health professionals and the cost to establish such facilities.

While in Australia opportunities grew for sub-standard recruits to enter the army by lowering of standards and recruiting laxity, at the other side of the world Howse was engaged in the vigorous campaign for their return to Australia.

The next medical imperative from a recruitment perspective was an immediate consequence of the Third Battle of Ypres in the Passchendaele offensive (38,000 casualties over eight weeks). Both Fetherston and Howse did their best to support and advise their respective masters.

Senator Pearce noted on 12 January 1918 that of the soldiers returned to Australia up to the end of 1917, 10,333 had not been in any theatre of active operations.

> I have for some time been much concerned with the large percentage of rejection of A.I.F. recruits recently in England. These recruits have been medically examined three times [emphasis added] before leaving Australia so that it is extraordinary that any unsuitable men should get away. The matter is most serious in view of the shortage of recruits, and the effect on recruiting of the returned rejects is disastrous.[33]

Conclusion

War journalist Charles Bean estimated that by 1918 the AIF could only be maintained by recruiting 5,400 men each month. But after an initial rise to 4,885 in May that year the numbers steadied at about half the minimum required.[34] Had the war not ended when it did Australia could not have sustained its contribution to the war effort with both the introduction of conscription and a drastic lowering of physical recruit standards.

The professionalism of Australia's small medical establishment in dealing with recruitment issues grew during the war years, helped with the greater combat experience of many AAMC officers between 1915 and 1918. Within the political and military constraints of the day it generally responded well to changing policies and standards. Whether, after 1918, it could have continued to do so is open to debate. This is particularly the case had there been a shift from an environment in which potential recruits subverted the medical system to enlist to one in which men actively tried to evade conscription. Politics and vacillating government policy did not help matters.

The tensions between the two senior officers of the AAMC for the duration of the war did not help matters, although as we have seen, their motives were understandable given their respective combatant and home environments. Howse resolutely held his belief that a smaller fit force would achieve more in the field than a larger one diluted with unfit men. He always maintained that deploying unfit men could not 'pay'; that their enlistment was false economy. For his part, Fetherston took a more pragmatic approach, especially on standards for soldiers identified for home service only. It may be argued, given their personalities, that neither really understood the imperatives under which the other had to work.

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2. Walker A. Australia in the War of 1939–1945. Series 5 – Medical. Vol. II. Middle East and Far East. Canberra: Australian War Memorial: 1962 reprint: 33. According to Walker the rejection figures for the full-time Services in 1938 were "navy 45 per cent, army 55 per cent and air force 43 per cent, whereas less than 4 per cent of volunteers for the militia were rejected." But he added that "…examinations were often perforce carried out by busy practitioners under the handicap of poor facilities and [in] numbers too great

to be examined in the time available." Walker, ibid.: 32.

3. Butler, op. cit.: 743.
4. Enlistment and Examination of Recruits – procedure. Australian War Memorial. Canberra. (hereafter AWM) 32/90.
5. Post recruitment and on active service there were additional categories of fitness standards which were introduced over the course of the war. From 1917 others were added, for example: B1 – unlikely to be fit in less than three months and B2 – temporarily unfit. Sub categories by 1918 included: Permanent Base, Temporary Base. Enlistment and Examination of Recruits. AWM 32/91.
6. Butler A.G. The official history of the Australian Army Medical Services in the War of 1914-1918. Vol. I. Canberra: Australian War Memorial; 1938: 524.
7. ibid. 525.
8. Official Historian, Butler A.G. Enlistment and Examination of Recruits, Standards, AWM 41/797.
9. Fetherston R. Report. 1916 18 August. AWM 41 [2].
10. Summons W. A Plea for Increased Efficiency in the Medical Examination of Recruits. Australian Military Jnl. 1915 October; 6 (4): 841.
11. AWM 27 533/45.
12. AWM 27 533/45.
13. Butler.Vol.1. 1938: 514.
14. op.cit: 515.
15. Enlistment and Examination of Recruits – rejections. AWM 32/92.
16. Enlistment and Examination of Recruits – medical examinations. AWM 32/95.
17. It was an offence under the War Precaution Regulation for any person to give false information (especially about a family history of mental health issues or epilepsy) on a medical examination. But at no time during the war were any civilian doctors charged over falsifying recruiting documents, although anecdotal evidence suggests that this practice did occur.
18. Enlistment and Examination of Recruits – reports of PMOs upon medical examination of recruits. AWM 32/100.
19. Army Circular No 168. 22 June 1917.
20. Tyquin M. Neville Howse: Australia's First Victoria Cross Winner, Melbourne: Oxford University Press, Melbourne; 1999: 87.
21. Butler A.G. The official history of the Australian Army Medical Services in the War of 1914-1918. Vol. III. Canberra: Australian War Memorial; 1943: 773.
22. There were two referenda during the war, on 28 October 1916 and 20 December 1917. Both sought authority for enlisted soldiers to serve overseas. Both referenda failed.
23. From 15 December 1917 medical conditions no longer included hernia, hammer toes, varicocele, varicose veins, haemorrhoids, fistula in ano, undescended testes or testicular hydrocele. While they were hospitalised recruits could only draw on an allowance of 10 shillings (for single men, plus an additional five shillings for married men). They were not entitled to army pay.
24. Official Historian, Butler A.G., Enlistment and Examination of Recruits, Standards. AWM 41/797.
25. Cable to Army HQ Melbourne, 11 September 1917. Official Historian, Enlistment and Examination of recruits. AWM 41/768.
26. Enlistment and Examination of Recruits – reports of PMOs upon medical examination of recruits. AWM 32/100.
27. Tyquin M. op. cit.,: 97.
28. Butler A.G. The official history of the Australian Army Medical Services in the War of 1914-1918. Vol. II. Canberra: Australian War Memorial; 1940: 847.
29. Howse had an advantage over Fetherston in that he had direct access to, and corresponded regularly with, both Birdwood and White, as well as to Lieutenant General Sir Arthur Keogh, the senior British medical officer. In Australia Fetherston not only lacked a support network but was exposed to political pressure and interference from both Federal politicians and the Governor-General.
30. Butler, Vol II. op. cit.: 473.
31. Enlistment and Examination of Recruits – procedure. AWM 32/90.
32. AWM 27 533/45.
33. Butler. Vol. II. op. cit.: 849.
34. Bean C.E.W. From Anzac to Amiens. Melbourne: Penguin; 1983: 439.