

Working in a 'World of Hurt'. Nursing and Medical Care Following Facial Injury During World War One

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Abstract

This article aims to explore the impact of facial injury on British military personnel during the First World War. It focuses primarily on the Queen's Hospital, Sidcup, which became the First World War's major centre for maxillo-facial and plastic surgery in the UK, and considers some of the ethical dilemmas that medical and nursing personnel encountered. It focuses primarily on nursing care, as although the role of nurses in the First World War has been increasingly acknowledged and examined, the contribution of nurses to the development of this new specialism has hitherto been largely unexplored. It finds that although pioneering surgery and nursing care helped to restore men's faces, many had to adjust to a much-altered body image as well as physical impairments that affected them for the rest of their lives. They often had to endure a series of operations and spend many months in hospital. There is no clear evidence of the long-term outcomes for the men who underwent treatment, due to a paucity of sources, which enables only tentative conclusions to be drawn. While tales of depression and withdrawal are often recounted, alternative narratives can be found of men who went on to live contented lives and find fulfilling work. The aftercare for these men, within the context of the development of social welfare, will also be examined. Among the ethical dilemmas that faced medical and nursing staff were those experienced across medical specialities in this and other wars; specifically that they had to conform to military discipline and that in restoring men's health they also enabled their patients to be sent back to battle. Added to this was that maxillo-facial surgery was often experimental, as new techniques were attempted but were not always successful.

Keywords: Facial injury, Plastic surgery, First World War, Sidcup, Gillies, Nursing Practices, 20th Century

1 Introduction

In their book, 'Working in a World of Hurt', Acton and Potter said of the First World War that 'the war's psychological impact on the participants has been central to the way it has been perceived'.¹ The ways in which this conflict caused psychological, as well as physical, suffering are myriad, but this paper will focus on the impact of facial injury on British military personnel.

It will begin by considering the nature of facial injuries and how these occurred during the First World War, and will outline how British medical services for facial injury developed in response to rising numbers of casualties. The role that nurses played in this developing speciality will be considered and located within the context of existing research on the history of nursing care in the First World War. By utilising oral histories and written accounts, this paper will explore the impact on the lives of veterans who suffered the trauma of facial injury. It will also address the issue of social welfare for war-disabled veterans in Britain. Some of the ethical dilemmas that were encountered by medical and nursing personnel working with facially injured men in this 'world of hurt' will be examined and situated within the debate as to whether or not war can be good for medicine.²

¹ Acton/Potter 2015, p. 310.

² Cooter 2004, p. 333.

2 Facial Injury

The First World War saw a new industrial and technological type of warfare in which soldiers faced bombardment by artillery fire and bullets and shrapnel from high explosive shells, all of which could cause severe damage to the body, including the head and face.³ In the early months of the war this was exacerbated by the fact that none of the warring armies provided their troops with steel helmets. Instead they went into battle wearing cloth, leather or felt headwear which offered no protection.⁴ In November 1915, The British Illustrated War News reported a new innovation, “Our Army has now followed the French by adopting steel helmets, calculated to stop shell-splinters and shrapnel”.⁵ Steel helmets, though, while providing some protection to the skull could only play a limited role in protecting men’s faces from the onslaught of bullets and shrapnel that awaited them. Another cause of severe facial injuries was burns from explosives and poison gas. Burns were also the most common cause of facial injury for sailors and members of the fledgling air force. In addition, airmen’s faces were injured in plane crashes and by ordinance wounds (anti-aircraft artillery fire).⁶

In August 1917, John Bagot Glubb, a young British soldier, was wounded on the Western Front. He later wrote:

I heard for a second a distant shell whine, then felt a tremendous explosion almost on top of me [...] the floodgates in my neck seemed to burst and the blood poured out in torrents [...] I could feel something long lying loosely in my left cheek, as though I had a chicken bone in my mouth. It was in reality, half my jaw, which had broken off, teeth and all, and was floating about in my mouth.⁷

His account paints a compelling picture of his experience of receiving a facial wound during the First World War and indicates the challenges for those caring for such patients. He was one of an estimated 60,500 British combatants⁸ who sustained head or eye injuries during this conflict, many of whose lives were to be changed forever by the nature of their wounds and the disfigurement and disability that followed. As Biernoff notes, “Disfigurement and mutilation were ubiquitous on the battlefields of the First World War” and many soldiers were shot in the face, she argues, because they had no experience of trench warfare.⁹

Neale states that while facial injuries were not unique to World War I, improved medical treatment in the field and advances in transporting the wounded meant that many soldiers who would have died from such injuries in earlier conflicts now required further treatment.¹⁰ Initially there was only rudimentary treatment open to those men with severe facial injuries who did survive long enough to receive medical and nursing care. In the early part of the war, for

³ Bamji 2017.

⁴ Bamji 2016, p. 20.

⁵ Illustrated War News 1915, p. 9.

⁶ Sir Harold Gillies’ Patient Case Files, 1915–1925, Royal College of Surgeons’ Archives, Ref. MS0513.

⁷ Glubb 1978, p. 185.

⁸ Biernoff 2011, p. 1.

⁹ Biernoff 2011, p. 1.

¹⁰ Neale 2014, p. 1.

example, it was not always realised that being carried in a supine position on a stretcher or being laid down in bed to rest could result in a soldier with a facial injury asphyxiating.¹¹ If they reached hospital, surgeons did not possess the skills to repair their ravaged faces.

3 The Emergence of Plastic Surgery and its Impact on Nursing Practice

Plastic surgery as a medical speciality was to emerge in the UK as a direct result of these wartime facial injuries as surgeons began to respond to the challenge of repairing disfigured faces. The most famous of these surgeons in Britain, Harold Gillies, was originally from New Zealand, and had trained as a doctor at Cambridge University and St Bartholomew’s Hospital in London. He led a pioneering plastic surgery service for facially damaged servicemen, a 220-bed unit within an existing military hospital, the Cambridge Hospital at Aldershot, which opened early in 1916.¹² Catherine Black, a British Army nurse¹³ who worked there, recalled in her 1939 autobiography:

In all my nursing experiences those months at Aldershot in the ward for facial wounds were, I think, the saddest. Sadder even than the casualty clearing stations which I went to afterwards, for there death was swifter and more merciful, and it is not so hard to see a man die as to break the news to him that he will be blind and dumb for the rest of his life. And that was something we had to do so often in the silent ward where only one in every ten patients could mumble a few words from the shattered jaws.¹⁴

For Gillies and his colleagues it was a chance to develop their skills in plastic surgery and restore some hope to men with shattered faces and lives.

Gillies himself was to acknowledge the vital role that the nursing staff made in the care of these wounded men. In 1920 he published his seminal textbook, ‘Plastic Surgery of the Face’, which described the treatment he and his colleagues had pioneered during the First World War. In the preface, Gillies pays tribute to the staff he worked with:

Matron, and the theatre- and ward-nursing staffs of this hospital, whose shoulders have borne the brunt of the work. Assiduous and intelligent care in the after-treatment of these cases is a prime necessity and calls for the highest standard of watchful skill.¹⁵

Nurses in this emerging speciality of maxillo-facial surgery have, however, received little attention from historians compared to their medical colleagues.¹⁶ As Hallett points out, ‘some medical histories of the First World War might persuade the reader that nurses were invisible

¹¹ Holmes 2012, p. 266.

¹² Pound 1964, p. 24.

¹³ Catherine Black was a Nursing Sister in the Queen Alexandra’s Imperial Military Nursing Service Reserve.

¹⁴ Black 1939, pp. 86–87.

¹⁵ Gillies 1920, preface.

¹⁶ Chatterton/McInnes 2016.

– or that they never existed’.¹⁷ Hallett’s work (together with others such as Yvonne McEwen¹⁸) have addressed what she refers to as, some of these ‘empty spaces’ in the historical record by detailing and analysing what actually comprised the work of nurses and how their role expanded considerably under the exigencies of war.¹⁹ This paper aims to add to this growing canon of knowledge by exploring the work of nurses in facial injury, which has remained a somewhat ‘empty space’ in historical research.

For those nursing men with facial injuries, it was to prove challenging work as they adapted their nursing skills and techniques, such as promoting nutrition and wound care, to this new area of patient care. Promoting nutrition for men with facial injuries was to take up much nursing time. Sister Catherine Black gives a vivid account of the challenges of feeding men with damaged faces at the Cambridge Hospital:

The problem of feeding was acute [...] for very few of the patients in that ward could take even a particle of anything solid, and yet their strength had to be kept up at all costs. So we had to ring the changes as best we could in two-hourly feeds [...] tomato soup made with milk, Benger’s food, iced coffee, egg flip. Often we would use as many as three hundred eggs a day in one ward alone. The VAD’s worked [...] all day long, cooking and clearing away, for no sooner was one feed finished than it was time to start preparing another.²⁰

Her account resonates in the writings of other nursing staff during the conflict. For example, Marjorie Starr, a VAD at the Scottish Women’s Hospital in Royaumont, wrote in her diary of the challenges of being responsible for patients’ diets on her ward and of the rigours of tube feeding a patient with extensive injuries to his jaw and mouth.²¹

As Hallett notes, although there was nothing in their previous experience that could have prepared nurses for the wounds created by the industrial weaponry of the First World War, they responded to the resultant challenges by pioneering new methods of wound treatment. She describes the lengthy and time-consuming dressing rounds that nurses undertook; sometimes taking up to an hour to painstakingly clean, debride and redress a complex wound, knowing that this was often intensely painful for the patient but vital if the wound was to have any chance of healing.²² She argues that nurses honed their skills with constant practice and that trained nurses during the First World War became, “competent and confident wound dressers [...] [who] passed on their technical know-how to their volunteer assistants, the VADs”.²³

¹⁷ Hallett 2009, pxi.

¹⁸ McEwen 2014.

¹⁹ Hallett 2009, p. xi.

²⁰ Black 1939, p. 87.

²¹ Starr 1915, unpaginated.

²² Hallett 2014, pp. 87–92.

²³ Hallett 2009, p. 41. VAD was a common abbreviation used for a member of a Voluntary Aid Detachment, which operated under the auspices of the British Red Cross Society or the Order of St John of Jerusalem.

In the process, wound care, historically the domain of surgeons, established itself firmly with the nursing orbit, as boundaries merged and blurred in wartime.²⁴ As *The Nursing Times* noted, many patients with facial injuries arrived with septic wounds and those wounds had to be dressed by nursing staff until the wound was ready for surgery.²⁵ Gillies identifies the challenges of post-operative wound care with some patients having a ‘sump of pus’ in their mouths, necessitating what he calls ‘frequent forceful irrigation.’²⁶ The innovative but contentious Carrel-Dakin treatment for wound care,²⁷ which he describes as continuous irrigation, was not always he notes, practicable in maxillo-facial injuries. He advocates that post-operatively, facial wounds should be left open to the air as much as possible but that when a skin flap has been utilised from skin which he describes as having ‘precarious viability’, hot saline packs should be applied at the close of the operation and renewed two-hourly, a task for the nursing team.²⁸

4 The Queen’s Hospital, Sidcup

The Battle of the Somme, which began on 1 July 1916 and continued into the autumn of that year, led to a seemingly never-ending flow of wounded men to the unit in Aldershot just months after it opened. Gillies later recalled, “Men without half their faces, men burned and maimed to the condition of animals. Day after day, the tragic, grotesque procession disembarked from the hospital ship and made its way towards us”.²⁹ He remarks that they expected 200 patients and received 2,000.³⁰ A few other hospitals, mainly in London,³¹ also accepted some facially injured patients but demand for beds rapidly outstripped the existing provision. In January 1917, the Joint War Committee of the British Red Cross and Order of St John purchased the freehold of Frognal House in Sidcup in Kent and there in the grounds, a hospital was rapidly constructed.³² It was to be known as the Queen’s Hospital (after Queen Mary who became its Patron). It opened on the 1 August 1917 with 100 beds and within a year, it had 1,000 beds at its disposal.³³ As the foremost treatment centre for facial injury in the UK during World War One, its personnel carried out 11,572 operations between 1917 and 1925 (when it closed) on over 5,000 service men.³⁴ The hospital records reveal that men came not just from

²⁴ Hallett 2009, p. 46.

²⁵ *The Nursing Times* 1917, p. 94.

²⁶ Gillies 1920, p. 7.

²⁷ *The War Office* 1917, pp. 3–4.

²⁸ Gillies 1920, p. 32.

²⁹ Gillies/Millard 1957.

³⁰ Hussey 2014.

³¹ Wallace 1987, p. 2; Bamji 2017, pp. 345–46. These included the 3rd London General Hospital in Wandsworth, King George V Military Hospital in Stamford Street, London; two donated townhouses in London operating under the auspices of the Order of St John and the British Red Cross (74 Brook Street and 24 Norfolk Street), which were attached to the 1st London General Hospital in Camberwell and a Red Cross maxillo-facial unit in Kennington. In Leeds a jaw unit was established at Beckett Park Hospital.

³² *The British Journal of Nursing* 1917, p. 61.

³³ *British Journal of Nursing* 1921, p. 320.

³⁴ Wallace 1987, p. 3.

the army but also the navy and air force.³⁵ Although 80 % of the wounds were from gunshot or shrapnel, they also dealt with burns. Most men came from the Western Front, but the case records reveal that they also came from other theatres of war including Egypt, Mesopotamia, and the war at sea.³⁶

Gillies is the most well-known of the team of surgeons who were to work at Sidcup, but surgeons also came from Australia, New Zealand, Canada, and the USA to Sidcup to work alongside their British colleagues and to gain experience and help develop this new speciality. They worked alongside pioneering anaesthetists (including from 1919, Ivan Magill), dental surgeons (perhaps the most famous being William Kelsey Fry), and technicians such as Archibald Lane, who were vital in helping rebuild shattered jaws.³⁷ As Hussey notes, “the dental laboratory became a sight of innovation as surgeons and technicians worked together to create custom splints and prostheses to repair or replace bony tissue”.³⁸ Where surgery could not repair the extent of the damage (or the patient was unable to endure further surgery) facial prostheses and masks were sometimes offered.³⁹ X-rays played a vital role in identifying fractures and charting progress. Progress was also recorded by photographers as well as artists including Henry Tonks.⁴⁰ The case notes reveal that some men underwent a whole series of operations over several years thus necessitating long periods in hospital.⁴¹

5 The Consequences of Facial Injury

Robert Tait Mackenzie, who inspected convalescent hospitals for the British Royal Army Medical Corps during the war, described the facially injured patients he saw as the “most distressing cases” in military surgery:

[...] the jagged fragment of a burst shell will shear off a nose, an ear, or a part of a jaw, leaving the victim a permanent object of repulsion to others, and a grievous burden to himself. It is not to be wondered at that such men became victims of despondency, of melancholia, leading, in some cases, even to suicide.⁴²

³⁵ The British Royal Air Force (RAF) was formed on 1 April 1918 with the merger of the Royal Flying Corps and Royal Naval Air Service.

³⁶ Some of the case files of the British and New Zealand sections of the Queen’s Hospital, Sidcup are in the Archives of the Royal College of Surgeons, London, RCSEng Archives, Ref. MS0513.

³⁷ Bamji 2017.

³⁸ Hussey 2014.

³⁹ Feo 2007; Nicholson 2009, pp. 64–68, 72–73. Sculptors involved in this work include John Edwards and Kathleen Scott at Sidcup, Anna Coleman Ladd in Paris, and Francis Derwent Wood at the 3rd London General Hospital in Wandsworth. The latter’s workshop became known colloquially as the ‘Tin Noses Shop’.

⁴⁰ Bamji 2016.

⁴¹ Case files in the Archives of the Royal College of Surgeons, London, reveal this. For example, case file 006, a soldier wounded in the face on 20/09/1917 and discharged home on 07/09/1920.

⁴² McKenzie 1918, p. 117.

As Christine Hallett notes more recently, “just as shell-fire and shot created rents in the body, emotional distress created rents in the psyche”.⁴³ Many men with facial injuries experienced both. Nursing Sister Catherine Black expresses this eloquently:

Hardest of all was the task of trying to rekindle the desire to live in men condemned to live week after week smothered in dressings and bandages, unable to talk, unable to taste, unable even to sleep without opiates because of the agony of lacerated nerves, and all the while knowing themselves to be appalling disfigured.⁴⁴

Gillies’ wife Kathleen, herself a nurse, was a frequent visitor to the wards (despite caring for a young family), where she tried to “revive hope in despairing hearts”.⁴⁵

Nurses, and their colleagues, had to learn the art of not reacting to the distressing sights to which they were exposed.⁴⁶ In a letter home from a French hospital in 1917, Julia Stimson, an experienced American nurse, writes, “These frightful sights would work havoc with one’s brain”.⁴⁷ Volunteer British Red Cross nurses, such as VAD Daisy Colnett Spickett (who worked at Bagthorpe Military Hospital, Nottingham), had to learn this quickly. In an oral history interview recorded in 1974, she recounts the first time she saw a man with a severe facial injury in 1915:

A patient came in with his head bandaged up [...] only his eyes showing [...] as I took (off) bandage after bandage. I thought to myself, ‘there’s going to be no face left here at all, how dreadful it will be [...]. And then I realised he was gazing intently at me and I thought, he’s waiting to see my reaction. Then of course it was absolutely different. I chatted to him and teased him a little and tried to make him smile [...]. One would have been shocked if one could afford to be [...] but one couldn’t afford to be [...]. That was our salvation [...] We were thrown head first into the work but we had to do something about it [...]. It was a thing that came back to me again and again and again. But one had to do something and that was what saved you.⁴⁸

Despite the passage of time between the encounter she describes and her telling of it, the impact it had on her was clear. At the same time, this quote vividly illustrates what Hallett describes as “emotional containment”; the need for nursing staff to control their own emotions in order to be able to function professionally and best help their patients.⁴⁹

Many of the men who came to Sidcup needed extensive treatment with time to recuperate between operations. The British Journal of Nursing extolled the location of the hospital within

⁴³ Hallett 2009, p. 228.

⁴⁴ Black 1939, p. 87.

⁴⁵ Pound 1964, p. 47.

⁴⁶ Macdonald 1980, p. 154.

⁴⁷ Stimson 1918, p. 84.

⁴⁸ Colnett Spickett, Daisy: Imperial War Museum Sound Archives. Oral history interview, recorded 1974, catalogue number 514, reel 7.

⁴⁹ Hallett 2014, p. 155.

an estate with extensive gardens and a farm, reporting that its “delightful surroundings and country air” would brighten up the lives of those convalescing there.⁵⁰ Sidcup offered all kinds of what would now be called occupational therapy in the hope of enabling its patients to successfully return to civilian life. Contemporary newspaper articles depicted the men tending chickens, making toys, and repairing watches and clocks among other activities. Sporting competitions were encouraged.⁵¹ As the *Daily Mirror* reported at the time, these activities “not only fit the men for self-support in civil life but keep their minds from dwelling on their injuries during the long time it must take to restore them”.⁵²

Just as many of the men had experienced the comradeship of the trenches, so the culture at Sidcup helped to promote what Reznick describes as “a comradeship of healing”.⁵³ Commentators noted the camaraderie between the men and also the close therapeutic relationships that developed between them and the medical and nursing staff caring for them.⁵⁴ This often raised the men’s spirits, helped them develop their resilience, and aided their recovery. Nurses played their part, working long shifts with their gravely injured patients and being a constant and often comforting presence. Sidney Beldam, recovering from what his local paper described as “being dangerously wounded in the right cheek and nose” wrote home to his mother that “The Sisters are jolly good. They are so gentle with a chap’s wounds and do everything you want and never get out of patience”.⁵⁵

This “comradeship of healing” is also evident in a photograph from 1967, which depicts a reunion of some of the men back at the hospital with Gillies’ widow.⁵⁶ Many oral histories talk of how popular Gillies was with the men and how he inspired their confidence.⁵⁷ Marilyn McInnes says that her grandfather, Sidney Beldam, recalled “that Gillies went beyond the norm with his great sense of fun and encouragement of the wounded and for whom he did the very best he could”.⁵⁸ He later worked for Gillies as his chauffeur. Sister Catherine Black described Gillies as “the man who [...] made life worth living again for thousands of despairing war-disabled men”.⁵⁹ Other staff too played their part. Joseph Pickard, a Sidcup patient, recalled later in life in an oral history interview, the support he had received from his surgeon, Thomas Kilner, and he recounted some of the banter between them that helped to sustain his morale.

⁵⁰ The *British Journal of Nursing* 1917, p. 61.

⁵¹ A scrapbook of newspaper cuttings depicting these can be found in the London Metropolitan Archives, HO2/QM/Y/01/005P.

⁵² *Daily Mirror* July 1917 – cutting on p. 11 of a scrapbook of newspaper cuttings in the London Metropolitan Archives, HO2/QM/Y/01/005P.

⁵³ Reznick 2004, p. 137.

⁵⁴ Anderson 2011 noted a similar phenomenon at Stoke Mandeville Hospital (for spinal injuries) during the Second World War.

⁵⁵ Reported in the *Cambridge Daily News* 1917, unpaginated.

⁵⁶ Presswell/Bamji 2005, p. 28.

⁵⁷ Bamji 2017.

⁵⁸ Chatterton/McInnes 2016, pp. 57–58.

⁵⁹ Black 1939, p. 85.

“Doctors”, he says, “you could talk to them. They would do anything for you and the nurses, the sisters, was the same”.⁶⁰

However, at the same time, mirrors were banned from the wards and benches in the local area were painted blue.⁶¹ The latter was a visual signal to Sidcup residents that the blue benches would be used by the hospital’s patients, “a code that warned townspeople that any man sitting on one would be distressful to view”.⁶² This arguably served a dual purpose, protecting the public from seeing the extent of the men’s injuries but also protecting the men from public reaction and possible revulsion. They therefore formed part of the men’s rehabilitation by providing encouragement to leave the hospital grounds as the blue benches provided, what could be seen as, safe spaces, for hospital patients.

Blue benches though, could also be seen as part of what Biernoff calls a “culture of aversion” or a “collective looking away”.⁶³ She argues that there was a lack of parity between men with wounded faces and those with wounded bodies, comparing and contrasting the patients at Sidcup with men who had lost limbs and were fitted with prostheses at Queen Mary’s Auxiliary Hospital at Roehampton. The latter and their missing limbs, she says, featured prominently in public wartime discourse, such as in newspaper reports, whereas pictures of severely facially injured men were not on view. Those men that did appear in newspapers were those with less visible facial injuries or whose injuries were hidden behind bandages. Showing their disfigured faces was taboo. In addition, men whose faces were severely injured were never officially celebrated as wounded heroes, unlike amputees.⁶⁴ As a corollary to this, Bourke posits that although severe facial injury affected the men’s ability to function physically, its key impact was on the men’s appearance and self-identity and points out that “very severe facial disfigurement” was to become one of the injuries for which a war veteran could receive a full pension, together with losing two limbs or their sight.⁶⁵

Writers have described how some of those with facial injuries refused to see their loved ones and others were rejected by their families and fiancées. Muir Ward, an orderly who worked at the 3rd London General Hospital, said of some of the men he cared for:

Suppose he is married, or engaged to be married? Could any woman come anywhere near that gargoyle without repugnance? His children...Why, a child would run screaming from the sight. To be fled from by children! That must be a heavy cross for some souls to bear.⁶⁶

Pam Parish, in remembering her childhood, speaks of her mother’s kindness to a local man, Stuart Lloyd, who suffered severe facial injuries during his war service. She recounts how she

⁶⁰ Pickard, Joseph: Imperial War Museum Sound Archives. Oral history interview, recorded 1986, catalogue number 8946, Reel18.

⁶¹ Bamji 1996, p. 498.

⁶² Alexander 2007, unpaginated.

⁶³ Biernoff 2011, p. 3.

⁶⁴ Biernoff 2011, p. 3.

⁶⁵ Ministry of Pensions 1918.

⁶⁶ Ward 1918, p. XX.

and her sister dreaded his visits because they were expected to kiss his cheek and how when he stayed for supper, they would turn their faces away because of the reappearance of food through his nose as he tried to eat.⁶⁷ It is interesting to note that in France, facially injured soldiers referred to themselves as, gueules cassées (broken mugs).⁶⁸ The London Metropolitan Archives has a scrapbook that contains a large number of newspaper cuttings about the Queen’s Hospital, Sidcup.⁶⁹ While some paint an upbeat picture of the pioneering plastic surgery taking place there, using terms such as “shattered men remade” by “wizards of surgery”, others dwell on the suffering of the patients with headlines such as the ‘Loneliest of all Tommies’⁷⁰ and talk of a hospital where “men do not wish for mirrors”.⁷¹

Nurse Catherine Black tells a heart-rending story in her memoirs of the one of the men that she nursed whom she calls Corporal X. Before the war he had been a young solicitor in the Midlands and was engaged to a girl called Molly. She writes to him frequently and wants to visit him, but he keeps delaying her visit. Finally, his bandages are removed, and his facial disfigurement (caused by a shrapnel wound on the Somme) is revealed. “Captain Gillies had done everything humanly possible but he could not work miracles”, says Black. She continues:

Mirrors were prohibited in that ward, but to my dismay I found Corporal X in possession of one that evening. None of us had known that he had a shaving-glass in his locker. I pretended not to see it when he called me over and asked me to put screens around his bed. Every nurse learns that there are moments when it is better to leave a patient alone because sympathy would only make things worse. I think he must have fought out his battle in the night, for early in the morning he asked for a pen and paper and wrote a letter which he asked me to post.⁷²

Black later asks when Molly will visit, and he tells Black that he has written to her saying that he has fallen in love with a girl he had met in Paris and is ending their engagement. “It wouldn’t be fair to let a girl like Molly be tied to a miserable wreck like me”, he tells Black. “I am not going to let her sacrifice herself out of pity. This way she will never know”.⁷³

This poignant story is retold in Louisa Young’s novel, ‘My Dear I Wanted to Tell You’,⁷⁴ which, together with Pat Barker’s trilogy of novels⁷⁵, portrays in fictional form the lasting psychological and physical wounds experienced by some survivors of facial injury and surgery in this

⁶⁷ Cited by Nicolson 2009, p. 62.

⁶⁸ Gerhardt 2013 b, p. 21.

⁶⁹ The Queen’s Hospital, Sidcup, Kent: Newspaper cuttings, London Metropolitan Archives, HO2/QM/Y/01/005P.

⁷⁰ Sunday Herald June 1918 and p. 41 in a scrapbook of newspaper cuttings, London Metropolitan Archives, HO2/QM/Y/01/005P.

⁷¹ Daily Sketch June 1918 and p. 42 in a scrapbook of newspaper cuttings, London Metropolitan Archives, HO2/QM/Y/01/005P.

⁷² Black 1939, pp. 88–89.

⁷³ Black 1939, pp 88–89.

⁷⁴ Young 2011, the first in a trilogy of novels that has facial injury as its theme.

⁷⁵ Barker 2012. The novel ‘Toby’s Room’ is the most well-known of her trilogy (‘The Life Class Trilogy’) on this subject.

period. Pritchard argues that patients with facial wounds experienced a double trauma, resulting in both “the loss of function, and the emasculating loss of identity. In one moment, soldiers were robbed of their personality, their capabilities, and the basic capacity for self-care”.⁷⁶ Not only did they have to sometimes learn to eat and talk again, and cope with the physical ramifications of their injury; they also had to come to terms with changes to their face and body image, and to others’ reactions to them, which could result in deep psychological wounds.⁷⁷ Pritchard points out that:

Photographs of veterans with facial disfigurement are some of the most striking and disturbing images from the First World War. Even when seen through the lenses of antiquated cameras one hundred years later, it is difficult not to recoil at the sight of men with no eyes, jaws, or noses. In the immediate aftermath of World War I, the disfigured soldier evoked a combination of fear, disgust, and pity.⁷⁸

One of the challenges facing historians seeking to understand facial injuries is the scarcity of sources. While some of the medical records on the men still exist, others were destroyed or lost, and those that do exist often contain only brief notes. Few medical and nursing personnel wrote about, or later recounted, their experiences of working in the field of facial injury (nor did patients), so there is sometimes insufficient primary source material to support any definite conclusions. There was no systematic follow-up once patients were discharged, partly because the hospital changed its function in the post-war years and also possibly because of the sheer numbers involved, alongside many other injured servicemen in a post-war Britain that was facing austerity.

As Bamji points out, “The patient experience is dimmed by the passage of time”⁷⁹ and it is now over a century since these events occurred. He has made concerted efforts to trace the stories of survivors (recording nearly 100 of them) and tells some of their stories using a combination of photographs of them in later life and information from their families.⁸⁰ Marilyn McInnes for example, recalls of her grandfather, Sidney Beldam, who despite his injury and enduring many operations always regarded himself as one of the lucky ones, “He had made it through, got married and had a happy family life”.⁸¹ Other testimonies also recount stories of men who were accepted by their families, found fulfilling careers, and found love after their injuries. Perhaps a man’s ability to adapt and survive following facial injury could relate to his “pre-morbid disposition”, in other words his personality prior to his injury.

This ability may also be related to their wider wartime experiences rather than their injury per se. Bamji conceptualises this as a “spectrum of adjustment to post-war life, from those who shrugged off their injuries with complete insouciance to those who were and would remain

⁷⁶ Pritchard 2016, p. 20.

⁷⁷ Bourke 1996; Coyne-Carden 2017.

⁷⁸ Pritchard 2016 p. 2

⁷⁹ Bamji 1996, p. 500.

⁸⁰ Bamji 1996, 2016, 2017.

⁸¹ Chatterton/McInnes 2016, p. 58.

withdrawn from society”.⁸² This is supported by *The Nursing Times*, which, reporting in 1917 on the new hospital at Sidcup, noted the variety of responses made by the men to their changed facial appearance:

Many of the men of course are permanently blind. Most of them suffer from acute depression and some are so conscious of their affliction they refuse to go home, until they are sure that everything possible has been done; whilst others are so pleased with the result of treatment that they do not wait until the surgeons are completely satisfied.⁸³

Some of the men developed the ability to cope with public reactions to their injuries. One Sidcup patient, Joseph Pickard recalls how being stared at, which he refers to as being “gawped at”, by people in the street initially damaged his confidence but that he then learnt to overcome it and ignore it.⁸⁴ Thus, Bamji concludes that he has revised his opinion over time and now states that “the majority of men who acquired severe facial injuries lived largely contented lives after their treatment”.⁸⁵ This is also supported by the existence of some accounts written by patients attending a literacy class at Sidcup. Although they only number six in total, these patients provide upbeat descriptions of how they are feeling.⁸⁶

Grigsby takes issue with Bamji, arguing that he is unduly optimistic and points to some of the harrowing tales that she has encountered.⁸⁷ Many men, however, have disappeared from the historical record and so there can be no definitive account or statistics of how many, for example, committed suicide or hid themselves away from public view. Bamji mentions one patient who was found dead of alcohol poisoning in a cottage close to the hospital at Sidcup.⁸⁸ Nurses who worked at the hospital in the 1950s remembered two night watchmen who were former patients from the First World War and so badly disfigured that they had chosen to stay at the hospital and work at night, away from the public gaze.⁸⁹ Others, Nicolson states, also found it impossible to “muster the courage to appear in daylight, seeking refuge in work as projectionists in the screened-off booths of cinemas”.⁹⁰

Neale has traced Australians who were patients at Sidcup and identifies in the Australian case files she has studied that men did sometimes experience feelings of self-consciousness, isolation, withdrawal, even depression. However, she argues that this does not constitute a com-

⁸² Bamji 2017, p. 117.

⁸³ *The Nursing Times* 1917, p. 294.

⁸⁴ Pickard, Joseph: Imperial War Museum Sound Archives. Oral history interview, recorded 1986, catalogue number 8946, Reel 17.

⁸⁴ Bamji 1996, p. 498.

⁸⁵ Bamji 2016, p. 209.

⁸⁶ There are six of these essays entitled ‘My Personal Experiences of the Great War’ written by Privates McGowan, Wordsworth, Murray, Faragher, Best and Cullimore as part of an education class run by Lady Gough. They are located in the Liddle Collection at the University of Leeds. LIDDLE/WW1/GA/WOU/34.

⁸⁷ Grigsby 2017.

⁸⁸ Bamji 2017, p. 156.

⁸⁹ Presswell/Bamji 2005, p. 19

⁹⁰ Nicolson 2009, p. 77.

plete picture of the experience of facially injured first world war veterans, which she believes is considerably more nuanced. She recounts the stories of two men, Ivo Howell and William Kearsey, whom she describes as examples of adaptation and resilience.⁹¹

6 Aftermath

Disabled war veterans like the men who were treated at Sidcup were also written out of the history of post-war reconstruction.⁹² The First World War caused the deaths of 9.5 million military personnel and permanent disability to 8 million of the survivors. Britain had over 750,000 disabled veterans.⁹³ According to Deborah Cohen, these men suffered the worst injuries that had ever been seen. “Shrapnel”, she writes, “tore ragged paths through flesh and bone”.⁹⁴ These injuries included the severe facial injuries that are the focus of this paper.

And yet, the British state took the bare minimum of responsibility for the war disabled. This stance condemned them to a life on the periphery, where they were often segregated from society (in sheltered workshops, for example) and rarely included in Armistice Day parades. Gerhardt suggests a possible reason for this: “Their wounds were visually evocative of the conflict, they constituted an intrusion of war into everyday life, especially once it was over. This intrusion was not always well received by societies, who oscillated between a “moral obligation” to remember and the wish to forget.”⁹⁵

Despite the narrative of a land ‘fit for heroes’, the British government (which had established a Ministry of Pensions in 1917) offered only modest compensation to disabled veterans. Cohen suggests that “In Britain, civil servants in the new ministry charged with their care sought to limit the state’s obligations towards disabled veterans”.⁹⁶ This is supported by other commentators, who have noted the unwillingness of the inter-war British government to intervene in social problems.⁹⁷ This led to disabled veterans often having to rely on their own resources or the benevolence of a previous employer or philanthropist. Although some cities did give them preferential access to housing, many others did not.

In addition, employment was hard to come by for disabled ex-servicemen. In this case too, Britain took a different path from some of her European neighbours. Unlike in France, Italy, and Germany, where the state required the compulsory employment of severely disabled veterans, the British government adopted a more laissez-faire approach. As Cohen says, in Britain they were “left to their own wits and the goodwill of their fellow citizens”.⁹⁸ Even for those who did manage to find employment initially, the impact of economic austerity during

⁹¹ Neale 2014.

⁹² Cohen 2001.

⁹³ Cohen 2001, p. 1.

⁹⁴ Cohen 2001, p. 1.

⁹⁵ Gerhardt 2013 b, p. 56

⁹⁶ Cohen 2001, p. 4.

⁹⁷ E.g. Reznick 2004.

⁹⁸ Cohen 2001, p. 109.

the inter-war years was to make both finding and retaining work even more challenging as severely disabled men found themselves competing with the able-bodied.

There has been less research on the impact on women and families who lived with men disabled by war. Jessica Meyer, for example, has examined some of the pension files kept by the British government in the aftermath of the First World War. She states that she found in these evidence of suffering on the part of both veterans and their wives, of physical strain, financial hardship, emotional pressure, and often family breakdown.⁹⁹ Cohen points out that the care of a badly disabled man not only required tremendous stamina, but that if their husbands were unable to work, women would in addition to completing all their own domestic duties and childcare responsibilities often also have to supplement their husbands’ meagre pensions by finding work outside the home.

This problem was particularly acute for those women who married veterans after they had been injured, as the British government’s pension system only considered those men for a higher allowance who had had wives and children before they were injured. Those who married after their discharge from military service were only eligible for a single man’s pension. This contrasts sharply with France and Germany, where a man’s war pension was raised if his family circumstances changed.¹⁰⁰ As a result, many British families were condemned to penury.

7 Ethical Issues

The narrative reveals that care of British men with facial injuries sustained during the First World War also encompassed a range of ethical issues. Gillies outlined what he saw as his duties at an address to the Medical Society of London towards the end of 1917. The first was to send “back to duty as many soldiers as possible in the shortest time”, the second to “the patient and to do the best for him”, and the third “to contribute as much as possible to science and to the knowledge of surgery”.¹⁰¹

These three aims, he says, frequently clashed, and some of the ethical dilemmas that confronted both medical and nursing staff in this war (and others) are clearly illustrated by these comments. It could be argued that one of the great conundrums for military medical and nursing staff is that they treat and care for men only to see them return to the war zone in which they sustained their initial injury.¹⁰² A good illustration of this is provided in Case 37 from the Sidcup files. In this account, a patient undergoes surgery to repair a large gaping facial wound. The wound appears to be making good progress, whereupon he returns to active duty, only to die of wounds to his legs in the same casualty clearing station that first received him with his original facial wound.¹⁰³

⁹⁹ Meyer 2004. The Ministry of Pension Files are in the National Archives, Kew (PIN 26) and consist of 18,472 folders.

¹⁰⁰ Cohen 2001, p. 106.

¹⁰¹ Cited in Petty 2013, p. 24.

¹⁰² Harrison 2010.

¹⁰³ Cited in Pound 1964, p. 55.

Whitehead has discussed the ethical dilemmas that faced British Regimental Medical Officers (RMOs) working in France, Flanders, and other theatres of war during this conflict. Their primary duty, he argues, was to maintain the fighting strength of their unit, which could also mean that the needs of the army were placed above the needs of the individual.¹⁰⁴ Jones says of a doctor who embarks on military service: “The context in which he practises medicine is transformed. As a civilian, he is taught to serve the interest of his patient with the proviso that he does no harm. By contrast, the army doctor is presented with a very different set of priorities.”¹⁰⁵ Thus, the Hippocratic Oath can be superseded by the exigencies of war.

Another ethical dilemma is the experimental nature of the work. Grigsby explains that ‘Three decades before Archibald McIndoe’s burnt airmen formed the Guinea Pig Club in 1941, First World War Soldiers were the guinea pigs of fast-developing maxillofacial surgery’.¹⁰⁶ Gillies reflects that “This was a strange new art and unlike the student today, who is weaned on small scar excisions and gradually graduated to a single harelip, we were suddenly asked to produce half a face”.¹⁰⁷ Surgeons, nurses, dentists and anaesthetists had to learn as they went along and sometimes had to learn from their mistakes. An oft-quoted example of this is the story of a badly burned pilot, Ralph Lumley, who died at Sidcup in March 1918, after Gillies attempted to replace the whole skin of his face with a chest flap. This failed and Lumley died of gangrene.¹⁰⁸ As Bamji notes, ‘There is no doubt that the casualties of the Western Front were the vital experimental subjects which enabled the modern speciality of plastic surgery to develop.’¹⁰⁹

For some this meant enduring painful surgery that was not always successful, as in the case of Norman Wallace who underwent 21 operations at Sidcup but was left severely disfigured.¹¹⁰ Some made the decision to refuse further treatment against surgical advice when they could no longer endure any further surgery.¹¹¹ Gillies describes plastic surgery as being “a constant battle between blood supply and beauty”¹¹² or function and form, a sometimes difficult balancing act.

Cooter has described the concept of a positive audit of war and medicine, describing the conventional narrative as being “that war, with all its horrors and its sufferings, has nevertheless brought lasting medical benefit to mankind.”¹¹³ The First World War is often cited as being responsible for a whole host of innovations in military medicine and nursing care due to the demands of the wartime environment in which doctors and nurses had to operate and the medical and surgical needs that industrial warfare created. In addition to the development of

¹⁰⁴ Whitehead 1996, p. 470.

¹⁰⁵ Jones 2008, p. 1658.

¹⁰⁶ Grigsby 2017, p. 1.

¹⁰⁷ Gillies/Millard 1957.

¹⁰⁸ Bamji 2017, pp. 97–98.

¹⁰⁹ Bamji 1996, p. 500.

¹¹⁰ Bamji 2017, p. 98.

¹¹¹ For example, case file 007, Royal College of Surgeons’ archives – patient refused further treatment.

¹¹² Gillies/Millard 1957, p. 49.

¹¹³ Cooter 2004, p. 333.

plastic surgery as a speciality, advances were made in orthopaedic care, psychiatric treatment for shellshock, the growth of radiology, and the use of blood transfusions, among many others.¹¹⁴ One of the requirements for the development of medical specialisation is the high incidence of a specific medical or surgical problem. The First World War provided these and facial injury was one such problem.

Although war might be described as having a positive impact on the development of nursing, medicine, and surgery, a negative audit of war and medicine is also possible.¹¹⁵ Cooter summarises this cogently when he says, “war appears still less medically beneficent when attention is directed to the ostensible objects of military medicine: the troops”.¹¹⁶ This could also be said to include their families and loved ones, as earlier discussion has outlined. Commentators¹¹⁷ have also drawn attention to the negative impact that the First World War had on both the mental and physical health of the doctors and nurses who served, including some who lost their lives. In addition, medical progress during the war was not always translated into civilian medicine and Waddington argues that wartime innovations, such as plastic surgery for facially injured men, did not make further progress until the Second World War.¹¹⁸ When considered in ethical terms, the concept of war being good for medicine might be seen as being related to the concept of consequentialism. However, when the human cost of the conflict is considered, a deontological approach would point to the enormous pain and suffering that many men with facial injuries experienced, as some of the examples in this article have revealed.¹¹⁹

8 Conclusion

This paper has discussed the nature of facial injuries, how these occurred during the First World War, the ways in which British medical services for facial injury developed in response to rising numbers of casualties, and in which pioneering treatments were utilized. The sometimes-overlooked role that nurses played in this emerging speciality has been explored in relation to the existing research on the history of British nursing care in the First World War in order to help fill the ‘empty space’ previously referred to at the beginning of this paper.¹²⁰ As the discussion has revealed, the paucity of primary source material allows only tentative conclusions to be drawn.

It could be argued that in order to give their patients the best chance they could to rebuild their sometimes shattered lives, the medical and nursing teams who cared for these men both provided physical treatment and strove to engender a spirit of therapeutic optimism in their patients. In so doing, a number of ethical issues arose, and it is difficult to know how many men were able to lead contented and fulfilling lives in a society in which after-care and

¹¹⁴ Lane 2001.

¹¹⁵ Cooter 2004, p. 342.

¹¹⁶ Cooter 2004, p. 342.

¹¹⁷ For example, Poynter 2008.

¹¹⁸ Waddington 2011, pp. 298–316.

¹¹⁹ Scott 2017.

¹²⁰ Hallett 2009, p. xi.

financial support was often lacking and in which facial injuries could lead to rejection and revulsion. Family testimonies provide evidence that some did thrive and live contented lives: as one daughter wrote, “As a family we give thanks for those at Sidcup which enabled our father to live such a fulfilled and active life.”¹²¹

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¹²¹ Cited in Bamji 2017, p. 202.

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