

**'The Malingerers are to Blame':
The Dutch Military Health Service
before and during the First World War**

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Introduction

Military and medical history are two of the oldest branches of the discipline but so far there has been little interest in the synthesis of the two. Military historians have often failed to see the point in describing or analyzing medical help in wartime, and medical historians have often lacked interest in military subjects, or have been reluctant to engage in medical military history, for in doing so they would have to describe what some might regard as the less reputable side of the medical profession.¹ A medical doctor working in the army not only has to consider what is medically the right thing to do, but also – and especially in wartime – what is militarily the right thing to do. That these considerations do not always produce the same conclusion will be obvious. A medical doctor has to act according to what is necessary for the physical and mental health of his individual patient. A military man has to act according to what is tactically or strategically necessary. Looking into the history of military medical men, one might conclude that most of them were more concerned with military requirements than with the medical. This explains why – to bring me to my main subject – the history of the Dutch Military Health Service has been almost completely neglected.

It has often been said that following public outrage at the medical disasters of the Crimean War, the introduction of military conscription in most Continental countries; and the foundation of the Red Cross in 1863; healthcare for military men began to improve substantially, and continued to do so throughout the nineteenth and early twentieth centuries. I do not wish to dispute this – in regard to militarily strong countries such as Germany, France and Britain – but

it leaves the questions of to what degree it was improved and did military medicine advance more in some countries than in others? Improvement does not necessarily mean that, afterwards, the situation was good or even satisfactory. For instance, during the Gallipoli campaign in 1915 the Royal Army Medical Corps was only prepared for a ridiculously small number of casualties. As a consequence one of the hospital-ships had to carry 600 wounded to Egypt: a journey of four days with just one doctor to attend them, and he was a veterinary surgeon.²

This incident makes one wonder about the condition of the military health service (MHS) in countries that had less experience of war, such as the Netherlands. Did expenditure on the Dutch MHS keep pace with military expenditure more generally? Was improvement of weaponry followed by improvement of medical care? What, in other words, was the fate of military medicine in the army of a declining military power, which had withdrawn from most of its prior commitments. That is, of course, except in the colonies, in which the Netherlands, as many other European countries, were still militarily active. But, as one Dutch military doctor stated, military healthcare was not necessary in such countries, for 'there are not many wounded in colonial wars'.³

The early years

The Dutch MHS was set up in 1814, shortly after the end of the French occupation. The foundation eight years later of the Royal Training college for military medical men was intended to secure a constant flow of medical men into the army.⁴ This could hardly have been called successful in the early years, and sheer improvisation formed the basis of medical assistance during the Belgian uprising of 1830-1831. Every soldier or officer who had ever bandaged a wounded companion was proclaimed a 'health-officer'. Despite their lack of formal training, these men would later, under the protection of King William the III, rise to the top of the MHS and exercise considerable influence in the Dutch Red Cross (DRC). As a result, this humanitarian society quickly saw a conflict between a conservative, medically-unqualified head and young, progressive and medically-qualified doctors who had to execute his orders. This conflict has never been satisfactorily resolved.⁵

When, in 1848, the Dutch liberal constitution was set up and a liberal cabinet came into power, a period of retrenchment in military expenditure began. The cuts were logical, although, as one might expect, they were contrary to the wishes of the military staff and the

(in 1849) newly-crowned King William III. The Netherlands was no longer an important military power and, with the loss of Belgium, its territory had been reduced by almost 50 per cent. The retrenchment ended in 1852 but its legacy did not become apparent until 1870, when the Dutch army mobilised during the Franco-Prussian War. The short-comings of the MHS in 1807-1871 were, however, less a consequence of the cuts themselves, than of the way in which the remaining money had been spent. Up until 1870 the Netherlands, like Great-Britain and France in 1914, had prepared itself for a type of war that was no longer feasible. Sieges were out of date. Armies moved faster as a result of, for instance, the railroads. Firepower had grown immensely. However, this does not mean that all sections of the army kept pace with the rapidly-changing requirements of modern warfare. The Dutch MHS – like other military medical services – was cut disproportionately, losing one-third of its budget up until 1860, even though the costs of treating sick and wounded remained the same. The importance of a good medical service for maintaining morale and manpower had still to impress itself on the government.⁶ Another reason for this state of affairs was Dutch complacency in the years before the Franco-Prussian War. The vast majority of the Dutch were convinced that their country would never embark on a war, at least on European soil. This tempered the call for an efficient military medical service: it was believed that there would not be that many sick and wounded to take care of.⁷

This was true not only of the general public but the army itself. Not even the MHS seriously contemplated that they might be involved in battlefield-action in the near future; nor did the majority of those involved in the Dutch Red Cross, founded by William III in 1867 on the advice of his minister of war (partly in order to make good the deficiencies in the MHS).⁸ The balance of power, Dutch neutrality, and the supposed impregnability of 'Bastion Holland', seemed to guarantee a peaceful future. Thus, the MHS was ill prepared for its task in times of war. It was said that there was no money to keep the MHS prepared for war in peacetime, and that the MHS probably would never be needed in any case. Problems in times of peace – resulting from epidemics for instance – were to be solved with the cooperation of the civil health service.

Another factor which made for complacency in the MHS was that few of its members had been intent on a military career. Few showed any signs of enthusiasm for active service and the majority had fallen into the MHS because it offered a stable if unremarkable income. Being a doctor in the Dutch army, poorly

played as it was, was a way of eluding hunger and poverty in an increasingly competitive medical marketplace. Most military doctors belonged to the lower classes from which they tried to escape through study at the Royal Training college. It is, therefore, unsurprising that medically and politically speaking they were progressives. A number of them helped to raise the standard of social medicine in the Dutch civilian population, and/or were members of the Society for Hygiene. But, although an important segment of the MHS was interested in military medical reform – and constantly emphasised the threat of war, even in the Netherlands itself – the majority had little interest in reform or wider matters of military policy.⁹

The DRC suffered from a similar lack of support and a shortage of members. It tried to improve its position by seeking more and more cooperation and consultation with the MHS but there was an obstacle to this in the form of the Royal Decision of 19 July 1867, which had brought the DRC into being. This Decision appeared to allow cooperation with the MHS *only in times of war*. A new Decision in 1895 cleared the way to cooperation in peacetime but cooperation between the military and voluntary medical services existed in theory only, and the DRC did not begin to grow steadily until the beginning of the twentieth century, when it was enlarged to help civilian victims of disasters, attaining a membership of 30,000 on the eve of World War II. This peacetime work was undertaken not only because of the hopeless situation in which the DRC found itself but also, and more especially, because it would help prepare for their task in wartime. Although the DRC referred to it as 'peacework', it had more to do with the fact that it took place in time of peace, than that it helped to preserve peace. The above-mentioned conflict between a conservative board and some more progressive sections of the DRC still existed however, and as an organisation the MHS was in a terrible mess.¹⁰ Nevertheless, because of its growth, the DRC became vital to the functioning of the MHS in the event of war. Indeed, the Dutch military medical officer D. Romeyn argued that the DRC should be transformed from an organisation for helping wounded and ill soldiers irrespective of nationality, into one for helping the MHS. The medical officers could do the medical work on the battlefield, the DRC could take care of all the other activities;¹¹ an arrangement that was essentially the same as the one that developed between the British and German armies and their respective Red Cross Societies.¹²

The Great War

Romeyn's plea, on the eve of the Great War, for civilian medical assistance suggests that the MHS had improved little since the days of the Franco-Prussian war. The Netherlands apparently had not followed in the footsteps of Germany, which had the largest and best-equipped MHS of all European countries; a Germany that was politically seen as hostile, but at the same time admired ideologically and militarily. The severe criticism which the MHS received in the press as well as in the Second Chamber (which can be compared to the British House of Commons) shows this was indeed the case. It was argued that the situation of Dutch MHS was as pitiable as that of the DRC;¹³ an impression confirmed by several articles on the MHS, by the Minister of War N. Bosboom, as well as by medical officers like Romeyn.

Already four years before the violent death of archduke Franz Ferdinand, a commission had been appointed to study the military health service and it had recommended improvements. Members of this commission included Miss G.J. Beynen, matron of the Red Cross-hospital in The Hague, the military doctor C.J. Prins, the right-hand man of MHS-general A.A.J. Quanjer, and Quanjer himself. According to Prins, Quanjer was not only the chairman but also the soul of the commission. That is why criticism on the MHS by press and politics was completely out of line when aimed at Quanjer. Quanjer was asked to advise, which he did, and that his advice was not taken, was not his fault.¹⁴

Romeyn went even further. In 1912 he had written that not one single member of the MHS was to blame for the faults of the service, for it was the MHS itself that had predicted the abominable situation, and had at the same time recommended a list of measures by which this situation could have been prevented.¹⁵ As a consequence of the professionalization of the MHS at the end of the nineteenth century – military doctors from that moment on had to have a university degree too, as a result of which the Royal training college had ceased to exist – the MHS had to contend with a lack of personnel.¹⁶ This shortage of staff was so great that it was incalculable, even before mobilisation. Already in the previous century it was decided that the MHS should consist of one inspector-general, three directing health-officers first class, fifteen directing health-officers second and third class, and ninety-six non-directing health-officers first and second class.¹⁷ The army as a whole had expanded rapidly during this period, but not only was the number of appointments within the MHS never

altered, they were also never completely filled. In the last few years the number of health-officers had even dropped and Reserve health-officers were unable to bridge the gap. Not only were they insufficient in number, they were also unfamiliar with the specific aspects of war surgery. Considering the morale of fighting men, Romeyn believed that 216 non-directing health-officers was the absolute minimum necessary to service the army.¹⁸

In view of this, it may come as no surprise that a commission for the improvement of the MHS was put together, its aim being to give an overview of the service and to decide if it was really necessary to give female nurses access to military hospitals. As a result of the experience gained in the Boer-War, in which the Dutch doctors and nurses were very much opposed to imperialistic Albion, it was decided in 1910 that this should take place. In practice however, it did not alter very much.¹⁹

In an article of March 1916, J. Rongans, former as well as future member of the DRC-council, tried to clear the MHS, as well as the mobilisation-cabinet, of all blame. The shortcomings that had been revealed in August 1914 and the months thereafter, were: 'a result of mistakes made by a list of previous cabinets. In time and under the circumstances they grew to the magnitude that had made the discontent as rampant as it was.' Apparently the MHS had always been 'a unwanted child of the army leaders'. This is not so strange if one considers that medicine was seen as a very civilian profession, which smelled, as far as some combatant officers were concerned, of 'weakness and sentimentality'.²⁰ Furthermore, the hospital was thought to be a refuge for malingers, simulators, shamers, slackers and loafers, present in every army when it is composed of men who had to don the military cloth involuntarily.²¹

Bosboom agreed wholeheartedly with the 'unwanted child'-remark, and he also had an explanation. In peacetime the Netherlands had a small army, mainly composed of recruits who were declared healthy. So in the Dutch army there was little for a doctor to do. This was on the one hand accompanied by a belligerent European atmosphere, which, according to Bosboom, made necessary a strengthening of the military force whilst on the other hand there was the wish to keep the military budget as low as possible in times of peace. The consequence was that every year there was a laborious debate over the war-department budget. Bosboom asked rhetorically:

Was it under these circumstances strange that the army headquarters primarily kept an eye on the things they thought important for the fighting-ability of the army, and that because of this the needs of an army unit the urgency of which was not daily apparent, came under pressure?²²

Rongans and Bosboom were certainly right in so far as on the rare occasions some extra money could be spent, it was not spent on medical care. So, in 1903, it was decided to postpone the building of a new military hospital in The Hague, which, in fact, was urgently needed. Instead the funds were used to pay for the changes in the army, which were a consequence of the militia-law of 1901. In later years new weapons for the artillery, modernisation and expansion of the barracks and improvement of the coastal-defence system were repeatedly preferred above improvements in the MHS. This was furthermore followed by an army-expenditure as a consequence of the militia-law of 1912.²³ Of course, none of the medical services of the fighting armies were ready for the task they had to accomplish in the dreadful war of 1914-1918. The Dutch MHS, however, was, as a consequence of the above cuts, not only unprepared for the expected war, it was not even prepared for the much simpler task that awaited it in practice. This task was described by Bosboom as 'the medical treatment of a large army, which had to be mobilised for a number of years, constantly renewing itself in the course of time, and, as a consequence of the continual expectation in which it existed, was also, from a psychological point of view, a completely different army than a peacetime army'.²⁴ The MHS had to see to it that, 'in cooperation with the army commander, the men were kept in an excellent physical condition, so that as few men as possible were absent from training'.²⁵

Bosboom blamed the malingers that the MHS did not succeed in ensuring that only a few soldiers did not attend the exercises. It was this group of men he had in mind when he wrote that 'from a psychological point of view' a mobilised army differs from a peacetime army. By feigning an illness or exaggerating a wound, the loafers and shamers – which Bosboom detested from the bottom of his heart – tried to avoid having to march. Bosboom described their attitude as a 'catching army disease', an evil that undermined army-discipline'. Unless nipped in the bud, it could easily become a psychic epidemic.²⁶ According to Bosboom, this army-disease had already obtained unacceptable proportions, so the military doctor had to be a policeman and a medical man at the same time. As a result some of

the malingers went to hospital, and some of the really sick were sent back to the barracks to march and exercise, which did not contribute to their speedy recovery. Furthermore, it was necessary to give some of the work to Reserve health-officers and even to civilians, who had, quoting Bosboom, 'fewer problems giving in to the complaints of the loafers', because 'they sooner believed the so-called sick than their military colleagues'. Apart from this, they were, at least in the early wartime-days, not completely aware of the responsibility that rested on them from the military point of view.²⁷ On top of this, in many cases 'no cooperation in the military interest could be expected from the civilian doctors; far too easily they handed out certificates, and this made controlling visits by military doctors inevitable, with loss of time and withdrawal from more important duties as a consequence'.²⁸

According to Bosboom and Prins approximately 90 per cent of the hospital-patients were malingers, who on top of that did not even know how to behave themselves. A report published some ten years before the war even mentioned a sickness-percentage of 3/2.²⁹ Of course, all these figures hail from military die-hards, who detested anyone who tried in whatever way possible, to make military life somewhat less trying. Furthermore, doctors were probably more keen to weed out malingers than their combatant colleagues, since the existence of malingering reflected badly upon them. By emphasizing this problem they could draw attention to the importance of an MHS, an importance so often ignored. A military doctor was not only a doctor but also a detective.³⁰ But even if horror and frustration made them slightly exaggerate the percentages, it is clear that malingering was a serious problem.

As this debate was going on, in July 1916 a commission was again established to look into frequent complaints made about the MHS. Amongst others the members consisted of the above-mentioned Quanjier, W.F. Veldhuyzen, of the Amsterdam Red Cross Committee, and P.P.C. Colette, who was also a member of the military court of justice, headcommissioner and, in later years, honorary-member of the DRC.³¹ The first point of their conclusion was that 'simulators and malingers wasted time that was badly needed for investigation of the really sick and wounded'. Although the report was published a half a year after his dismissal, it made Bosboom a happy man. The commission was also convinced that the loafers undermined the trust that had to exist between doctor and patient. They were therefore 'jointly responsible for diagnostic mistakes, made towards seriously ill patients'. Also, the addition that simulation and malingering were

due to the spirit of the people – to deficiencies of national character – had Bosboom's wholehearted consent. All in all, the report confirmed that, while in office, Bosboom was right to defend himself and the MHS against the most severe criticism. Yes, the MHS was in urgent need of improvement, but this was neither the fault of the MHS, nor of its chief (Bosboom was probably referring to Quanjier rather than to himself).³²

But Bosboom did admit that the MHS had its shortcomings, and they certainly could not all be attributed to malingers. At the beginning of mobilisation, the Netherlands had 44 military hospitals for 48 garrisons, to which in 1915 the hospital in Venlo, near the German border, was added. Furthermore it was agreed that 21 civilian and twelve psychiatric hospitals would nurse military sick and wounded also. These numbers do not seem too large, but raw statistics do not tell the whole story. One has to bear in mind that of all the 'military hospitals' only twelve were originally intended for medical use. The 'military hospital' at Utrecht for instance, was a former monastery dating from the fourteenth century, of which a commission set up in 1912 by the minister of war – Collijn – described as 'unsuitable and beyond improvement'. Roughly the same verdict had already fallen upon the The Hague hospital in 1879, without this leading to alterations.³³ Although, as always, there were exceptions to the rule, the rule certainly was that most hospitals did not meet the requirements of a military hospital at the beginning of the twentieth century. Prins pointed out that even the hospital in Venlo, built in 1915, did not have either a surgical-department or a separate department for the infectious diseases. Most Dutch military hospitals were therefore obsolete and in urgent need of renovation. The only positive exception to the sorry state in which the MHS found itself was the supply of medical instruments, which were of good quality, although falling short of the quantity required. Moreover, of the hardly abundant staff only half were qualified. Partly because they were allowed to have a civil practice as well, the one-hundred regular doctors of the MHS were so busy that maintaining normal medical knowledge, let alone obtaining specialist know-how, was too much to be asked. Bosboom wrote in his memoirs, which were published in 1930, that:

Such was the condition on the first of August 1914. That in many ways it fell short, I will not argue. The inspector for the MHS, (Quanjier) did so even less. He wrote a circumstantial account, recommending necessary improvements, which he had handed over

to me. Of course I knew that these improvements would be costly, and that therefore they could only be realized after some years. As a consequence we had to call upon the entire nation for help if the Netherlands was dragged into the war. I trusted that societies and individuals would not hesitate to place their equipment at the disposal of the army, in particular the MHS, and take over the care of the sick and wounded the MHS would not be able to treat.³⁴

In 1913, as well as in 1914, the military doctors got a raise in salary to combat the lack of professional personnel. But, of course, the 72,000 guilders by which the MHS-budget was raised in 1914 could not alter the situation in the short term; even though, after the mobilisation, a considerable effort was made to remedy the situation. The burden fell upon the voluntary sector, and appeals for assistance were responded to enthusiastically; after all, both male and female nurses could now make a 'military' career without having to leave the sickbay. After 1914, another 119 civilian hospital agreements were made for the nursing of soldiers; emergency barracks were built and special hospitals were equipped for jaw injuries and other specialised forms of treatment. Nursing-measures were agreed upon with the DRC, the Order of Saint John, the Order of the Knights of Malta and with the Committee for Immediate Assistance. These voluntary bodies would, for example, take care of sixty emergency hospitals. But even without these hospitals, some 20,000 sick and wounded soldiers could have been accommodated at short notice. The improvement and increase in the numbers of hospitals was constantly worked at, and due consideration was given to the quality and quantity of the MHS's equipment. In 1916 the DRC handed over two ambulance trains to commander-in-chief C.J. Snijders. Personnel increased in knowledge as well as in numbers and, at the end of 1916, the military hospitals had three times more qualified male and female nurses than in 1914. Furthermore, whereas, in 1914, there had been 200 military doctors and reserve-health officers, in 1917 there were 500; not including the civilians who were also doing their part of that work. On top of that, a health-committee was set up, the chairman of which became Quanjer's hygienic advisor. Yet, in spite of all these efforts, Bosboom had to admit that 'in a few months time the mistakes of years could not possibly be set straight'.³⁵

Rogans saw a way out of the mess. In his 1916 article he advocated the improvement of medical care for soldiers, because a soldier who defended his country – especially in an army of

conscripts – simply had the right to be looked after if he got shot. Besides that, if this improvement was not undertaken in peacetime, too great a sacrifice had to be asked from the civilian population in wartime, because of the requisition of civilian hospitals for instance. But an adequate MHS and Red Cross-society were not enough. Military healthcare had to be above strength, so that it would not only have a curing effect, but that it would also contribute to raising the fighting strength of the Dutch army. Rogans was well aware that pushing the MHS to such untold limits would, to put it mildly, not be easy, especially in these days in which a war was likely to cost not hundreds, but tens of thousands of wounded.

Even without regarding the duty of the state towards its wounded sons, it will not go unpunished if the value of healthcare for an army is underrated. The curing army (as Rogans referred to it) has to develop in the same tempo as the fighting army. The insufficient recognition of this demand is severely felt nowadays. The more the work is in arrears, the more impossible improvement gets.³⁶

Rogans' judgement was that improvement without a radical change of the system would be impossible and that reorganization was inevitable. That the authorities, at first, had wanted to wait for a complete reorganization of the MHS until after the war, was understandable. Was not everybody convinced that the war would be over by the Christmas of 1914? But now it was clear that it could go on for years and the press, therefore, pushed for reorganization. Although a part of the Dutch army saw war as the engine of society – amongst them some military doctors – all in all few men wanted the Netherlands to join the war. But one could never know how it developed. If the Netherlands became involved, the MHS had to be ready and therefore reorganization could not be postponed. That was precisely why the DRC had called a reorganization-committee into being after a meeting in 1915 that had got completely out of hand.³⁷ Local committees were fed up with the authoritarian style of government of the central-committee; a committee that a critical medical doctor typified as being extremely conservative, militaristic and non-medical, very male and very aristocratic in the most negative sense of the word.³⁸ However according to Rogans, who was a member of the central-committee of the DRC, the DRC had seen that it had to cut off its roots, not to take the life out of the organisation, but to give new life a chance to come in. The result of the DRC-reorganization was not however a more democratic style of government, but the complete subordination of the DRC to the

MHS. Submission to military doctors had already been the practice in the first years of the war, but it was now made statutory. This meant that the task of the DRC increasingly became that of the MHS. To the extent that it was not already the case, the DRC no longer offered impartial assistance to the sick and wounded of all nationalities, but preferentially to soldiers of the Dutch army. Not medical but military necessity prevailed.³⁹ Rotgans thought this reorganisation of the highest importance, not only for the DRC, but for Dutch military medical care as a whole. Now that the DRC was reorganised, the MHS could also be rebuilt on new foundations.⁴⁰

To make the total reorganisation of military healthcare a success, certain measures were unavoidable. New hospitals had to be modern and spacious: a well equipped hospital was an inspiration for a mediocre physician and kept the good ones interested and in high morale. Wages had to be improved still further to make the profession attractive, for only then would the best doctors choose the military profession, a profession they had to become acquainted with in a very early stage of their medical education. To accomplish this, Rotgans thought it inevitable that the civilian health care should be militarised in its entirety. Only then would the physicians have the military attitude that was so badly needed, and only then would enough doctors be willing to enter the barracks. This could be achieved if military education started already during their medical education. Medical students would be free of conscription, but were obliged to serve for some time in the medical corps, from the lowest rank of stretcherbearer up to assistant health officer. For the student this had the advantage of going into society as a reserve officer of health, with the knowledge that one would never have to serve involuntarily, unless there was a general mobilisation.⁴¹

Rotgans estimated that with these measures the army would have about a thousand reserve-health officers at its disposal within ten years. Also, a lot of the students would be willing to become professionals. In peacetime, however, the professional corps would have to be contracted somewhat, to facilitate better wages. As far as nursing was concerned, Rotgans thought female military-medical conscription unavoidable. Women could serve either as a MHS-, or as a Red Cross-nurse.⁴²

In spite of all this, it would still be necessary to requisition some of the civil hospitals in wartime. About two thirds of the nursing personnel, and one third of the doctors had to come to the rescue. The difficulties this would bring for nurses and doctors could be met by spreading them equally. Doubtless everybody would

accommodate themselves to the circumstances and give up peacetime-privileges without complaining. Rotgans did not say which measures had to be taken to make the civilian patient give up what he called the 'privileges of peacetime', such as expert care. Not the civilian, but the military patient was his sole concern. As Rotgans stated:

Maybe after the war, many will be of the opinion that there will never be another war. As a consequence old habits will rear their heads, even more so than before 1914. I hope with all of my heart that this will indeed be the last war, and if the above opinion is well founded, then the army may disappear as well. However, as long as a fighting army is thought necessary, a curing army is necessary. As long as it is necessary to enlarge and strengthen the fighting army, the curing army should be enlarged and strengthened with the best men available from the Dutch medical world and with the best equipment, science and technology can produce.⁴³

Rotgans did not see much point in minor improvements in the military-healthcare organisation. Total reorganisation was the only way forward.

Aftermath

What was the result of all this? As far as the MHS was concerned, not much: it fell victim to a large reduction of the ministry of war's budget in 1922; a reduction that was defensible militarily.⁴⁴ However, all-in-all, military healthcare would get sufficient attention. Under the leadership of a minimally expanded military-medical corps, more and more tasks were to be handed over to the DRC – although it is questionable whether this organisation could cope with them. As a result, the DRC had to live up to what was officially the MHS's task, even more than already was the case. It was now charged with taking care of the morale and manpower of the entire, national army instead of taking care of the sick or wounded soldier irrespective of the country he had fought for.⁴⁵

Eleven years later the DRC was asked officially to take over completely the care of the sick and wounded in the evacuation-areas. The MHS and the DRC now were, essentially, one organisation. The hierarchical order of military medicine had also become a geographical order. The MHS would work in the direct neighbourhood of the battlefield, the DRC in the hinterland. Among other things this meant that it was the MHS and the MHS alone that decided which sick and wounded soldiers were or were not taken to

the hinterland for further Red Cross treatment. One of the main reasons for setting up the Red Cross – taking care of the wounded the MHS had to put aside because they were of no value to the army anymore – no longer existed.⁴⁶

A mobilisation plan was set up in 1938, in which there was talk of 40,000 sick and wounded soldiers if the Netherlands should become the scene of warfare. To be able to accommodate such numbers, all the hospitals in the evacuation-areas had to enlarge their capacity by 25 per cent and then clear at least $\frac{1}{3}$ of the beds. This meant that some 60 per cent of the civilian patients had to leave the hospitals.⁴⁷ In Great Britain, where a similar measure was taken, hospital-almoner C. Morris said: 'Surely never before has a nation inflicted such untold suffering on itself as a precaution against potential suffering. Why should it have been considered less disastrous for anyone to die untreated of cancer, appendicitis or pneumonia than as a result of a bomb?'⁴⁸

However, criticism was unable to make the hospital-boards resist. They adhered to the measures, probably because only an at least partially militarised hospital was entitled to put the protective red cross-sign on its roof. So they were not to blame that the fantastic theory of the mobilisation plan had absolutely no value when it had to be put into practice on 10 May 1940. Not only had the German attackers no regard for the boundaries of the evacuation-areas, they had no intention whatsoever to fight at those places which the Dutch army-headquarters had two years earlier planned to fight. Also, the mobilisation plan was based on the premise that there would be a struggle of many months; instead, within five days, the fighting had ceased. The vast majority of hospital beds had not even been slept in.

Conclusion

Events during the two world wars highlighted what had been persistent weaknesses within the Dutch MHS. Indeed, in World War II it may have been a blessing that the Netherlands was defeated so quickly, considering the state of military healthcare and the problems experienced in mobilising the army in 1914-1918. With respect to the main task of the MHS – taking care of the strength of the entire army, and raising the fighting spirit – it can only be hoped that Dutch soldiers were not aware of its weakness. This weakness was a result of several dilemmas the MHS had to face. It was part of an army that kept on pressing for more and more funds because in its eyes it was too small and too ill-equipped to stand even the slightest change of holding back any aggressor, be it Germany, France, or

Britain. But the Netherlands was no longer the European power it had been some centuries ago. Budgetary restraint was unavoidable and, because the army regarded the MHS as less important than its combatant branches, most of the remaining resources were diverted to other parts of the organisation. This left the army with frustrated doctors who had to work in hospitals which were ill-equipped and under-staffed, and who were regarded by their superiors as second rate. Spotting malingers was one way in which military doctors could prove themselves of true military stock, hence their virtual obsession with the 'problem' in 1914-1918.

Another way out was to show the military men that nursing and caring were not 'weak and sentimental'. Not only military doctors, but also the civilian doctors of the DRC, cultivated a military air and had few reservations about providing assistance to the MHS. For doctors in the MHS and the DRC, the needs of the army were paramount, not those of the individual soldier. Some even went so far as to suggest a complete militarisation of the medical education in order to prepare civilian doctors for their role in any future war.

But the Netherlands was not Prussia: The Hague not London; and King William III not Emperor Napoleon III. Most Dutch men did not want to engage in fighting and never thought that the Netherlands would ever engage in a war, at least not in Europe. However, the suggestions that were made to get the Dutch MHS out of its misery, were suggestions that suited militarily strong countries, countries that indeed fought wars. The Netherlands in the second half of the previous century, and the first of the twentieth, was anything but a warring country. Politics as well as military strategy were aimed at neutrality and peace, as befitted a declining military power.

Notes

- 1 See for instance: Fielding H. Garrison, *Notes on the History of Military Medicine* (Hildesheim & New York: 1970; 1st edn., 1922), 5, note 1: 'One of the greatest of modern medical historians, when approached on the matter, replied: "The subject is distasteful to me".'
- 2 Lyn MacDonald, *1914-1918. Voices and Images of the Great War* (London: Penguin, 1988), 76.
- 3 D. Romeyn, 'De oepsing van de conventie van Genève in den Zuid-Afrikaanschen oorlog en eenige noodzakelijke wijzigingen en aanvullingen in die conventie', *Organ van de Vereniging ter Beoefening van de Krijgsgeneeskunde*, 1902-1903, 517-614, 529.
- 4 D. de Moulin (ed.), *Rijksoetendekerk voor Militair Geneeskundigen te Utrecht (1822-1865)* (Amsterdam 1988); J.A. Verdoorn, *Art en*

- Orlog. *Medische en Sociale Zorg voor Oorlogslachtoffers in de Geschiedenis van Europa* (Rotterdam 1995; 1st edn., 1972), 192.
- 5 Conversation with prof. dr. M.J. van Lieburg, 5-9-1990; J.H. Rombach, *Nederland en het Rode Kruis* (Amsterdam: De Bataafsche Leeuw, 1992), 36.
- 6 W. Bevaart, *De Nederlands Defensie 1839-1874* (The Hague: SMG, 1993), 116, 155, 160, 462-3, 470, 604-605. W. Klinkert, *Her Vaderland Verdedigd. Plannen en Opmatigen over de Verdediging van Nederland 1874-1914* (The Hague: SMG, 1992), 23-4; H. Hardenberg, *Overzicht der Voornaamste Bepalingen Betreffende de Sterkte, Samenstelling, Bevoering, Verzorging en Verpleging van het Nederlandse Leger, Sedert den Vrede van Utrecht in 1713 tot den Tegenwoordigen Tijd*, part 2 (The Hague: Gravenhage, 1861), 442-3; 'De geneesher op het slagveld', *Onze Tijd*, 5 (1870), part 2, 310-323, 315-16.
- 7 Bevaart, *op. cit.* (note 6), 160; N. Bosboom, *In Moelijke Omstandigheden, Aug. 1914-Mei 1917* (Goinchem: J. Noorduyt & Zoon, 1933), 175.
- 8 Het Rode Kruis en de Amsterdamsche linie', *De Nieuwe Militaire Spectator*, 1874, 188-205, 189.
- 9 Hoe zal men onze toekomstige officier van gezondheid voor de militaire dienst kunnen behouden', *De nieuwe militaire spectator*, 1867, 290-294; 'Hoe een toekomstig officier van gezondheid nu reeds over zijne betrekking denkt', *De Nieuwe Spectator*, 1863-1864, 102-105; 'Geneeskundige dienst', *De nieuwe spectator*, 1855-1856, 463-471, 464; A.H.M. Kerkhoff, 'De militair-geneeskundige dienst en de medische hervormingen in de negentiende eeuw', in *De Moulin, op. cit.* (note 4), 3-16; *Grieten der Geneeskundige Dienst in Nederlandsch-Indië* (1867), 3-5, 50-1; 'Open brief over de geneeskundige dienst in Nederlandsch-Indië', *Tijdschrift voor Nederlandsch-Indië*, 23 (1861), part 1-3, 172-86, 173; E.S. Houwaart, *De Hygiënisten. Afsien, Staat & Volksgezondheid in Nederland 1840-1890* (Groningen: Historische Uitgeverij, 1991), 341-50.
- 10 Leo van Bergen, *De Zwaargevoonden Ernst? Het Nederlandse Rode Kruis en het Vraagstuk van Oorlog en Vrede* (Rotterdam: Erasmus, 1994), 154-160, 174-93.
- 11 D. Romeyn, 'Iets over ons Rode Kruis', *Het Reddingwezen in Vredes en Oorlogstijd*, 5 (1916), 263-71, 271; D. Romeyn, 'De commissaris van het Ned. Rode Kruis bij de divisie van ons veldleger', *Het Redding wezen in Vredes en Oorlogstijd*, 4 (1915), 83-91, 88-9.
- 12 With thanks to Mark Harrison.

- 13 J. Rotgans, 'De militair geneeskundige dienst', *Algemeen Handelsblad*, 31-3-1916, evening-edition, second paper, 1, column 1-2; Bosboom, *op. cit.* (note 7), 187-196; C.J. Prins, 'De militair geneeskundige dienst van 1 mei 1910 tot 1 mei 1917', *Militair Geneeskundig Tijdschrift*, 21 (1917), 5-10, 9-10.
- 14 Prins, *op. cit.* (note 13), 5.
- 15 D. Romeyn, 'De geneeskundige dienst', *Wetenschappelijk Jaarbericht Krijgswetenschap*, 8 (1912), 460-77, 462.
- 16 De Moulin, *op. cit.* (note 4), 89.
- 17 In 1860 there was talk of one inspector, two dir. off. of first class, and five of the second class. 33 non-dir. off. of health first class, and 100 second and third class. *Inlichtingen Omtrent den waren Toestand der Militaire Geneeskundigen in Nederland* (1867), 22.
- 18 D. Romeyn, 'De geneeskundige dienst', *Wetenschappelijk Jaarbericht Krijgswetenschap*, 6 (1910), 412-34, 413-14; o.c., 1911, 428-48, 428.
- 19 *Ibid.*, 414.
- 20 Rotgans, *op. cit.* (note 13), column 2.
- 21 *Ibid.*, column 2.
- 22 Bosboom, *op. cit.* (note 7), 175.
- 23 *Ibid.*, 175-6.
- 24 *Ibid.*, 178.
- 25 *Ibid.*, 182.
- 26 *Ibid.*, 183.
- 27 *Ibid.*, 183.
- 28 *Ibid.*, 184.
- 29 D. Romeyn, *op. cit.* (note 18), 416-34, 425.
- 30 Thanks to Mark Harrison.
- 31 Bosboom, *op. cit.* (note 7), 196-7.
- 32 *Ibid.*, 199; J.P. Bijl, 'De militair geneeskundige dienst', *Wetenschappelijk Jaarbericht Krijgswetenschap*, 10 (1914-1919), 474-87, 485.
- 33 Bosboom, *op. cit.* (note 7), 176-7.
- 34 *Ibid.*, 177-178 (quotation: 178); E. Kraft, 'Militaire hospitalen', *Militair Geneeskundig Tijdschrift*, 20 (1916), 110-13.
- 35 Bosboom, *op. cit.* (note 7), 176, 178-82 (quotation: 182); Bijl, *op. cit.* (note 32), 477-82, 484-85; D. Romeyn, *op. cit.* (note 28), 424-25.
- 36 Rotgans, *op. cit.* (note 13), column 1-2 (quotation: 2).
- 37 *Verlag der handelingen van de vereniging Het Nederlandsche Rode Kruis*, XXV (1917), 18.
- 38 'Tribunaal', 'Noodzakelijke reorganisatie van het Nederlandse Rode Kruis', *De Amsterdammer*, 3-10-1915, 1.

The Malingers are to Blame

- 39 Van Bergen, *op. cit.* (note 10), 243-56.
40 Roegans, *op. cit.* (note 13), column 1-2, 4.
41 *Ibid.*, column 3.
42 *Ibid.*, column 3-4.
43 *Ibid.*, column 4.
44 H. Amersfoort & P.H. Kamphuis, *Mei 1940. De strijd op Nederlands grondgebied* (The Hague: Staatsdrukkerij Uitgeverij, 1990), 54.
45 Van Bergen, *op. cit.* (note 10), 280-94.
46 *Ibid.*, 400-6.
47 *Ibid.*, 401-2.
48 H. Huijenga, 'Het ziekenhuiswezen in oorlogstijd', *Symposia gewijd aan de Vraagstukken betreffende de Bescherming Bevolking en Gezondheidszorg in Tijden van Oorlog en in Geval van Grote Rampen*, 22, (1954), 27-43, 32.