Soldiers don’t go mad: shell shock and accounting intransigence in the British Army 1914-1918

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Abstract
This research examines intransigence in accounting systems. Using historical research methods and archival sources, it explores intransigence in the Royal Army Medical Corps’ accounting systems in the context of the incidence of shell shock among British Army soldiers fighting at the battlefront during the First World War. The Army did not recognise shell shock as a medical condition and made few changes to its medical accounting systems for soldiers with shell shock. The four factors of system stability of the AGIL scheme (adaptation, goal attainment, integration, latency) are used to understand the limited medical accounting response to shell shock. This research indicates that in addition to historical and internal political reasons for intransigence, intransigence will occur unless a factor in the AGIL scheme is sufficiently impaired to make the accounting system unstable and force system change. This research finding has contemporary relevance, explaining accounting intransigence in response to issues of social concern.

Keywords
Adaptation, AGIL, Goal attainment, Intransigence, Latency, Medical accounting, Military accounting, Systems integration.

1 Introduction
This research explores why accounting systems remain intransigent when faced with external criticism. Contemporary and historical accounting examples of intransigence abound. They include limited regulatory and practical accounting responses to financial crises (Cooper, 2015; Sikka, 2009), the rights of First Nations (Greer & McNicholas, 2017; Miley & Read, 2018; Neu, 2000), environmental issues such as climate change (Andrew & Cortese, 2011; Larrinaga-Gonzalez & Bebbington, 2001), social issues such as the #metoo movement (Rebuck, Forthcoming) and workplace harassment (Hammond, 1997; Stanley & Baldwin, 2011). Extant research focuses on political intransigence (Randall, 1979) and intransigence in tertiary education, particularly business schools (Oviatt & Miller, 1988, 1989). In both areas, intransigence has been linked to internal politics and historical factors (Yaniv & Yishai, 1981). This research extends the notion of intransigence to accounting systems, using the theoretical lens of Talcott Parsons’ AGIL scheme (Parsons & Smelser, 1956).
Understanding accounting system intransigence is a precursor to affecting accounting system change.
This research uses the historical example of intransigence in British Army accounting systems during the First World War. It investigates the British Army’s responses to soldiers with shell shock. Shell shock was first posited as a medical condition during the First World War by British Army doctors seeking to name symptoms observed in front-line soldiers that could not be explained by physical battle wounds. Although the term shell shock was popularised in the First World War, symptoms consistent with shell shock were described by the Father of History, Herodotus, having been observed in Assyrian soldiers three millennia ago (Abdul-Hamid & Hughes, 2014). They were also described by Shakespeare in Henry IV Part 1 (1597: 2015 II:iii).

Shell shock symptoms include unexplained nervousness, uncontrollable shaking, inability to talk or use limbs, unexplained blindness or deafness, uncontrollable sweating and fear responses to loud or sudden noises (Jones & Wessely, 2005). Throughout the First World War, accounting for shell shock was problematic: the British Army and medical opinion were divided on whether shell shock was a legitimate medical condition or a ploy used by soldiers to avoid fighting (Babington, 1997). Although contemporary movies and histories often present shell shock sufferers kindly, such sympathetic treatment reflects post-war attitudes rather than First World War attitudes (Holden, 1998; Miley & Read, 2017). Doubt about shell shock’s legitimacy as a medical condition contributed to the stigmatisation of soldiers with this condition (Babington, 1997). The closest contemporary example of a new medical condition that divided public and medical opinion is the response to HIV AIDS in the 1980s, when governments doubted its legitimacy (Mbali, 2004) and AIDS’ sufferers were stigmatised (Deacon, 2006). First World War poet Siegfried Sassoon described both the trauma and stigma of shell shock in this extract from his poem Repression of war experience (Sassoon, 1918), written while receiving medical treatment for shell shock:

No, no, not that,—it’s bad to think of war,
When thoughts you’ve gagged all day come back to scare you;
And it’s been proved that soldiers don’t go mad
Unless they lose control of ugly thoughts
That drive them out to jabber among the trees.

Studying intransigence in accounting responses to shell shock extends prior military accounting research on the impact of military accounting processes on battle effectiveness (Funnell, 2005; Miley & Read, 2012) and on moral issues concerning military accounting systems (Chwastiak, 1998, 2008). Military accounting has been of recurring interest in accounting research because examining accounting systems under extreme stress of war can reveal weaknesses not otherwise evident (Collins, Holzmann, & Mendoza, 1997; Miley & Read, 2012, 2014; S. P. Walker, 2000). Historical examples have been used in extant military accounting research to reveal the full consequences of accounting failure (Miley & Read, 2012). Also, chronological distance can circumvent political sensitivities that might obfuscate analysis (Connor & Davidson, 2001; J. R. T. Davidson & Foa, 1991; Rosen, Spitzer, & McHugh, 2008). This research also expands accounting research on healthcare beyond its focus on management accounting discourses ( Abernethy, Chua, Grafton, & Mahama, 2006; Malmmose, 2015).
During the war, the Army did not maintain records on the number of frontline soldiers with shell shock, so it is difficult to ascertain how many soldiers suffered from this condition. Military historians estimate 40% of British battle casualties, or approximately 670,000 soldiers, suffered from shell shock (Holden, 1998; van Creveld, 2004). One Army doctor estimated that by December 1914, 7% to 10% of officers and 3% to 4% of non-officers suffered shell shock (MacLeod, 2004). In a post-war government inquiry, the Army stated that approximately 80,000 men, or 1.6% of soldiers, were receiving medical treatment for shell shock (War Office (UK) Committee of Inquiry into Shell Shock, 1922). Doctors Salmon and Mott, who specialised in the post-war treatment of men with shell shock, estimated that one-seventh of officers and one-third of non-officers medically discharged from the Army suffered shell shock (Mott, 1919; Salmon, 1917). All these figures under-estimate the problem because they exclude soldiers refused medical treatment, those undiagnosed or misdiagnosed during the First World War, and those whose symptoms first manifested after discharge from the Army. It is the Army’s accounting response to soldiers with shell shock, not the exact number of men with the condition, that is salient to this research. All British Army soldiers were male. These soldiers were not the only sufferers of shell shock (Bogacz, 1989; Holden, 1998) but this research is confined to that group.

Primary archival sources used in this research include Parliamentary debates, Army accounting manuals, memoranda and directives, Royal Army Medical Corps (“RAMC”) accounting manuals and reports, official diaries from RAMC medical units, court martial records, personal letters written by soldiers with shell shock, personal diaries from soldiers writing about those with shell shock and a book by a senior RAMC officer, originally for RAMC use, which consolidates manuals, routine orders, military directives and standard practices applicable to the RAMC throughout the First World War (Nicholls, 1937).

In the next section, background information is provided about medical care in the British Army during the First World War, shell shock and the problems it created. This is followed by a description of RAMC medical accounting practices and the Army’s accounting response when soldiers were diagnosed with shell shock. The subsequent discussion explores the Army’s accounting intransigence in the context of the AGIL scheme (Parsons & Smelser, 1956). In this historical example, the Army’s need to attain its goal of winning the war, and the need to maintain the moral commitment of internal and external stakeholders to the goal of military victory, irrespective of the cost, were the key reasons for intransigence. The conclusion from this historical example has contemporary relevance, enhancing understanding about accounting intransigence in response to contemporary issues of social concern.

2 Background

In 1898, the British Army formed the RAMC to manage soldier health. It was staffed by male doctors, medical orderlies and clerks (Harrison, 1996). Simultaneously, the Army introduced medical accounting systems to manage patient care and the resupply of resources to Army medical units.
These systems included detailed reporting and accountability mechanisms. The RAMC reported to senior Army commanders located at Army headquarters. Copies of all RAMC reports were also forwarded to budget administrators located in the War Office in London, which was the part of the public sector responsible for managing Army finance. In 1914, when the First World War commenced, the RAMC comprised 9,000 men. By the end of the war, in 1918, it had expanded to 113,000 men. There were no women in the RAMC, nor was there an equivalent women’s medical corps. The RAMC was supported by volunteer ambulance units, volunteer doctors and volunteer female nurses. There were also other personnel at an RAMC military unit, including members of Queen Alexandria’s Imperial Nursing Service, which had a staff of 3,000 female nurses, nurses’ aides and clerks in 1914, expanding to 23,000 by the end of the war. Although Queen Alexandria’s Imperial Nursing Service served in all theatres of war, they primarily staffed Army hospitals in Britain and located behind the battlefront. Irrespective of who provided medical care, RAMC staff were responsible for meeting Army accounting requirements (Joynson-Hicks, 1915; Macpherson, 1927).

In war, frontline soldiers are a critical battle resource. In the trench warfare environment that prevailed on the Western Front for most of the First World War, maximising the number of frontline soldiers was viewed by senior Army commanders as critical to military success (Brown, 1998) and so the primary role of RAMC accounting systems was to ensure senior commanders received information about the number of soldiers unable to fight for medical reasons and the number of soldiers returned to fighting following medical treatment. This allowed military planners to estimate available fighting strength, plan the timing of battles based on available fighting strength and determine whether additional troop support was required (Harrison, 2010; Macpherson, 1927). Since senior commanders believed battle-hardened soldiers were more effective than newly-trained recruits (Sheffield, 2000; van Creveld, 2004), the RAMC was required to prioritise the treatment of soldiers who could be returned quickly to frontline service (Harrison, 2010; Nicholls, 1940). Civilian medicine prioritised patient care based on medical urgency but Army triage prioritised battle needs (Carden-Coyne, 2014; Mitchell, 2008). The British medical profession was concerned that this was contrary to the Hippocratic oath of the medical profession because it did not place the medical needs of patients first (Whitehead, 1999). RAMC staff were sympathetic to the suffering of soldiers and knew soldiers could die while awaiting treatment but believed maximising fighting capability supported a greater good, based on the belief that rapid victory meant fewer wounded and less loss of life in total (Harrison, 2010).

Shell shock challenged all that was known, and accepted, about military medicine. In 1915, medical doctor Charles Myers wrote in the medical journal The Lancet about a previously unknown medical condition observed in soldiers, termed shell shock. At the time, Myers was working in a private hospital in France, having been rejected by the British Army as too old to serve in the RAMC (MacLeod, 2004). He attributed it to physical trauma of colloidal tissue in either the spinal column or brain from the shock waves of exploding heavy artillery shells (Myers, 1915). When men who had not been near exploding shells developed similar symptoms, psychological trauma was proposed as an alternate explanation, though quickly dismissed (Head, 1916; Mott, 1916; Rivers, 1917; G. E. Smith &
Fear, 1917). Psychological medicine was in its infancy and treated with scepticism by the British medical profession after a series of 19th century law cases discredited non-physiological explanations. In these cases, early railway travellers without signs of physical injury sought damages for back pain. Following these cases, the term railway spine became a synonym for feigned illness (Harrington, 2003). Shell shock without physical injury was treated with similar scepticism (Caplan, 1995; Harrington, 1996) and some soldiers with shell shock were diagnosed with railway spine (Jones & Wessely, 2005).

Illness has been theorised as a form of deviance where the behaviour patterns of the sick differ from the norm (Parsons, 1951). Unlike most forms of deviance, sickness is seen as an acceptable reason for deviance from the norm (Varul, 2010). This serves to legitimise sickness and its legitimisation acts as proof that a person really is sick (Lupton, 1997). It also gives two important rights to the sick person: the right not to be blamed for the illness and the right to be accorded some leeway or dispensation from normal duties (Parsons, 1951). Hence, soldiers who were sick or wounded were given dispensations from frontline service. Soldiers who were not classified as sick or wounded were expected to serve in the front line if so ordered and if they did not, then their deviance was punished. Punishments could be severe. In 2008 the British Government pardoned 306 soldiers court-martialed and executed for cowardice during the First World War, stating that most, if not all, of these men had suffered from shell shock and not been responsible for their behaviour (Fenton, 2008).

From the inception of the RAMC, the British Army standardised its medical diagnoses. From an Army perspective, soldiers fought unless they had a battle wound or illness listed in the RAMC manual. Otherwise, they were malingerers or cowards. (War Office (UK) & Royal Army Medical Corps, 1911). The Army provided each RAMC officer with a manual listing potential battle wounds and illnesses (War Office (UK), 1914b). The manual was stated to be comprehensive and exhaustive (War Office (UK) & Royal Army Medical Corps, 1911). RAMC staff were required to use the manual for their medical diagnoses (War Office (UK) & Royal Army Medical Corps, 1911). The manual transferred the power to classify sickness from the individual and the doctor to the medical hierarchy in the British Army. It reflected the scientification of medicine in civilian practice in the 19th century (Foucault, 1973). Standardised practices have long been used by armies as a way of reducing uncertainty and managing resources (van Creveld, 2004). By controlling as much as possible, the focus in battle is limited to uncontrollable issues. During the First World War, all Army processes and procedures were detailed in printed manuals issued to officers (Evetts, 2003). All soldiers, including those in the RAMC, were trained to follow the requirements of Army manuals unquestioningly (Samuels, 1995). Obedience was enforced by military law (Green, 1990). Failure to comply was a breach of military discipline for which a soldier could be prosecuted under military law (Sloan, 2012). Punishments were severe because senior commanders believed insurrection in one area could lead to insurrection in others (Sloan, 2012). In addition to standardising treatment regimes, the RAMC manual gave recovery times for each illness and an expected recovery time for each type of battle wound. Parliament expressed concerns about the Army’s mechanistic application of the recovery times for illness but the Army responded that past experience proved that recovery times for illness could be
accurately determined (Hansard HC Debates Vol 99 Col 592W, 1917). The problem with shell shock was that nothing could be standardised: treatment regimes, recovery paths and times, and whether a soldier might return to frontline fighting were unknowns. The manual did not include psychological illnesses. It recognised two medical conditions involving the head: soldiers could receive head wounds in battle or be insane. Insanity led to discharge from the Army and institutionalisation in an asylum (War Office (UK) & Royal Army Medical Corps, 1911).

When RAMC doctors first suggested they were seeing a new medical condition, which they called shell shock, the British Army adopted the position of the British medical profession, which was that there was no such medical condition (Babington, 1997). The Army held this position from the start of the war until 1916. Extant research has suggested reasons why the Army adopted the view of the medical profession in Britain over the medical opinion of RAMC doctors, even though it was RAMC staff, not doctors in Britain, who were seeing soldiers with shell shock. Whitehead (1999) says RAMC doctors were perceived by their medical peers as less skilled than other doctors. Harrison (2010) describes a medical career as an RAMC doctor as a medical job of last resort. RAMC doctors did not have the prestige accorded officers in fighting corps (Brown, 1998) and received less pay than a fighting corps officer of equivalent rank (Whitehead, 1999). Whitehead (1999) claims that because of their low position on the status hierarchy among Army corps, RAMC doctors did not have the traction to bring about a change to the medical manual. While cogent explanations, there may be other reasons for the Army’s official position on shell shock prior to 1916. Senior commanders came from the fighting corps of infantry, cavalry and artillery. They had no medical training and had risen through the rank structure in the years before the RAMC was formed. Thus, when RAMC doctors first presented information about a new psychological medical condition among soldiers, senior commanders may have exercised caution by adopting the position of the British medical profession (War Office (UK) Committee of Inquiry into Shell Shock, 1922). Senior commanders may have reasoned that any legitimate medical condition would have been identified during the British Army’s long history of military involvements (British Expeditionary Force, 1922). Also, before 1916, only a few RAMC doctors thought shell shock was a legitimate medical condition (Harrison, 2010).

By 1916, opinion in Britain on shell shock was changing as soldiers with severe shell shock were returned to Britain for long-term medical treatment, although medical opinion in Britain continued to be divided about shell shock throughout the war (Holden, 1998; Miley & Read, 2017). Instead of reviewing its position on shell shock as British medical opinion shifted, in mid-1916 the Army banned diagnostic use of the term shell shock by the RAMC, stating that there was no such medical condition (War Office (UK) Committee of Inquiry into Shell Shock, 1922). Throughout the war, the Army’s attitude to shell shock was complex and inconsistent. While banning use of the term at the battlefront, it was establishing medical wards in military hospitals in Britain for the most severe cases of shell shock. However, the ban on the use of the term shell shock meant RAMC doctors used euphemisms or deliberate misdiagnoses in the medical records of soldiers admitted to the Army’s shell shock wards: for instance, the hospital records of one soldier admitted to a shell shock ward and treated for severe shell shock conditions states that his admission was for an infected toe (Linden & Jones,
2014). At the battlefront, as the number of men with shell shock symptoms escalated, the Army discounted it as mass hysteria among easily influenced soldiers, caused by a few malingerers feigning illness to avoid fighting. Unit commanders were ordered to speak sternly but kindly to their soldiers, believing it would stem the hysteria (War Office (UK) Committee of Inquiry into Shell Shock, 1922).

In August 1916, the Adjutant-General's Office in General Headquarters sent an order to all units demanding "economy of men and reserves" (Shepherd, 2000, p. 46) and clamping down on wastage, which was specifically defined in the order as stopping the evacuation of too many men for shell shock (Shepherd, 2000). Fighting units with high levels of shell shock were punished. The 11th (Lonsdale) Battalion of the Scottish Border Regiment had received many individual awards for bravery, been in constant battle and suffered among the heaviest losses of any unit (Downing, 2016). It failed to participate in an attack when unit commanders determined that most of its men were suffering severe shell shock. On the orders of Army commander General Gough, the unit was reprimanded by its divisional commander in front of its peers for failing in its duty and bringing disgrace on itself and its battalion. For the Army, such a reprimand represented a severe censure.

Simultaneously, RAMC doctors sympathetic to men with shell shock were removed from frontline medical units, disciplined under military law for disobeying Army orders (Roper, 2009) then returned to Britain in disgrace (Macpherson, 1927). For instance, RAMC doctor Lieutenant Kirkwood was required to assess the fitness of a military unit to participate in an attack. He reported to Brigadier-General Jardine that most, if not all, soldiers in the unit had shell shock and were unfit to fight. Jardine ordered the attack to go ahead. So many soldiers lost their way finding the starting point of the attack, or were late for the start of the attack, that it had to be cancelled. Kirkwood was placed on a disciplinary charge for his diagnosis. At the Court of Inquiry, Jardine said Kirkwood was unfit for military duties because his role was not to provide an independent medical opinion but to maintain discipline by supporting Army commands. Two high ranking infantry officers and the Army’s Surgeon-General supported Kirkwood, claiming the Army’s system for assessing the fitness of soldiers was flawed, but Kirkwood was disciplined and transferred to clerical duties (Leese, 2002).

By late 1917, the Army’s treatment of men with shell shock caused so many adverse comments in Parliament that the Army adopted a new position (Hansard HC Debates Vol 99 Col 592W, 1917). Though continuing to ban use of the term shell shock, it paradoxically permitted RAMC doctors to order a maximum of two weeks of hospital rest, which could not be extended, for men with shell shock symptoms, diagnosed as severe hysteria or neurasthenia (Loseby, 1919). By eliminating the name shell shock, the Army sought to eliminate the medical condition (War Office (UK) Committee of Inquiry into Shell Shock, 1922). Strict rules governed the period of hospitalisation because senior commanders were concerned that if other soldiers thought men in hospital received sympathetic care, they would feign symptoms to receive similar time off (British Expeditionary Force, 1922). The Army’s official response to criticism was that it was easy for those not charged with the responsibility of winning a war, and who did not have to ensure the Army had enough soldiers, to be sympathetic towards anyone claiming shell shock (British Expeditionary Force, 1922). The Army was in an
invidious position. Recognising soldiers with shell shock symptoms as ill meant recognising that a full complement of soldiers might not equate to full fighting strength. Relieving soldiers with shell shock from frontline fighting meant finding replacements but the Army had insufficient replacements to pursue this option (War Office (UK) Committee of Inquiry into Shell Shock, 1922). Instead, the Army ignored this conundrum, even though it meant senior Army commanders were making battle decisions on the incorrect assumption that all soldiers were fit to fight, thereby over-estimating the capacity of the Army as a fighting resource.

The Army’s position against shell shock remained unchanged throughout the war (War Office (UK) Committee of Inquiry into Shell Shock, 1922). Without accurate Army medical records, it is not possible to determine the number of RAMC doctors sympathetic to shell shock. Personal diaries of RAMC doctors treating shell shock indicate a range of responses. For instance, some considered it a ruse to avoid fighting (Downing, 2016). Others became more sympathetic as they saw more cases of shell shock (Loseby, 1919). Fighting soldiers also evidence the full gamut of reactions to those with shell shock (Babington, 1997). In Parliament, the Opposition expressed concern when Army statistics provided by the War Office indicated that 75% of soldiers who sought permission from their unit commanders to obtain medical treatment for shell shock were rejected. The Under-Secretary of State for War justified these rejections by explaining that just because a soldier claimed he had shell shock did not mean that shell shock existed. The Under-Secretary said that the real problem was that the need for rapid recruitment meant the Army had recruited men with pre-existing mental deficiencies, who would normally be rejected from Army service. According to the Under-Secretary, their mental imbalances only became evident in battle and were being labelled shell shock when they should be seen as pre-existing mental weakness. He said the only way to manage such soldiers was with firm direction and ordering them to fight (Hansard HC Debates Vol 99 Col 1658W, 1917). Neither Parliament nor the Army addressed the fundamental flaw in the system: soldiers had to be given permission from unit commanders to seek medical treatment. Hence, the first point of medical diagnosis for soldiers was a unit commander with no medical knowledge, a vested interest in soldiers remaining in the front line, and who knew the potential disciplinary consequences he would suffer if seen to disobey the Army’s position on shell shock.

As the war progressed, soldiers’ attitudes towards shell-shocked peers became increasingly negative (Bourke, 2000). The diary of Charles Moran, who served in the Royal Fusiliers and later became personal physician to British Prime Minister Winston Churchill during the Second World War, typifies this hardening attitude. Initially sympathetic, he later described men with shell shock as worthless, writing that soldiers fell into one of three categories: the brave, those prepared to do their duty though they disliked war, and cowards, which included all soldiers claiming to have shell shock (Holden, 1998). The resentment of other soldiers towards soldiers with shell shock is documented throughout military unit diaries, personal diaries, and both official and personal correspondence (Leese, 2002; Linden & Jones, 2014; van Bergen, 2009). Resentment may have been fuelled by fear that someone with shell shock could jeopardise the safety of all men in the unit (Babington, 1997; Loughran, 2012). Also, shell shock was viewed as weakness and inconsistent with contemporaneous notions of
masculinity, nationalism and the virtue of fighting for King and country (Bourke, 2000). Men with shell shock were frequently disbelieved or mocked by their fellow soldiers and the incidence of self-inflicted injury was higher among men with shell shock (van Bergen, 2009). Comments about feelings of guilt, shame and a need to conceal their symptoms recur in war diaries by men with shell shock (Leese, 2002). In letters home they describe their stigmatisation, inability to manage growing despair and fear, and their shame and guilt at letting down their military unit, family and country (Holden, 1998; MacLeod, 2004; Reid, 2010). Soldiers’ diaries also indicate that some avoided seeking medical treatment for shell shock for fear of a diagnosis of insanity, with the social stigma it brought to a patient and his family (Shephard, 1999).

On recovery, wounded soldiers wore a special stripe on their uniform (Hansard HC Debates Vol 84 Col 533-4, 1916, cc533-534) to signal their bravery (Loughran, 2012). It was viewed like a battle honour (van Bergen, 2009), similar to the American Purple Heart medal. Soldiers treated for illness and those who had recovered from shell shock wore no such distinguishing marks. Limiting the stripe to wounded soldiers was based on a belief that only weak soldiers became sick but it created a status hierarchy: wounded soldiers were accorded a status not given to those who had been ill, and soldiers who had been ill were accorded more status than those known to have suffered shell shock (Reid, 2010). Soldiers’ letters indicate those treated for shell shock were stigmatised when returned to their military units, viewed as weak and distrusted. The morality of returning soldiers to the environment that had caused their shell shock was not considered. Soldiers who had been treated for a sexually transmitted disease were less stigmatised than soldiers who had suffered shell shock, even though there was a moral taboo associated with sexually transmitted disease (Adler, 1980; Evans, 1992). By ignoring the problem of shell shock, the Army could ignore its moral and social issues.

This section has described how, despite inconsistencies in the Army’s attitude towards shell shock, it failed to address adequately the medical, management or social issues connected with shell shock. Contemporary understanding concerning the legitimacy of mental illness may increase the difficulty of understanding the British Army’s perspective during the First World War, but recognising and treating shell shock was medically problematic (Blair & Hildreth, 1991). However, the purpose of this research is not to criticise the Army but to understand accounting intransigence in the context of shell shock. For an Army whose strategy and tactics depended on maximising the number of frontline soldiers and which assumed illness could be managed by a standardised approach (Bond, 1972), shell shock was particularly problematic.

3 Army medical accounting and shell shock

This section summarises RAMC accounting practices and accountability requirements, focusing on the accounting problems of shell shock. It also describes the tensions between the Army’s control of its accounting systems and War Office budget administration of the Army.
3.1 RAMC classification

The medical treatment process commenced with RAMC staff classifying soldiers as sick or wounded in accordance with the RAMC manual (War Office (UK), 1914b). The RAMC manual stated that wounds occurred in battle but sickness was caused by local epidemic, unsanitary battle conditions or poor food preparation (War Office (UK), 1909a, 1914a). Classification preceded medical treatment and involved a simple accounting process whereby a field medical card in an envelope was affixed to each soldier’s jacket (War Office (UK) & Royal Army Medical Corps, 1911). Classification occurred at or near the battle front and was a dangerous task (Bairnsfather, 1916): during the Battle of the Somme, over 400 RAMC staff were killed or wounded while classifying patients (Whitehead, 1999). On the envelope was the letter W if a man was wounded and S if a man was sick. A colour coding system was also used. White envelopes were for British and Allied soldiers. Red envelopes were for prisoners of war. Serious cases had white envelopes edged in red (Leese, 2002). Without initial classification, soldiers could not receive medical treatment. Using medical resources to treat unclassified soldiers was an illegal use of Army resources, which was a military offence (Nicholls, 1937). Excluding shell shock from the Army’s list of recognised illnesses made it unclassifiable and untreatable, which Reid (2010) found impacted adversely on the self-esteem of soldiers with shell shock.

The Army believed its classification system was efficient, effective and suited to all medical eventualities because its system was developed through past experience and had served the Army in prior conflicts (Army Court of Inquiry, 1916). Since the Army rejected shell shock as a legitimate medical condition, shell shock did not trigger a need to amend the RAMC manual for a new medical condition, so the Army was not made aware that its medical classification system was flawed and it could not be adapted to handle this new medical condition. Whether RAMC staff classified soldiers with shell shock as ill, treated them without classifying them, or intentionally misdiagnosed soldiers with shell shock to find a way of ensuring they received some medical treatment, they were disobeying Army orders and risking punishment under military law. The extent of this disobedience is unknown because the Army’s official policy on shell shock ensured RAMC resistance remained a surreptitious act. RAMC compassion did cause resentment: other soldiers believed men claiming shell shock and receiving medical treatment had conned RAMC staff, wasting medical time and resources better spent on men with wounds or genuine illness (van Bergen, 2009).

3.2 The burden of accounting

The British Army developed an accounting system that provided all available information rather than the information required for decision-making. Senior commanders justified the emphasis on quantity, not quality, of information by claiming that battle could be unpredictable and information needs could change rapidly (Macpherson, 1927) even though the reality of trench warfare was that it was primarily static and information needs rarely changed rapidly (van Creveld, 2004). This notion of providing as much information as possible was developed in the fighting corps and came from the importance of providing as much military intelligence as possible (Bond, 1972). However, when applied to RAMC accounting (Nicholls, 1937), it merely increased the reporting burden on RAMC staff.
Army regulations stated that timely and accurate accounting information on the return of soldiers to frontline fighting was critical for tactical planning (War Office (UK) & Royal Army Medical Corps, 1911) but the accounting burden on RAMC units led to duplication of information and reporting inefficiencies. Before the First World War, the Army had recognised the problems with the RAMC accounting systems but they were not addressed (Nicholls, 1937). Whitehead (1999) attributes this to the low status accorded RAMC doctors but Miley and Read (2014) found that many of the endemic problems in the Army’s accounting systems were due to the lack of feedback loops.

RAMC units prepared, and accumulated, many accounting records. While some of these records would have been prepared by staff in any medical establishment, many were specific to the military medical environment. Unlike a civilian medical accounting system, all records were primarily for Army planning purposes, with patient care being their secondary purpose (Nicholls, 1937). The requirement for RAMC units to keep accounting records, and maintain an adequate supply of spare accounting forms, hampered unit mobility. One RAMC diary entry expressed thanks to enemy artillery who destroyed a tent containing a unit’s accumulated accounting records (Lucas, 2014; H. F. B. Walker, 1917). All Army accounting documents had to be completed in triplicate (C. Harris, 1911). RAMC units kept the triplicate copy. The original and duplicate copy were forwarded to Army Headquarters. Headquarters retained the original and forwarded the duplicate copy to the War Office in London (Nicholls, 1937). All records were typed and signed. They had to be error free. Corrections were unacceptable (C. Harris, 111). This was justified as a fraud control, a mechanism to increase confidence in medical information used for strategic planning (War Office (UK) & Royal Army Medical Corps, 1911) and important for soldiers:

In justice to the soldier, we must keep accurate records of his being absent from duty through sickness or wounds. Without this information it is impossible to fairly estimate any pension to which the soldier should be entitled, and, furthermore, the State has to be safeguarded against fraudulent claims to compensation (Nicholls, 1937).

Each day, RAMC units completed forms on total strength (number of patients receiving medical care), fighting strength (number of patients cleared for return to active duty) and the number of casualties (incoming wounded patients). A daily hospital report detailed care provided to each patient and another roll described each patient’s medical state. Information about officers, non-officers, nurses and civilians were reported separately (Macpherson, 1927). Separate from the daily accounting reports, RAMC units provided weekly accounting reports including lists of officers and non-officers being treated, a weekly progress report on serious cases and a roll of patients brought by field ambulance to the unit. A list of serious cases included RAMC recommendations about medical discharges or transportation to military hospitals in Britain for long-term treatment. Other accounting records compared field ambulance rolls with requests for fuel for ambulances (Macpherson, 1927; Nicholls, 1937). RAMC staff completed weekly rolls of men for embarkation to Britain. RAMC staff prepared labels to pin to the clothing of patients due for transportation to other medical facilities. These were affixed beside the envelope containing a patient’s field medical card. Labels included personal details and information about medical care in transit. Information on all labels was copied
onto rolls carried by accompanying medical staff. There were many other reports. For instance, RAMC staff provided senior commanders with weekly reports on accidental and self-inflicted injuries. Following weekly stocktakes of inventory, inventory lists were prepared listing the quantity of each item. New lists had to be prepared each week. Past lists could not merely be updated. In addition, each inventory item required a new typed label each week.

Many daily accounting records were accompanied by summary reports for senior commanders. Summary records accompanied admission and discharge records, individual medical case sheets, a syphilis case sheet, requisitions for resupply, equipment and transport ledgers, medical certificates sent to fighting unit commanders, pack store records which recorded supplies given to men returning into active service, daily hospital diaries, individual ward records, diet sheets for each patient, a daily morning report on the state of sickness and death, medical sick returns for patients being transported by train or ship, temperature charts, return of detachment forms for RAMC staff returning from accompanying casualties to Britain, corps pay records for both RAMC staff and patients, records of applications for extra duty pay and diagnosis tally sheets (War Office (UK), 1914b). In addition, RAMC units were responsible for all accounting records pertaining to the pay, feeding, clothing and accommodating patients. They managed transportation records for men returning to fighting, being discharged or sent to other military hospitals (War Office (UK), 1909b). RAMC staff cared for the personal possessions of their patients. Details of valuables were recorded and patients received a receipt. Frontline RAMC units often moved quickly as battle lines shifted, particularly in the early period of the war known as the race to the sea and the latter period of the war known as the 100 days: since valuables and personal items regularly disappeared during these moves, soldiers said that RAMC stood for “Rob All My Comrades”.

The Army said RAMC accounting was the RAMC’s first priority because it was vital for military planning (Macpherson, 1927) but the value of sending so many reports to senior commanders must be questioned. Operational officers were not trained to include RAMC reports in tactical planning (War Office (UK), 1914a). Although some RAMC accounting information was summarised, it was not in a format conducive to rapid decision-making. There is no archival evidence of RAMC accounting information influencing tactical planning. It may have been used so routinely that its inclusion was not documented, although that would have breached Army regulations which required all reasons for, and supporting information relevant to, decisions to be stated in writing (Brown, 1998).

The Army’s contradictory position concerning shell shock was evident in the accounting it required from RAMC units. After banning the RAMC from diagnosing shell shock, the Army directed RAMC units to prepare a detailed report on each soldier with shell shock. RAMC diaries suggest over-worked staff resented this additional accounting burden and, consistent with literature on the psychology of resentment, resented the men whose medical condition caused this burden, even if sympathetic to their condition (Feather & Sherman, 2002; Folger, 1987). The time required to prepare the shell shock reports decreased the time available for medical care.
The reports on shell shock were for the Army to identify malingerers requiring disciplinary measures (Shepherd, 2000; van Bergen, 2009). Army prosecutors used these reports to demonstrate a soldier’s dereliction of duty (Army Court of Inquiry, 1916). Paradoxically, the Army said that these reports, being about a non-existent medical condition, were inadmissible as defence evidence so those prosecuted could not use them to explain their incapacity to perform military duties (Army Court of Inquiry, 1916). The court martial of Lieutenant Eric Skeffington Poole is an example of the use of these reports. While his unit was participating in an attack, Poole was seeking medical treatment for shell shock. Since he did not have his commanding officer’s permission to seek treatment, he was charged with desertion. At the time, Poole had recently re-joined his unit after being hospitalised with symptoms consistent with severe shell shock. During his trial, RAMC doctors stated he had shell shock at the time he sought medical treatment. This evidence was held inadmissible because it concerned a medical condition the Army did not recognise. Found guilty of desertion, Poole was sentenced to execution. Military law required that two RAMC doctors attest that Poole was fit for execution. Both doctors stated that he continued to suffer severe shell shock. The Army stated that this evidence of shell shock was inadmissible, so the court found him fit for execution. In 1916, he became the first British officer executed for desertion (Army Court of Inquiry, 1916). Many similar cases are documented in Army Court of Inquiry records. There is no archival evidence on the response of RAMC doctors, whose Hippocratic oath concerned the saving of life, to an order to prepare accounting reports that could lead to taking the lives of soldiers.

Illness classification continues to influence medical insurance and medical treatment. Medical classification becomes an accounting issue when classification alters the time, cost or treatment regime available for a medical condition or when classification determines the nature, or amount, of medical insurance payments (Baraff, Cameron, & Sekhon, 1991; Kotov et al., 2011; Malterud, 1987; Tarricone, 2006).

3.3 Inventory accounting and medical resupply

The method of resourcing RAMC units was established before the First World War (War Office (UK), 1914b). In accordance with standard Army practice, each medical unit had an establishment quota. This was a list establishing the number and rank of RAMC staff in each unit together with all medical and other equipment for that unit, including medical supplies, food, hospital beds, bedding and blankets. Requisition times for resupplying each unit were fixed. Resupply returned a unit’s resources to its establishment quota (Nicholls, 1937). RAMC establishment quotas were determined using a fixed budgeting approach based on Cron’s formula. Cron was an Austrian general who developed a formula in the 19th century to predict the number of battle casualties:

\[
\text{Expected number of battle casualties} = 10\% \times 60\% \text{ of total fighting force}
\]

The formula assumes that at any time, 60% of a fighting force would be deployed and 40% held in reserve. The figure of 10% was an estimate based on Cron’s observations of nineteenth century battles. For instance, if an RAMC unit was responsible for a battle area with 60,000 British soldiers, the RAMC should expect 3,600 casualties per battle:
Expected number of battle casualties = 10% x 60% of 60,000 = 3,600 soldiers

This represents 6 per cent of the fighting force. Hence, this RAMC unit could seek resupply at the pre-determined time to return supplies to the level required for the care of 6% of the fighting force (Brown, 1998; War Office (UK), 1909b). During the First World War, on average, 8% of soldiers were wounded in prolonged battles, although in some battles, more than 20% of soldiers were wounded in the first 24 hours of fighting and 40% were wounded after one week of battle (Nicholls, 1937). Despite this large variation from the forecast mean, there was no provision to increase quotas or seek more frequent resupply so RAMC units were chronically under-resourced. Similar restrictions were places on all Army units: they were designed to achieve economy of force, which is military jargon for frugal use of supplies (Brown, 1998). Frugality was to minimise the stress on logistical supply lines.

The Army maintained an inconsistent policy on resupply for battle. Frontline fighting units received extra supplies if military intelligence indicated that an enemy attack was imminent but RAMC units did not receive additional medical supplies before an enemy attack because senior commanders believed it would lower soldier morale by signalling how many men might be wounded (Nicholls, 1937). Also, they believed that the enemy would be forewarned of a British attack if RAMC units received additional supplies or were resupplied prior to their normal requisition time (Nicholls, 1937). Unlike civilian hospital management during the First World War, actual patient numbers and actual medical requirements had no impact on RAMC unit resourcing. Archival documents do not explain the contradiction in thinking about resupplying fighting versus RAMC units but there was one key difference in approaches to resupply: as non-combatant units, RAMC units were supplied during daylight hours but fighting units were resupplied by stealth at night to hide this activity from the enemy.

The under-resourcing of RAMC units disadvantaged all men requiring medical care but Holden (1998) found that soldiers with shell shock suffered the most disadvantage. The detail of RAMC accounting reports made it difficult to hide the use of resources on men with shell shock. Studies of RAMC medical treatment indicate that soldiers with shell shock were less likely than other soldiers to be allocated a bed in medical ward tents or receive other RAMC resources (Holden, 1998; Webb, 2006). Whether these records are accurate cannot be known. RAMC doctors concerned about repercussions may have protected their own positions by corrupting accounting records pertaining to the allocation of medical resources. If the records are accurate, there are explanations other than a lack of sympathy by RAMC staff which could explain why soldiers with shell shock received little treatment. RAMC doctors were learning by trial and error how to treat shell shock so did not necessarily know how to help soldiers with shell shock (Jones, Fear, & Wessely, 2007; MacLeod, 2004). Also, RAMC units near the battlefront were neither resourced nor staffed to handle long-term medical conditions. (Leese, 2002; Myers, 1940).

### 3.4 The War Office and Army accounting

The War Office received copies of all RAMC reports yet failed to detect the discrepancy between predicted and actual battle casualties, and consequent under-resourcing of RAMC units. The War
Office was more sympathetic than the Army towards shell shock, recognising its existence in 1916 and suggesting a medical classification system based on a soldier's rank and main symptoms (Macpherson, 1927). The Army ignored this suggestion (War Office (UK) Committee of Inquiry into Shell Shock, 1922). Although the War Office could have used its control over Army finances to compel Army compliance, it did not pursue the matter, allowing the Army to control the dialogue on shell shock.

There was a long history of tension between the public sector and the Army (Funnell, 2006). The Army had responded to War Office attempts at expenditure control by arguing that implementing military objectives could not be constrained by cost considerations. Tensions were circumvented with the interposition in 1904 of ad hoc Committee of Imperial Defence to determine broad Army strategy and direct the War Office (Johnson, 1960). It determined broad strategies within which the Army could plan and manage military operations. When managerial power shifted to the Committee, the War Office lost its power over Army operations, while retaining a responsibility to secure funding for Army plans (Brown, 1998).

Their different attitudes towards shell shock re-opened past issues between the Army and War Office. Parliament supported the Army's position, stating that although it was concerned about the number of men with shell shock, Britain's public hospitals could not cope if all soldiers with shell shock required medical treatment (Loseby, 1919). In a post-war government inquiry into shell shock, the Army blamed the War Office for the high incidence of shell shock among soldiers. The Army said the War Office had forced it to make cost savings. Since these could only be made in recruitment and training procedures, not warfighting, the Army argued that this had given it insufficient time to identify men of nervous disposition (Burton-Fanning, 1917; Wolfsohn, 1918). The War Office denied responsibility, responding that Army psychological processes to assess recruits had been flawed (Jones, Hyams, & Wessely, 2003). The inquiry committee said that both the Army and War Office had vested interests in hiding the extent of shell shock among soldiers but it could not assign blame because neither party maintained accounting records to support its case (War Office (UK) Committee of Inquiry into Shell Shock, 1922).

This section has provided some historical and internal political factors for intransigence in RAMC Army accounting. The Army’s reliance on standardised accounting and resupply practices were so entrenched historically that they were not adaptable when the frequency of soldiers with shell shock became a medical crisis. Concern to maintain a sufficient number of fighting soldiers, without considering the implications of using soldiers whose fitness to fight was impaired by shell shock, was linked to budget funding for Army operations (Brown, 1998) and internal Army politics in an atmosphere of arrogance by senior military commanders who ignored concerns for soldiers with shell shock, despite the concerns of medical professionals and parliamentarians (MacLeod, 2004). The following section discusses some reasons for accounting intransigence that go beyond the explanation of historical factors and internal political factors advanced in prior intransigence research.
4 Discussion

The British Army maintained numerous highly integrated systems. For instance, RAMC accounting systems were integrated with the recruitment and training systems to ensure a steady stream of replacement soldiers, and the supply accounting system to re-equip soldiers returning to frontline fighting. War stressed these systems but the systems adapted to challenges that included the medical treatment and replacement of soldiers incapacitated by poison gas attacks (Jones, 2014), recruitment and training of replacements when advances in weaponry led to large numbers of deaths in every battle (Prior & Wilson, 2016), and the difficulty of developing a small permanent fighting force into a large professional Army (Brown, 1998; Gregory, 2008). The Army continued its practice of learning from experience: despite the Army’s policy on shell shock, its management taught the RAMC to maintain specialist frontline medical units and train its staff to link medical treatments to critical points in the progress of an illness (Jones, 2014). The system flexibility in other areas is at odds with the accounting intransigence towards shell shock. In particular, it seems counter-intuitive that the first reporting priority of the medical accounting system was to inform senior Army commanders about diminished fighting capability while excluding shell shock, a major cause of diminished fighting capability, from the reporting system. It was also inconsistent with the British Army’s policy of removing soldiers with sexually transmitted diseases from frontline fighting because their diminished fighting capability jeopardised the safety of their military unit (Peers, 1998; Wald, 2014).

In May 1916, Field Marshall Sir Douglas Haig wrote to the editors of the main British newspapers in his capacity as commander of the British Army on the Western Front. An extract from his letter indicates that the Army’s sole goal was military victory and no price was considered too high to achieve that victory:

No amount of skill on the part of the higher commanders, no training, however good, on the part of officers and men, no superiority, however great, of arms and ammunition, will enable victories to be won without the sacrifice of men’s lives … We must be prepared to accept great losses in future without flinching whenever and wherever it becomes necessary to sacrifice men in order to gain some important advantage or to foil the enemy’s endeavours to gain one… While, therefore, it would be advantageous to postpone the decisive battle until our men are fully trained and until supplies of all sorts are abundant, we may be forced to carry out counter-offensives on a considerable scale before that… The nation must be prepared to see heavy casualty lists for what may appear to the uninitiated to be insufficient object and to have produced unimportant results … The aim for which the war is being waged is the destruction of German militarism. Three years of war and the loss of one-tenth of the manhood of the nation is not too great a price to pay in so great a cause (Haig, 1916b).

General Haig has both been praised for leading Britain to military victory and castigated for military incompetence and lack of concern about number of lives lost in battle (J. Davidson, Major-General, 2010; Dixon & Dixon, 2011; Perlmutter, 1978). It would be simplistic to attribute accounting intransigence towards shell shock solely to Haig’s authoritarian influence (Otley & Berry, 1980), the Army’s approach to shell shock was more complex and often contradictory.
American sociologist Talcott Parsons (Parsons & Smelser, 1956) supplies a theoretical framework which provides an explanation for Army’s accounting intransigence to shell shock. Parsons’ AGIL scheme states that a stable system is adaptable, can attain goals, is integrated and has sufficient latency to withstand internal and external pressures (Parsons & Smelser, 1956). The AGIL scheme has been used in prior accounting research to enhance understanding of the implementation of management accounting systems (Skaerbaek, 1992), the role of structuration theory in developing shared meanings in accounting (Boland, 1996), control systems in accounting (Hechter, 2008) and the role of accounting in society (S. P. Walker, 2016). Applying the AGIL scheme to British Army intransigence extends the scheme to research using historical methods of inquiry and to the study of the susceptibility, resilience or resistance of accounting systems to change. Table 1 summarises the AGIL scheme and its application to RAMC accounting systems.

<table>
<thead>
<tr>
<th>Category</th>
<th>Definition</th>
<th>Applied to RAMC accounting systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Adaptation</td>
<td>The system’s ability to adapt to changes in its environment.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The system’s ability to support supply of medical services in wars in different locations, of different styles, and at different levels of intensity.</td>
</tr>
<tr>
<td>G</td>
<td>Goal attainment</td>
<td>The system’s ability to attain its goals.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The system’s support of winning wars by the return, after treatment, of sick and wounded soldiers to battle and providing information on the return soldiers to battle for battle planning.</td>
</tr>
<tr>
<td>I</td>
<td>Integration</td>
<td>The systems degree of integration with units and sub-systems of the system and with super-systems within society.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The system’s integration with other systems of the RAMC, British Army, British economy and British society.</td>
</tr>
<tr>
<td>L</td>
<td>Latency</td>
<td>The system’s ability to maintain the integrity of its values in response to internal (tension management) and external (pattern maintenance) challenges.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ability to maintain commitment by RAMC members to the goal of winning the war even at the cost of lives and suffering of soldiers. Ability to maintain commitment of British society to the goal of winning the war even at the cost of lives and suffering of soldiers.</td>
</tr>
</tbody>
</table>

Table 1: Summary of the AGIL scheme and its application to RAMC accounting systems. Source: (Parsons & Smelser, 1956).

The AGIL scheme facilitates assessment of the stability, or resilience, of a system in response to internal and external pressures (Parsons & Smelser, 1956). A stable system can resist internal and external pressures to change. It can attain its goals, adapt to changes in its environment, is well integrated with other systems and incorporates a value system to which people are strongly committed. Conversely, an unstable system has weaknesses in one or more AGIL system categories that inhibit or prevent systems’ change. Systems rarely achieve total goal attainment, perfect adaptability, complete integration and boundless latency. Most, if not all, systems have imperfections in one or more attributes. A limitation of the AGIL scheme is that it does not indicate what degree of
imperfection can be tolerated before a system becomes unstable (Parsons & Smelser, 1956). It is only in hindsight that the impact of problems on system stability become visible, which is why historical research suits this analytical approach. The AGIL scheme is only useful for analysing system stability or instability, not for predicting when a system will become unstable. From the Army’s perspective, shell shock did not affect the stability of RAMC accounting systems so was not a reason to change them.

4.1 Adaptation
System change and system adaptation are different. Adaptation is the ability of a system to fine-tune itself to changes in its environment (Parsons & Smelser, 1956). Change is where the system is overthrown, and a replacement developed. The dividing line between the two is somewhat arbitrary and imprecise. A modification which replaces one primary system goal with another goal, not previously included in the system, would be an example of a system change. A modification that reprioritises existing system goals may be a change or an adaptation. A modification which maintains existing system goals and priorities is likely to be a system adaptation.

RAMC accounting systems adapted to many challenges such as the 12-fold increase in size of the RAMC over four years of the war (Macpherson, 1927), to military operation in diverse locations that included the Western Front, Gallipoli, Salonika, the Levant and a variety of smaller battlefields throughout Africa, Asia and the Pacific, and new forms of wounds arising from poison gas. However, it was unable to adapt to deal with shell shock. Shell shock differed from the other issues due to uncertainty: both the existence of the disease and methods for its effective treatment remained uncertain. There was not a simple chain of causality between event and medical condition, as there was with a battle wound or the enemy’s use of poison gas and soldiers stricken by the effects of gas. Also, except in the most severe cases, diagnosis usually depended on a soldier claiming he had shell shock, so it was difficult to know whether soldiers were being truthful or feigning illness (Leese, 2002). Although some attempts were made to adapt to shell shock such as opening treatment centres in Britain (Webb, 2006) and the provision for two weeks treatment for soldiers with neurasthenia (Loseby, 1919), the main response of the Army to this problematic condition was to deny its existence, which meant there was no reason to change RAMC accounting systems to accommodate shell shock (War Office (UK) Committee of Inquiry into Shell Shock, 1922).

4.2 Goal attainment
During the 1930s, Parsons (1937) argued that a stable system must have clear goals so those managing the system can exercise power to ensure resources are directed towards goal attainment. Parsons (1956, p. 226) gives victory at war as an example of a system goal. Throughout the First World War, military victory was the British Army’s sole focus to the exclusion of other goals (War Office (UK), 1914a). The key to victory was to maintain fighting capability (Hodgkinson, 2016). Eventually, Britain and her allies did attain their goal of victory, but it took over four years and came at an enormous cost, both financially and in lives.
During the war, Army systems pertaining to training, supply, and battlefield tactics were modified when seen as impairing fighting capability (Kennedy, 2010). RAMC accounting systems were not changed for shell shock because shell shock was not seen as impacting on goal attainment (Holden, 1998). There were two reasons for this view. First, senior Army commanders believed military objectives were being achieved, albeit slowly. The Army did not maintain performance measures related to the human cost of war, considering the human toll of meeting military objectives an unavoidable consequence of war to which the public must become hardened (Haig, 1916a, 1916b). Military success was only measured in terms of physical ground won. Second, the magnitude of the problem with shell shock was not visible. Senior Army commanders remained at Army headquarters located many kilometres behind battle fronts. Since few visited the battlefront, they had no firsthand knowledge of the deteriorating physical and mental condition of soldiers (Sheffield, 2003). Neither the accounting reports of RAMC staff nor fighting unit commanders included information on the mental health of fighting soldiers, so senior Army commanders did not receive reports on this issue. The focus on standardised reporting did not allow for reporting on other issues. Since it was not until after the Second World War that Army accounting systems included complaint mechanisms and feedback loops (Miley & Read, 2012, 2014), there was no mechanism for RAMC staff or soldiers to inform senior Army commanders of the weakness in the reporting system. Although shell shock impaired fighting capability, since senior Army commanders were not privy to the extent of that impairment, they did not appreciate its adverse impact on the Army’s capacity to attain its goal.

There may be additional reasons why unit commanders made no attempt to apprise senior Army commanders of the impact of shell shock on the soldiers under their command. Incompetence made some fighting unit commanders impervious to the suffering of the soldiers under their command (P. Harris, 2017; Perlmutter, 1978). Others ignored shell shock in misplaced gung-ho military fervour (Dixon & Dixon, 2011) or fear of the consequences of challenging the Army attitude to shell shock (Hansard HC Debates Vol 99 Col 592W, 1917). Also, some unit commanders were unable to respond to the suffering of other soldiers because they were overwhelmed by the horrors of war and also suffering shell shock (Bairnsfather, 1916).

The Army’s sole focus on military victory, to the exclusion of the fair and equitable treatment of all sick soldiers, appears unjust from a contemporary perspective. However, it is no different from contemporary organisations whose focus on wealth maximisation excludes consideration of their environmental or social impacts and which appear to only develop an environmental or social conscience when forced to consider these areas by external regulation or social pressure that threatens their primary profit-making goal (Hilton, Choi, & Chen, 2004; Lin, Dean, & Moore, 1974; Macintosh, 1995; Tilt & Symes, 1999).

### 4.3 Integration

RAMC accounting systems were heavily integrated within the rest of the British Army’s systems so that any significant change to RAMC accounting system impacted on the other systems. The main
elements of integration were the establishment quotas, the predicted recovery times and Cron’s formula.

If the Army had recognised shell shock as an illness, the RAMC would have required more resources to treat the soldiers with shell shock and soldiers sick with shell shock would be excused from fighting. Cron’s formula would have been inappropriate so uncertainty would have been introduced into areas the Army managed with standardisation. Apart from the flow-on effects for renegotiating medical supply contracts, increasing recruitment levels and determining new resourcing levels when the number of soldiers sent to battle increased to allow for depletion due to shell shock, there were political issues from recognising shell shock as an illness. Apart from the burden to the State of increased disability pensions and facilities for long-term medical treatment, a flood of soldiers returning to Britain with shell shock may have lessened the public commitment to the war and increased the burden on Britain and its allies to maintain a fit fighting force.

When the Army allowed the RAMC to diagnose neurasthenia or hysteria, treatment time was limited to two weeks and the number of soldiers treated was limited to the number of available beds at Army hospitals located in Continental Europe. By limiting the length of the treatment and number of soldiers who could receive treatment, the impact on other Army systems was minimised. No additional bed space was provided, and it was not permitted to transport soldiers to available Army hospital beds in Britain. Whether this was a logistical problem or an attempt to hide from the British public the number of soldiers requiring rest care is unclear from the archive.

The ramifications of changing RAMC accounting systems to accommodate shell shock were enormous. During the First World War, integration was managed by manual intervention: the Army did not have the advantages of computer-mediated integration. The more heavily integrated a system, the more difficult it becomes to change. Integration does not prevent system change but makes it more difficult to change and hence, lessens the likelihood of change.

4.4 Latency

The RAMC, the Army, the British Parliament and British society, with few exceptions, remained committed to the central goal of winning the war (Kennedy, 2010). There were pacifists and conscientious objectors opposed to the war but their numbers were few and they had little political influence (Ceadel, 2003; Kramer, 2014). The moral commitment to winning the war was rarely challenged during the First World War but considerable effort went into ensuring support for the war. Ensuring public commitment included managing propaganda to present a positive narrative. The image of shell-shocked soldiers continuing to fight was not consistent with that narrative so had to be suppressed. Also, changing systems to recognise shell shock after the problem became so large it could not be ignored would have sent the wrong message.

If the magnitude of the shell shock problem became public knowledge in Britain, public support for the war may have wavered (Hansard HC Debates Vol 84 Col 533-4, 1916; Hansard HC Debates Vol 99 Col 592W, 1917; Hansard HC Debates Vol 99 Col 1658W, 1917; Loseby, 1919). The impact of the
high casualty rates on public opinion and the support for the war by society as a whole was of concern to senior politicians. This concern was heightened after the overthrow of the Russian Czar and the Bolshevik revolution in 1917 (Lloyd George, 1933). Politicians worked hard to ensure public opinion remained behind the goal of winning the war rather than seeking some form of compromise and negotiated peace settlement. The image of shell-shocked soldiers was at odds with British notions of masculinity (Bourke, 2000) but it was also at odds with the propaganda of a strong Army able to fend off any attack (Messinger, 1992).

Throughout the war, soldiers in the British Army remained committed to the war effort, despite their dislike of their fighting conditions. There were no large-scale mutinies in the British Army unlike the mutinies in the French Army (L. V. Smith, 1995) and the German Navy (Bird, 1979) although there were some minor mutinies (Bean, 1941). Similarly, even though RAMC staff expressed dissatisfaction with their lower pay rates, lack of promotion, their onerous accounting burden and the conditions under which they provided medical care (Hansard HC Debates Vol 71 Col 2319-20, 1915), they supported the war effort, believing there was no alternative other than warfare (Kennedy, 2010; H. F. B. Walker, 1917). Senior Army commanders also retained a commitment to the war, believing that there was no alternative to the path they were taking (Haig, 1916a).

The commitment to the war, and support for the Army, outweighed adverse opinion. As soldiers with severe shell shock were returned to Britain for medical care, concerns were raised about their condition but the Army treated them as exceptional cases and the magnitude of shell shock remained hidden until the end of the war (War Office (UK) Committee of Inquiry into Shell Shock, 1922). It was not until after the war, when former soldiers with shell shock sought disablement pensions and public health treatment, that the magnitude of the problem with shell shock became apparent (Miley & Read, 2017). The strength of this commitment to war contributed to maintaining the stability of RAMC accounting systems and allowed it to resist forces seeking its change.

4.5 RAMC accounting systems and the AGIL scheme

Applying the AGIL scheme shows that, despite some degree of imperfection and weakness in each of the categories, RAMC accounting systems were resilient to change. It adapted to many of the different tasks it was required to fulfil during the war and, despite being onerous and cumbersome, it performed reasonably well in supporting the goal of winning the war. If RAMC accounting systems had been changed to accommodate shell shock, the flow-on effects would have made it hard to keep the extent of the problem hidden. The public was taught that the goal of winning the war at all costs meant accepting high casualties. Whether it would also accept that the cost of winning included the psychological devastation caused to so many men by shell shock was an untested area. From the Army’s perspective, the pressure from internal and external stakeholders as a consequence of shell shock was insufficient to cause wholesale changes to RAMC accounting systems. From the Government’s perspective, managing public attitudes was easier if shell shock was not considered a medical condition by the Army as there was no need to treat soldiers with shell shock as sick and make special allowances for them.
This research has provided an example where an accounting system could have changed in response to internal and external pressures but remained intransigent. Changing RAMC accounting systems to accommodate shell shock would have required changing from an exclusive goal to the multiple goals of military victory and the equitable treatment of all soldiers, especially those whose capacity to fight was impaired. For RAMC accounting systems to remain integrated with the other Army systems, all other systems would have required changes to enable and support continued integration. In addition, changing goals would have had resource allocation implications, taking resources from the goal of military victory and allocating them to care of soldiers, and, potentially most importantly, have undermined the moral commitment of stakeholders to the war. Accounting intransigence did not reflect the inability of the accounting system to change.

Using the AGIL scheme explains that RAMC accounting systems did not change because they did not become unstable. Minor adaptations were made to systems, such as the granting of two weeks hospital rest for sufferers of neurasthenia, helped maintain the internal moral commitment to the systems. However, major systems’ changes were not required because the high degree of integration made the systems resilient to pressures to change, and stakeholders remained morally committed to the goals. The AGIL scheme suggests that RAMC accounting systems would only have changed if shell shock significantly impaired military victory or if the latency of the system was weakened, so that the moral commitment of stakeholders to the sole goal of military victory was reduced.

5 Conclusion

This research has examined reasons for intransigence by RAMC accounting systems during the First World War in the management of soldiers with shell shock. RAMC accounting systems were resilient to change because they did not, in Parsons’ and Smelser’s (1956) terms, become unstable. The systems remained stable because none of the four categories in the AGIL scheme were sufficiently impaired to make the systems unstable and, hence, require systems change.

Extant literature has identified historical and internal political factors that can lead to intransigence. The example of RAMC accounting systems’ intransigence in the British Army indicates that historical and political factors are only part of the story and a broader understanding is available by subsuming the historical and political factors within the AGIL scheme which enables a richer analysis of the issues. Even if powerful stakeholders wanted the Army to recognise shell shock as a medical condition, there would have been intransigence because of the moral commitment to the single goal focus of military victory, the ability of accounting systems to adapt to and the integration between RAMC accounting systems and other systems.

While an historical example from the First World War may seem anachronistic, it provides lessons if accounting is to have relevance for current issues and if accounting systems are to change in response to contemporary social concerns. It suggests that to affect change in a system, one or more of the system’s categories in the AGIL scheme must be impaired sufficiently to make the system
unstable and precipitate a system change. It highlights that adaptable and integrated systems are likely to be more intransigent than less adaptable and less integrated systems. Parties interested in maintaining intransigence in a system can support the system through propaganda that deflects attention away from limitations in goal attainment or promotes system latency, that is bolsters the moral commitment to the goals of the system.

The AGIL scheme can be used to understand intransigence in other systems. For example, there has been pressure to modify financial reporting systems to require social and environmental reports. The financial reporting system used internationally has the goal of maximising returns for investors and creditors (International Accounting Standards Board, 2018). This system is heavily integrated with corporations and securities laws internationally and with decision-making systems used by investors and creditors. It also has inbuilt adaptability through the International Accounting Standards Board’s ability to fine-tune financial reporting through issuing new or revised accounting standards. Finally, there is substantial internal and external moral commitment to the capitalist ideal of maximising wealth which supports the system. An AGIL scheme analysis suggests that financial reporting systems will remain intransigent unless the moral commitment to capitalism is impaired significantly or organisations fail to achieve returns expected by investors and creditors.

The AGIL scheme helps to explain accounting system intransigence. It can be used to recognise potential areas of instability and intransigence so that resources are directed towards system stability and accounting systems are better prepared to adapt to change.

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Senior Army commanders could not ignore the medical impact on British soldiers of poison gas attacks when they were using poison gas as a weapon to cause the same debilitating effects on enemy soldiers (Jones, 2014).