

STATE, SERVICE, AND SURVIVAL: CANADA'S GREAT WAR DISABLED, 1914-44

STATE, SERVICE, AND SURVIVAL

CANADA'S GREAT WAR DISABLED, 1914-44

by

KELLEN KURSCHINSKI, BA, MA

A Thesis Submitted to the School of Graduate Studies in Partial Fulfillment of the
Requirements for the Degree Doctor of Philosophy

McMaster University © Copyright by Kellen Kurschinski, November 2014

TITLE: State, Service, and Survival: Canada's Great War Disabled, 1914-44

AUTHOR: Kellen Kurschinski, BA (Wilfrid Laurier University), MA (University of Waterloo)

SUPERVISOR: Dr. John C. Weaver

NUMBER OF PAGES: xii, 460

ABSTRACT

The following dissertation examines the little-known history of Canada's Great War disabled. During the Great War Canada mobilized 620,000 soldiers, most of them volunteers. Nearly 120,000 would one day receive compensation for a disability incurred on, or aggravated by military service. Thousands more suffered from related injuries, diseases, or traumas but lacked the documentary evidence necessary to garner material support from the state. The core objective of this dissertation is to explore how policy-makers responded to these challenges, and how their efforts shaped the daily experiences of veterans from all walks of life. By fusing an analysis of policy with a social history of disability, this study uncovers the multiple paths disabled veterans embarked upon during their civil re-establishment. Few followed uniform trajectories. The affects of disability on a veteran's wellbeing varied widely based on numerous factors including pre-war social standing, support networks, material resources, age, and overall health. While most studies of disability and the Great War have focused on the cultural, medical, or political impact of disability, few adequately explain how both government policy and extraneous forces affected the lives of disabled veterans. Utilizing a wealth of statistical data and a large sample group of case files, "State, Service, and Survival: Canada's Great War Disabled, 1914-44" is the first Canadian study to address this gap in our collective understanding of the war's legacy.

ACKNOWLEDGEMENTS

A PhD dissertation is a product of love, curiosity, frustration, and determination. The past four years have been a remarkable personal and intellectual journey, one that has inspired me to make a commitment to lifelong learning, and to do what I can to share my love of history with others. Many organizations and individuals enriched this experience and provided support along the way. During the first three years of my doctoral studies I was extremely fortunate to receive external funding from the Social Sciences and Humanities Research Council (SSHRC) in the form of J. Armand Bombardier Canada Graduate Scholarship. I am also grateful for the financial support I received from the Wilson Institute for Canadian History and Department of History at McMaster University. Each offered scholarships in addition to generous research and conference travel subsidies over my four years of studies. During 2013-14 a fellowship from the Sherman Centre for Digital Scholarship allowed me to devote extra time and resources towards the timely completion of this project. None of my research would have been possible without this essential financial support.

My time at McMaster was made all the more enjoyable by the relationships I formed with staff, faculty, and students. In particular, I would like to thank Nathan Coschi for his companionship and support. For three years Nathan and I carpooled to campus every week from our hometown of Waterloo, Ontario to attend seminars and TA courses. As I quickly found out, Nathan's intellect was surpassed only by his kind nature, robust sense of humor, and indepth knowledge of esoteric sports statistics. A caring person and a brilliant young mind, I know he will go on to do great things.

Academically, no one at McMaster has had a greater influence on this study and my development as a scholar than my supervisor, Dr. John C. Weaver. I first met Dr. Weaver in the spring of 2010, shortly after I made my decision to attend McMaster for my doctoral studies. After our first encounter, I knew that I had made the right decision. John was enthusiastic about the project and eager to share his own insights on the challenges and opportunities inherent to case file research. In the years that followed I benefited immensely from Dr. Weaver's keen editorial eye, thoughtful criticism, and persistent encouragement. At every stage he treated me not as a student, but as a junior colleague, a feature of our relationship that made my time working with him all the more rewarding. He is without a doubt one of the most remarkable scholars and mentors I have ever encountered.

Praise and thanks are also owed to my thesis committee members, Dr. Martin Horn and Dr. Nancy Bouchier. Both Dr. Horn and Dr. Bouchier are accomplished educators, supportive colleagues, and an immense credit to the Department of History at McMaster. I would also like to extend my gratitude to Dr. David Wright, who agreed to supervise a minor field in medical and disability history for me during the fall of 2010 before he moved on to a new position at McGill University. During the defence process, this study also benefited from thoughtful comments and feedback provided by my external examiner, Dr. Shelly McKellar of Western University.

The core documents that form the basis of this dissertation are the First World War veterans' pension records held by Veterans Affairs Canada. Without the hard work and dedication of several individuals I would have never been able to properly access and

utilize this valuable collection of primary materials. I would like to first express my appreciation to Michael Wert for taking the time to discuss his own experience working with the VAC records while I was still in the early stages of this project. When I finally headed to Charlottetown, PEI in the summer of 2012 to complete my research I was aided immensely by the staff at the VAC records repository, especially Michelle Noonan, Jennifer Neill-Band, and Debbie Bryan. Their hospitality and expertise made this frenetically paced trip a very fulfilling experience. I also owe a great debt to my digitization assistant Mallory Weatherbee, who worked during and after my stay to digitize tens of thousands of pages of material. Juliana MacEwen of Precision Document Management Solutions provided Mallory's services along with digital scanning equipment that saved precious time and resources.

Since 2007 I have had the good fortune of being affiliated with the Laurier Centre for Military Strategic and Disarmament Studies (LCMSDS) at Wilfrid Laurier University, first as a student employee during my undergraduate studies, and later as a Research Associate. In addition to providing financial support for this project and many other academic activities, the Centre has been instrumental to my personal and professional growth. Two LCMSDS mainstays in particular deserve mention for the lasting impact they have had on this study and my career as a whole: former LCMSDS Director, Terry Copp, and Dr. Mark Humphries, a long-time associate and the new director of the Centre. When I first came to LCMSDS in 2007 Mark was in the middle of his PhD and took me under his wing as a research assistant. Though Mark temporarily moved on to academic positions at Mount Royal University and Memorial University

after 2008, he always remained a vital mentor, a supportive colleague, and a generous friend. In one way or another Mark has stood behind me at every stage of my academic career, offering poignant advice that aided the development of this project and gave me new perspectives on academic life in general.

I am equally grateful to Terry Copp, an extraordinary historian and an even more impressive teacher whose enthusiasm for young people is virtually unmatched. Throughout my time at LCMSDS Terry was a constant source of encouragement and sound advice. His evidence-based approach to history and scrupulous dedication to the historian's craft have inspired me at each stage of this project, and will continue to throughout the remainder of my career. Together, Mark and Terry have provided an unbelievable foundation of support. I can only hope that this study does justice to the tremendous impact both have had on my life and career.

In addition to these two important figures at LCMSDS, I would like to acknowledge Dr. Roger Sarty and Dr. Cynthia Comacchio, both of whom taught me during my undergraduate studies and continued to offer their advice and support in the years that followed. In 2010 I had the great pleasure of completing my MA degree down the road at the University of Waterloo under the supervision of Geoffrey Hayes. Geoff, another LCMSDS associate, was instrumental in helping me conceptualize this project, first as a SSHRC proposal, and later as a series of essays.

My seven years at LCMSDS also brought about many enduring friendships that have in one way or another impacted this study. In particular I would like to thank Matt Symes, Caitlin McWilliams, Kirk Goodlet, Geoff Keelan, Jane Whalen, Trevor Ford, and

Eric Reis for their companionship, research assistance, and unwavering support. Each of you has had a special influence on me over the years. You've made me not only a better scholar but a better person as well. I am especially grateful to Matt for his mentorship and the numerous opportunities for professionalization that he helped facilitate while at the Centre.

Finally, I'd like to say thank you to a few of the most important people in my life. To my parents Bob and Drina, and my sister Kara, whose patience and encouragement helped me navigate through even the most overwhelming stages of this project, I need only say this: the impact of your enduring love is present on every page of this manuscript. None of this would have been possible without you. Whether it was finding extra time to help me around the house, inviting me over for a Sunday meal, or taxiing me from our rented cottage on the north shore to the VAC records office in Charlottetown during our family-vacation-turned-research-trip in 2012, you have always been there to help when I've needed you most. To my extended family and close friends, know that you have all contributed meaningfully to this journey as well.

To my best friend and partner of the last ten years, Steph Wong, I need only say this: It's finally done! All kidding aside, Steph, your love, patience, and encouragement have made even the most frustrating days of research and writing worthwhile throughout the duration of this project. You may never read farther than this, but know that every word I have written is dedicated to you.

Waterloo, Ontario
November 2014

TABLE OF CONTENTS

ABSTRACT		iv
ACKNOWLEDGEMENTS		v
LIST OF ABBREVIATIONS		xi
INTRODUCTION: Disability, the Great War, and its Legacy in Canada		1
CHAPTER 1:	The Medical War’: Managing Soldiers’ Bodies and Minds in the Great War, 1914-18	39
CHAPTER 2:	‘A Rude Awakening’: Managing the Crisis of the Disabled on the Canadian Home Front, 1914-19	100
CHAPTER 3:	‘The bill is a heavy one’: Canada and the Pension Question, 1914-21	149
CHAPTER 4:	‘The future of these glorious victims is a woeful question’: Retraining and Re-education on the Road to Civil Re-establishment, 1915-23	199
CHAPTER 5:	‘We have not had a square deal’: Austerity and the Politics of Veterans’ Health, 1919-1929	242
CHAPTER 6:	‘In Forma Pauperis’: Disability, ‘Burning out’, and the Limits of Reform, 1929-39	293
CONCLUSION:	Learning through Failure? Canada’s Great War Disabled in Context, 1914-44	35
APPENDICES		364
Appendix I:	Methodological Essay	
Appendix II:	Statistical Appendix	
Appendix III:	Dataset Variables Compiled from CEF Personnel Files and Pension Files	
Appendix IV:	Canadian Pension Scales, 1915 to 1920	
Appendix V:	Table of Disabilities for the Board of Pension Commissioners, 1918	
BIBLIOGRAPHY		438

LIST OF ABBREVIATIONS

ADMS	Assistant Director of Medical Services
ADS	Advanced Dressing Station
ATIP	Access to Privacy and Information Acts
BEF	British Expeditionary Force
BMJ	British Medical Journal
BPC	Board of Pension Commissioners
CAMC	Canadian Army Medical Corps
CCS	Casualty Clearing Station
CEF	Canadian Expeditionary Force
CNIB	Canadian National Institute for the Blind
CMAJ	Canadian Medical Association Journal
CPC	Canadian Pension Commission
CPF	Canadian Patriotic Fund
DAH	Disordered Action of the Heart
DBS	Dominion Bureau of Statistics
DDMS	Deputy Director, Medical Services
DPNH	Department of Pensions and National Health
DRS	Divisional Rest Station
DSCR	Department of Soldiers' Civil Re-establishment
DSTB	Disabled Soldiers Training Board
DVA	Department of Veterans Affairs
FA	Field Ambulance
FAB	Federal Appeal Board
GSW	Gunshot Wound
GWVA	Great War Veterans' Association
HO	Head Office (Veterans Affairs Canada)
ISC	Invalided Soldiers' Commission
LAC	Library and Archives Canada
MHC	Military Hospitals Commission
MP	Member of Parliament
MSA	Military Service Act (1917)
NYD(N)	Not Yet Diagnosed (Nervous)
PAC	Pension Appeal Court
PPCLI	Princess Patricia's Canadian Light Infantry
PTSD	Post-Traumatic Stress Disorder
PUO	Pyrexia Unknown Origin
RAMC	Royal Army Medical Corps
RG	Record Group
RMO	Regimental Medical Officer
RO	Regional Office (Veterans Affairs Canada)
SEF	Siberian Expeditionary Force
SG	Sample Group

SPSS	Statistical Package for the Social Sciences
SSB	Soldier Settlement Board
TB	Tuberculosis
VAC	Veterans Affairs Canada
VAD	Voluntary Aid Detachment
VDH	Valvular Disease of the Heart
WD	War Diary
WVA	War Veterans Allowance

Introduction: Disability, the Great War, and its Legacy in Canada

On 11 November 1936, thousands of Calgarians crowded the city's armouries to mark the 18th anniversary of the armistice that ended the Great War. Addressing the masses before him, Reverend R. Paton of the Scarboro United Church implored his audience to pause and consider the legacy the war had left behind, and the debt that remained unpaid. "If this is to be a day of remembrance, not merely the utterance of pious platitudes," he declared, "let us remember that the fruits of victory, if such it may be called, are not yet ours."¹ The Great War, both physically and materially, had "exacted a terrible toll," and none knew this more intimately than the hundreds of ex-soldiers "maimed in body and broken in mind" who, once more, had braved the frigid November weather to pay homage to their fallen comrades.² Similar words echoed in the speeches, prayers, and silent thoughts of Canadians gathered across the country as millions joined to reflect on a conflict that had wrought immense suffering on a generation and, tragically, continued to claim new victims with each passing day.

Canada's contribution to the Great War is well known, but the sacrifices borne by those who served are often recited without due consideration of the war's social magnitude or long-term impact. Between August 1914 and November 1918 some

¹ "Armistice Anniversary Observed by Thousands at Calgary Service," *Calgary Daily Herald*, November 11th, 1936, 1.

² "Armistice Anniversary Observed by Thousands at Calgary Service," *Calgary Daily Herald*, November 11th, 1936, 1.

620,000 soldiers enlisted in the Canadian Expeditionary Force (CEF). By the end of the war, over 400,000 had served overseas, including nearly 350,000 with the Canadian Corps in France. In only three years of combat operations, Canada's military evolved from a small colonial volunteer force into one of the most formidable fighting formations under the control of the British army. Canada's stellar military reputation, however, came at a steep price: nearly 60,000 dead, and 172,000 wounded, most of them on the Western Front.³ The more disturbing toll lay in the human wreckage the fighting left behind. Of 540,000 CEF veterans who survived the war, nearly 120,000 suffered from some variety of pensionable disability during their lifetime.⁴ By the outbreak of the Second World War, one in every three combat veterans had been awarded a pension for wounds or disease contracted on service. An even greater number sought compensation but were ultimately denied. In the 20 years after the armistice, over 10,000 Canadians died from wounds or disease attributable to their war service.⁵ For the generation of 1914-18, disability was a constant reminder that the 'war to end all wars' was never truly over.

The following study brings to light the history of Canada's Great War disabled, their stories of struggle, of tragedy, and perseverance. Beginning at the point of enlistment, it follows the life histories of these men from the front lines to civil re-establishment, interrogating the complex ways in which military service affected their health and wellbeing over the span of a generation. Disability, I argue, was a crucial

³ G.W.L. Nicholson, *Official History of the Canadian Army in the First World War: Canadian Expeditionary Force, 1914-1919* (Ottawa: Queen's Printer, 1962), Appendix C.

⁴ This is a general estimate deduced from the number of pensioners who died between 1915 and 1939, the number of one-time gratuities that were granted, and the number of soldiers who held a pension in 1939. See Figure 2.4 and Table 2.3 in Statistical Appendix. On the impact of gratuities see chapters 3 and 6.

⁵ See Figure 2.4 in Statistical Appendix.

feature of Canada's wartime experience, one that transcended the spatial and temporal boundaries of the military campaign and unequivocally transformed the lives of all Canadians it touched. In almost every community and every kin network within English Canada there existed a disabled veteran, a fact that has long been overshadowed by scholarly accounts and popular narratives of the Great War that privilege military achievements or the sacrifices of the dead above those who continued to live with the scars of war for the remainder of their lives. Without their inclusion, no history of the Great War is complete.

The prevalence of disability in wartime had a profound effect on the contours and trajectory of the Canadian state's evolving relationship with its citizens. Veterans' experiences with war disability were highly personalized, but disablement also fuelled popular anxieties surrounding war's lingering traumas. If left uncared for, many policymakers and social critics feared that the war's disabled—and disenchanting veterans in general—would quickly undermine the social, economic, and political harmony of the post-war order. The war, they believed, presented an unbridled opportunity to shed the inheritance of indifference and neglect that past generations had bestowed upon their war veterans. Canada's soldiers would fare differently, with the state and voluntary organizations working in concert to return damaged soldiers to a life of dignity and self-sufficiency. If dominion was to emerge from the war as a victor, the righteousness of its military contributions would be measured not only on the basis of battles won, but also by how it cared for its disabled heroes.

The state's response to the wartime crisis of disability marked the beginning of an unprecedented foray into the private lives of ordinary Canadians. What began in the summer of 1915 as a modest attempt by patriotic volunteers to find hospital space for returning wounded rapidly expanded into one of the largest ongoing federal expenses in the nation's short history.⁶ Despite its comparatively small role in the military effort in Europe, Canada's rehabilitation program rivalled or surpassed that of any other allied nation in both its complexity and generosity.⁷ A highly sophisticated and internationally touted vocational retraining scheme bolstered hopes that the tens of thousands of disabled men who were unable to return to their former occupations would contribute to the nation's future prosperity as breadwinners. The crowning achievement of Canada's rehabilitation program was the *Pension Act* (1919), a groundbreaking piece of social legislation that offered the most generous compensation rates for war disabilities in the world.

Although infused with progressive ideals, Canada's re-establishment scheme was not designed on the basis of universality. Access to benefits was contingent on a soldier or dependent's ability to demonstrate ongoing medical or, in certain cases, financial need. Like its international allies, Canada founded its policies on the contemporary belief that disability was principally an economic wound, the effects of which could be measured, managed, and in many cases, alleviated by the power of modern medical science. The objective of rehabilitation was to furnish ex-servicemen with care, financial support, and

⁶ Desmond Morton and Glenn Wright, *Winning the Second Battle: Canadian Veterans and the Return to Civilian Life, 1915-30* (Toronto: University of Toronto Press, 1987), 239.

⁷ *Report of the Work of the Invalided Soldiers' Commission* (Ottawa: King's Printer, 1918), 9-12.

skills that would propel them towards self-sufficiency. No medical procedure could effectively cure the loss of a limb or the loss of one's sight, but a soldier could be retrained in an occupation where his disability, at least in theory, posed no economic impediment. Pensions would ensure that those who could not return to a life of labour were able to make ends meet, but in order to discourage idleness, the Canadian system was structured in such a way that it only granted these levels of compensation to a select few candidates. Work remained the disabled soldier's means of salvation.

This vision of civil re-establishment as a program of temporary generosity and long-term limited intervention was not incongruent with veterans' own ideas about what the post-war society should look like. A life of family, work, and independence were all idealized norms upset by the Great War that many soldiers hoped to return home to. Medical innovations and re-education strengthened policymakers' convictions that civil re-establishment would be a process with a defined beginning and endpoint. A pension, a job, and stable health were all that was necessary for a disabled veteran to return to normalcy.

A key finding of this study is that few disabled veterans followed such a linear trajectory throughout their return to civilian life. War disabilities took on a multitude of shapes and forms that often conflicted with the popular iconography of disablement. Bodily mutilation, poison gas exposure, and shell shock aroused powerful images of the Great War's menacing impact on body and mind, but these sources of disability only accounted for a small proportion of the conditions soldiers developed—or aggravated—as a result of their military service. More Canadian veterans, for example, were diagnosed

with tuberculosis than received amputations.⁸ Gunshot and shrapnel wounds were the single most common cause of all combat injuries, however, collectively far more soldiers suffered from debilitating heart conditions, chronic respiratory illnesses, cancers, digestive disorders, and weakened immune systems.⁹ Physical wounds could easily be traced to incidents on the battlefield but medical science proved much more imprecise when it came to uncovering the genesis of disease. Prognoses were equally difficult to predict, leaving many veterans in the dark about the future challenges disability might pose to their overall health and ability to earn a livelihood.

The multitude of disabilities present within the veteran population, and particularly the prevalence of ‘invisible wounds,’ would have a growing influence on the shape of veterans’ politics throughout the 1920s and 1930s. Pensions figure prominently in this study both because of their material significance to ex-soldiers as well as for the important insight they offer on the evolving medical, social, and economic meanings assigned to disability during the first half of the twentieth century. Before the Great War disability remained first and foremost a private tragedy and a moral failing within Western societies. Whether a disabling condition was contracted at birth, resulted from advancing age, or came about as the result of an industrial accident, disabled persons were commonly relegated to the care of family, private charity, or in severe cases, public institutions, some for the remainder of their lives.¹⁰ Veterans posed a unique challenge to

⁸ *Report of the Work of the Board of Pension Commissioners for Canada* (Ottawa: King’s Printer, 1921), 27.

⁹ See Table 2.5 in Statistical Appendix.

¹⁰ Henri-Jacques Stiker, *A History of Disability* (Ann Arbor: University of Michigan Press, 1999); Kim Nielsen, *A Disability History of the United States* (Boston: Beacon Press, 2012).

this laissez faire approach. An ordinary citizen who had enlisted to fight for his country could hardly be at fault for the loss of an arm, exposure to poison gas, or in some exceptional cases, the loss of his mental stability due to the strain of combat. Accordingly, Canadian pension regulations compensated any disability that could be deemed ‘attributable’ in some way to military service, and would continue to provide treatment and compensation so long as the condition remained. Many ‘invisible wounds’ or latent diseases forced Canadians’ to reconceptualize their understanding of war disability, while also casting doubt on the totality of rehabilitation. This phenomenon also raised difficult questions about worthiness, fraud, and the feasibility of pension laws that placed the burden of proof upon the applicant. Did a soldier who enlisted with an unidentified tuberculosis infection deserve to be compensated on the same basis as an amputee? What of the thousands of overage and medically unfit soldiers who slipped through the cracks of the army’s medical screening only to break down once overseas? Could a soldier who was taken as a prisoner of war and developed a respiratory disease years after returning to Canada lay a rightful claim to a pension without proper documentation connecting his disability to conditions experienced during captivity?

In the years following the war, questions such as these spawned intense public debate surrounding the state’s treatment of veterans who had developed poor health without a clear linkage to military service. Politicians responded with reluctance to shifting understandings of disability by introducing incremental revisions to re-establishment legislation. In the 20 years after it was introduced, the *Pension Act* was amended on no less than 16 separate occasions. These frequent modifications did more to

confuse veterans and increase bureaucracy than improve the responsiveness of the pension system.¹¹ Seemingly subtle changes proved to have dramatic effects on eligibility and the capacity of authorities to handle new applications. Pension officials often bore the brunt of criticism from disabled ex-servicemen, but as this study reminds readers, policy changes brought on after the war were shaped primarily by parliamentarians and veterans' organizations. Bureaucrats and medical authorities retained their own agency within administrative settings, but their decision-making abilities were bound by the parameters of existing regulations. Even so, the Board of Pension Commissioners (BPC) and its successor body, the Canadian Pension Commission (CPC), proved an easy target for disenchanting veterans..

The economic hardships of the Depression years strained this delicate relationship further. Throughout the early 1930s waves of unemployed veterans came forward seeking restitution for old wounds and previously undiscovered illnesses that they believed emanated directly from their wartime experiences. The most troubling of these were the 'burn out cases'—once healthy combat veterans who were now physical debilitated or 'prematurely aged' for reasons that defied conventional medical explanation. Knowing the public would not stand for government parsimony towards the war's disabled, veterans' organizations seized on this emerging crisis to bolster their claims for additional access to entitlements and more generous social programs. Success was mixed, but their activism was instrumental in drawing attention to the disjuncture between the rigid medico-legal definitions of war disability enshrined in the Pension Act and the complex

¹¹ Peter Neary, "Without the Stigma of Pauperism': Canadian Veterans in the 1930s," *British Journal of Canadian Studies* 22, no. 1 (2009): 33.

aetiology characteristic to latent diseases. That thousands of war disabled continued to go uncompensated only contributed further to veterans' impressions that the promise and opportunity of civil re-establishment had gone unfulfilled.

To label Canada's efforts to re-establish its disabled soldiers a resounding failure, however, would be a gross oversimplification. The Great War challenged politicians, physicians, bureaucrats, and ordinary citizens to reassess well-established ideas surrounding disability, its social, material and medical implications, and the extent of the state's responsibility to care for those who answered the call of duty. With no previous model to follow, it should come as no surprise that the ideals, objectives and praxis of rehabilitation at times conflicted, or that myopic interpretations of disability persisted within government programs. Despite the shortcomings of official policy, what this study reveals most vividly are the ways in which veterans coped, adjusted, and persevered through shifts in government policy, changing material circumstances, states of health, and social attitudes. Few wanted to be seen as victims; they were ordinary Canadians who had endured extraordinary experiences.

To unearth these stories and advance a more nuanced understanding of the developing relationship between veterans, their families, and the state, this dissertation relies on a diverse collection of historical records and quantitative evidence. The most important body of sources it utilizes are the military service records of the Canadian Expeditionary Force held at Library and Archives Canada (LAC) and the First World War pension records held by Veterans Affairs Canada (VAC). When used together, they offer historians the unique ability to chart the life histories of veterans from their youth

until death, revealing fascinating details about family dynamics, material circumstances, disability, health and aging, as well as the burgeoning influence of the state in the lives of ordinary Canadians. Military service records—sometimes referred to as personnel files—provide a comprehensive overview of a soldier’s social background, wartime experiences, and medical history. For pension authorities, these documents were the core body of evidence relied upon to establish a right to compensation for illness or injury. As we shall see, however, confusion and disarray at the front lines during periods of intense combat meant that many disabilities went undocumented as more serious casualties were shepherded through the military medical chain.

The VAC pension records form the backbone of this study and are arguably the most robust collection of historical case files presently available to Canadian historians. In spite of this, only a handful of researchers have ever set eyes upon them. Even fewer have incorporated these key documents into a substantial scholarly work.¹² Each file represents a full account of a veteran’s evolving relationship with the state, the most detailed of which span over a period of 50, 60, and sometimes 70 years. The most extensive records exceed a thousand pages in length, but even those of more modest size can provide essential information on post-war financial circumstances, family life,

¹² Two exceptions are a BA thesis and corresponding journal article by Michael Wert and a MA thesis by Chelsea Clark. It is also worth noting that a project currently spearheaded by Wilfrid Laurier University’s Mark Humphries, Terry Copp, and Cynthia Comacchio seeks to preserve many of these files and utilize them for qualitative and quantitative research purposes. See Michael Wert, “From Enlistment to the Grave: A Case Study of the 34th Battalion’s Experience with the Great War,” (BA Thesis, Wilfrid Laurier University, 1990); idem “From Enlistment to the Grave: the Impact of the First World War on 52 Canadian Soldiers,” *Canadian Military History* 9, no. 2 (2000): 45–58; Chelsea Clark, “Not Attributable to Service: First World War Veterans’ ‘Second Battle,’ with the Canadian Pension System” (MA Thesis, University of Calgary, 2009). For methodological and historiographical considerations on the use of case files, see Franca Iacovetta and Wendy Mitchinson, eds., *On the Case: Explorations in Social History* (Toronto: University of Toronto Press, 1998).

demographics, disability benefits, overall health, and other vital information that can then be connected to each individual's military experiences.

The availability of digitized personnel files through LAC's "Soldiers of the First World War: 1914-1918" database presented a unique opportunity to explore the history of Canada's disabled veterans in a more comprehensive fashion than afforded by a conventional examination of a selected set of documents. From this database of digitized files a random sample of 384 veterans was selected and their corresponding pension records requisitioned from VAC (see Appendix I: Methodological Essay for a full description of the sampling process and other methodological considerations). Information was then extracted into a dataset that covering both wartime and post-war experiences. The most useful data found consistently within the records related to demographics, pension benefits, medical history, and circumstances surrounding death. This sample data is enhanced by tables and charts that have been compiled by the author from official government sources. They present a useful means of quantifying and contextualizing disability's impact on veterans' lives.¹³

There are, however, limitations to what this quantitative data can reveal.¹⁴ What motivated ex-soldiers to apply for a pension? How did their health impact their home lives, employability, or sense of belonging in their communities and society at large? To what degree did the war alter popular perceptions of disability, and conversely, to what

¹³ On the utility of quantitative analysis and soldiers' records see Larry M. Logue and Peter Blanck, *Race, Ethnicity, and Disability: Veterans and Benefits in Post-Civil War America* (Cambridge: Cambridge University Press, 2010).

¹⁴ For an overview of the opportunities and limitations of statistical analysis in historical scholarship, see Pat Hudson, *History by Numbers: An Introduction to Quantitative Approaches* (London: Arnold, 2000).

extent were pre-war attitudes sustained? Were veterans' authorities amicable, parsimonious, or indifferent to their disabled clientele, and what variance occurred across individual cases? In order to shed light on these questions, representative examples from case files, newspapers, or government investigations have been utilized throughout this study. Many references are merely snapshots of a veteran's life, while the narratives of others appear in more detail and with greater frequency. Veterans' words as well as those of friends, co-workers, and kin, are of especially great value, and have been retained using original spelling and form.¹⁵ In compliance with the provisions of Canadian privacy legislation and the author's research agreement with VAC, the identities of all veterans and kin have been altered.

Supplementing the above-described sources is a range of archival collections, government publications, and committee reports. Together, these documents offer the best means of establishing an overview of policy development between 1914 and 1939, and the changing shape of the institutions that administered care to veterans. The history of policy is often neglected in social histories of war or disability, however, as this dissertation will illustrate, changing criteria for pension eligibility, medical treatment, or programs such as the War Veterans Allowance had a meaningful impact on the daily lives of ordinary veterans. Importantly, such an approach reveals how Canadians relied extensively on the experience of other nations to guide their rehabilitation practices at

¹⁵ Where it was necessary to do so to convey the proper meaning of a passage, punctuation – especially separation of sentences with periods – has been added.

home and on the frontlines.¹⁶ Medical innovation and policy development did not take shape within a vacuum. Throughout the war and immediately following it, Canadians increasingly engaged in a vigorous international dialogue on the universal problem of the disabled soldier, tailoring their own scheme to the unique socio-economic and political conditions of the day.

Before going any further, it is an important consideration to define what is meant by terms such as ‘veteran,’ ‘returned soldier,’ or ‘ex-serviceman.’ Throughout official records such designations are amorphous and often invoked interchangeably. In particular contexts any one of the above labels could apply to a disability pensioner, a healthy veteran, or disabled veteran whose condition was not yet diagnosed or, perhaps had been rejected by pension officials. To underline this study’s central argument that disability was a pervasive feature of wartime and post-war society, I have adopted this same interchangeable usage when referring to the disabled veterans, though where possible, a distinction is made. The gendering of language in this study too, should not draw attention away from the fact that Canada’s small population of nursing sisters paid an equally heavy price for their service. Indeed, by 1933, almost 10 per cent of the army medical corps’ nursing sisters were receiving a disability pension.¹⁷ Finally, while the study deals principally with the efforts of federal authorities and their relationship with veterans, it is important to remember that re-establishment mobilized all levels of

¹⁶ See for example, Military Hospitals Commission, *Special Bulletin, April 1916* (Ottawa: King’s Printer, 1916); J.L. Todd, *The French System for Return to Civilian Life of Crippled and Discharged Soldiers* (New York: The Red Cross Institute for Crippled and Disabled Men, 1918).

¹⁷ *Report of the Work of the Department of Pensions and National Health* (Ottawa: King’s Printer, 1933), 54.

government and sectors of civil society in different capacities. As such, references to the ‘state’ are intended to imply all official structures of government power with which ex-servicemen interacted, be they local agencies, pension authorities, medical staff, or elected officials.

Disease, injury, and death are inherent outcomes of modern war, but only a select few historians have studied the physical and psychological legacies of combat on Canada’s veterans. An even smaller number of Canadian scholars have examined disability in the context of the Great War. Instead, the Canadian literature has generally been split along two broad lines of historical inquiry. The first is comprised of military historians and popular writers who have explored the participation of the Canadian Corps in the campaign on the Western Front and the combat experiences of Canadian soldiers. Beginning with the official histories produced by A.F. Duguid and G.W.L. Nicholson, this stream of scholarship examines military efforts with a particular eye to documenting and assessing key battles, appraising leadership, or charting the evolution of tactics and operational planning.¹⁸ The second category interrogates the great upheavals war engendered on the home front and in post-war society, highlighting the divisive effects of conscription, minority dissent, the process of remembrance and commemoration, as well

¹⁸ For a historiographical overview of Canadian writing on the Great War see Tim Cook, *Clio’s Warriors: Canadian Historians and the Writing of the World Wars* (Vancouver: UBC Press, 2006). Key works on the military experience include A.F. Duguid, *Official History of the Canadian Forces in the Great War, 1914-1919, vol. 1: From the Outbreak of War to the Formation of the Canadian Corps, August 1914-September 1915* (Ottawa: King’s Printer, 1947); Nicholson, *Official History*; S.F. Wise, *Canadian Airmen and the First World War* (Toronto: University of Toronto Press, 1980); Nathan Greenfield, *Baptism of Fire: the Second Battle of Ypres and the Forging of Canada, April 1915* (Toronto: HarperCollins, 2007); Tim Cook, *At the Sharp End: Canadians Fighting the Great War, 1914-1916* (Toronto: Viking Canada, 2007); idem, *Shock Troops: Canadians Fighting the Great War, 1917-1918* (Toronto: Viking Canada, 2008); Andrew Iarocci, *Shoestring Soldiers: The 1st Canadian Division at War, 1914-15* (Toronto: University of Toronto Press, 2008).

as the strains the war placed on dominant gender and familial norms.¹⁹ With rare exceptions, however, most major works have been unsuccessful at connecting the military campaign and home front experience. Despite a trove of information available on both facets of Canada's Great War, historians continue to adhere to geographic and chronological boundaries that do more to breed indifference to the war's long-term significance or, conversely, reinforce nationalist myths about the Canadian military effort overseas.²⁰

Despite serving as a crucial lynchpin between the military front and the home front Canadian writers have scarcely examined the wartime medical effort. With the exception of Bill Rawling's broad survey of army medicine in the twentieth century, Sir Andrew Macphail's official history of the Canadian Army Medical Corps (CAMC), and a handful of nursing studies, military medicine is generally treated as a tertiary feature of

¹⁹ See for example John Herd Thompson, *The Harvests of War: The Prairie West, 1914-1918* (Toronto: McClelland and Stewart, 1978); Jeff Keshen, *Propaganda and Censorship During Canada's Great War* (Edmonton: University of Alberta Press, 1996); Jonathan F. Vance, *Death So Noble: Memory, Meaning and the First World War* (Vancouver: UBC Press, 1997); Bohan S. Kordan, *Enemy Aliens, Prisoners of War: Internment in Canada During the Great War* (Montréal and Kingston: McGill-Queen's University Press, 2002); Desmond Morton, *Fight or Pay: Soldiers' Families in the Great War* (Vancouver: UBC Press, 2004); Sarah Glassford and Amy Shaw, eds., *A Sisterhood of Suffering and Service: Women and Girls of Canada and Newfoundland During the First World War* (Vancouver: UBC Press, 2012).

²⁰ One of the best 'connective studies' in the international literature Janet K. Watson, *Fighting Different Wars: Experience, Memory and the First World War in Britain* (Cambridge: Cambridge University Press, 2004). Also see Ian Miller, *Our Glory and Our Grief: Torontonians and the Great War* (Toronto: University of Toronto Press, 2002) and James Pitsula, *For All We Have and Are: Regina and the Experience of the Great War* (Winnipeg: University of Winnipeg Press, 2008).

Canadian army's operational history.²¹ Insights into the development of treatment regimes, hospital culture, and the challenges of care on the front lines appear primarily in the memoirs of former medical personnel or in scholarly case studies.²² The same holds true for the work of civilian authorities on the home front, and although many historians have recognized the foundational role that the Military Hospitals Commission (MHC) and Department of Soldiers' Civil Re-establishment (DSCR) played in the long-term development of Medicare in Canada, there remains much to be learned about the care these important agencies provided to disabled soldiers and their families.²³

The major exception to these historiographical patterns is the work of Desmond Morton. Throughout the 1980s and early 1990s, Morton's scholarship introduced Canadian and international readers to a range of fascinating and largely unexplored

²¹ Sir Andrew Macphail, *Official History of the Canadian Forces in the Great War, 1914-1919: The Medical Services* (Ottawa: King's Printer, 1925); Bill Rawling, *Death Their Enemy: Canadian Medical Practitioners and War* (Québec: AGMV Marquis, 2001), especially chapters 2, 3, and 4. Also see Heather Moran, "Stretcher Bearers and Surgeons: Canadian Front-line Medicine During the First World War, 1914-1918" (PhD Thesis, University of Western Ontario, 2008). The key studies on nursing and the Great War are G.W.L. Nicholson, *Canada's Nursing Sisters* (Toronto: S. Stevens, 1975); Linda J. Quiney, "'Sharing the Halo': Social and Professional Tensions in the Work of World War I Canadian Volunteer Nurses," *Journal of the Canadian Historical Association* 9, no. 1 (1998): 105-24; "'Assistant Angels': Canadian Women as Voluntary Aid Detachment Nurses during and After the Great War, 1914-1930" (PhD Thesis, University of Ottawa, 2002); Susan Mann, ed., *The War Diary of Clare Gass, 1915-1918* (Montréal and Kingston: McGill-Queen's University Press, 2000); idem, *Margaret Macdonald: Imperial Daughter* (Montréal and Kingston: McGill-Queen's University Press, 2005); Geneviève Allard, "Caregiving at the Front: The Experience of Canada's Military Nursing During World War I," in *On All Frontiers: Four Centuries of Canadian Nursing*, eds. Christine Bates, Dianne Dodd and Nicole Rousseau (Ottawa: University of Ottawa Press, 2005), 153-67; Mélanie Morin-Pelletier, *Briser Les Ailes de L'ange: Les Infirmières Militaires Canadiennes (1914-1918)* (Québec: Athéna éditions, 2006).

²² Two prominent examples are Captain R.J. Manion, M.C., *A Surgeon in Arms* (Toronto: McClelland, Goodchild & Stewart, 1918) and Frederick W. Noyes, *Stretcher Bearers ... At the Double!* (Toronto: Hunter-Rose Co., 1937).

²³ Morton and Wright, *Winning the Second Battle*, especially chapters 2 and 5; Katherine McCuaig, *The Weariness, the Fever, and the Fret: The Campaign Against Tuberculosis in Canada 1900-1950* (Montréal and Kingston: McGill-Queen's University Press, 1999). The best appraisal of the flu's impact on the state and public health is Mark Humphries, *The Last Plague: Spanish Influenza and the Politics of Health in Canada* (Toronto: University of Toronto Press, 2013).

aspects of the Great War, including military demobilization, vocational retraining, medical rehabilitation, and the politics of pensions.²⁴ His social history of the soldiers' experience, *When Your Number's Up*, was one of the first studies to present a comprehensive analysis of the men of the Canadian Expeditionary Force, and furthermore, drew important connections between life overseas and events on the home front.²⁵ However, Morton's most important contribution during this period related to the history of Canada's rapidly diminishing population of Great War veterans. His 1987 co-authored monograph with historian and archivist Glenn Wright, *Winning the Second Battle*, presented the first critical history of the veterans' movement in Canada, and contributed substantially to the still limited international literature on veterans and the politics of post-war reconstruction.

In *Winning the Second Battle*, Morton and Wright approach the veterans' experience from a social and political perspective, charting the evolution of veterans' policy from the earliest days of the war into the end of the 1920s. Their research broaches critical questions about the shifting relationship between the veterans' movement in Canada (spearheaded by the Great War Veterans' Association), politicians, and a burgeoning government bureaucracy. Throughout their work Morton and Wright offer a distinctive mixture of sympathy for the plight of veterans and cynicism toward the state's

²⁴ Desmond Morton, "‘Kicking and Complaining’: Demobilization Riots in the Canadian Expeditionary Force, 1918–19," *Canadian Historical Review* 61, no. 3 (1980): 334-60; idem, "‘Noblest and Best’: Retraining Canada's War Disabled, 1915-23," *Journal of Canadian Studies* 16, no. 3 (1981): 75-85; idem, "Resisting the Pension Evil: Bureaucracy, Democracy, and Canada's Board of Pension Commissioners, 1916-1933," *Canadian Historical Review* 68, no. 2 (1987): 199-224; Desmond Morton and Glenn Wright, "The Bonus Campaign, 1919-1921: Veterans and the Campaign for Re-establishment," *Canadian Historical Review* 64, no. 2 (1983): 147-67.

²⁵ Desmond Morton, *When Your Number's Up: The Canadian Soldier in the First World War* (Toronto: University of Toronto Press, 1993).

response, championing the original vision of leading post-war planners while deriding the alleged parsimony of pension officials and short-sighted politicians.

By their own admission, *Winning the Second Battle* serves as “no more than a preface” to the broader history of re-establishment, but it does not fall short of advancing an important, albeit highly contestable argument about the Great War’s legacy.²⁶ The war and its aftermath, they argue, served as a proving ground for the development of modern social policy in Canada, offering policy-makers the opportunity to test the limits of state affluence and broker entitlement to a special class of citizen. Though civil re-establishment ultimately “failed both its architects and its intended beneficiaries,” Morton and Wright suggest that these failures provided necessary ‘lessons learned’ that would allow a new generation of planners to craft their own innovative social policy during the Second World War.²⁷

As with any foundational piece of scholarship, *Winning the Second Battle* left many questions unanswered. The book’s emphasis on the politics of veterans’ organizations and debates over pensions was necessary in order to chart shifts in policy, but in doing so, veterans’ daily experiences go largely undocumented. The authors’ preoccupation with constructing a narrative in which veterans struggle against the pension system also tends to obfuscate the complex role the Board of Pension Commissioners and Canadian Pension Commission played as administrative bodies. More problematic is that the book ends prematurely in the early 1930s, leaving readers unsure of how revisions to

²⁶ Morton and Wright, *Winning the Second Battle*, xi.

²⁷ Morton and Wright, *Winning the Second Battle*, 223-25.

pension legislation affected veterans over the long-term.²⁸ The latter chapters of this dissertation address this shortcoming in Morton and Wright's study by illuminating how policy changes were developed by legislators and implemented by pension authorities during this period

Morton's early studies were published just as international scholars were beginning to investigate how and where Great War veterans fit into the politics of post-war society. Antoine Prost's 1977 three-volume history of veterans and inter-war France, for example, explored how disabled veterans served as a force for national unity and civil harmony, but remained "aggressive agents" against state parsimony.²⁹ In the German context, Robert Whalen's 1984 study *Bitter Wounds* employed a more sweeping approach by examining the struggles faced by 'war victims,' among them the disabled, orphans, and widows. To illuminate their diverse experiences, Whalen analyzed a broad spectrum of events including the German experience on the front lines, the politics of reintegration benefits, and the social and political exigencies faced by the Weimar Republic, arguing that war victims suffered from a collective state of 'melancholia' that bred complacency towards national socialism, and in some cases, even support for it.³⁰

These foundational histories by Morton, Prost, and Whalen highlight the important political and social influence ex-servicemen had on post-war society, but the

²⁸ This theme is also present within Morton's other writings on pensions.

²⁹ Antoine Prost, *In the Wake of War: Les Anciens Combattants and French Society*, translated by Helen McPhail (Providence: Berg, 1992), 31. Prost's work was originally published in French in 1977.

³⁰ Robert Whalen, *Bitter Wounds: German Victims of the Great War, 1914-1939* (Ithaca, NY: Cornell University Press, 1984), 16. On veterans politics in Germany also see James Diehl, "Victors or Victims?: Disabled Veterans in the Third Reich," *The Journal of Modern History* 59, no. 4 (December 1987): 705-36; James Crouthamel, *The Great War and German Memory: Society, Politics, and Psychological Trauma, 1914-1945* (Exeter: University of Exeter Press, 2009).

minutia of individual and familial experience, as well as the complex ways in which gender, class, race, and physical ability shaped veterans' identities, were scarcely considered. Joanna Bourke's seminal study *Dismembering the Male* sought to deviate from this pattern by investigating how the Great War affected contemporary attitudes towards masculinity and bodily norms. Drawing on an eclectic body of sources including soldiers' letters, memoirs, wartime propaganda, and oral histories, Bourke shows how killing, maiming, malingering, disability and death inspired a vigorous dialogue on the state of men's bodies and the health of British society. Rather than ushering in a reinvented, modern understanding of masculinity, she contends that the brutality of the Great War did more to entrench pre-war attitudes towards disablement and the male aesthetic than it did to jettison them.³¹ This was fuelled in part by the prevailing norms of English working-class life. Disability, while not nearly as endemic as it was during the war, had long been a feature of living and working in the nation's industrial cities. Accordingly, after the war the 'incomplete' bodies of disabled veterans were shunted to the private sphere while those of deceased heroes such as Lord Kitchener or the Unknown Soldier took centre-stage as part of a broader project of commemoration.³²

³¹ Joanna Bourke, *Dismembering the Male: Men's Bodies, Britain and the Great War* (Chicago: University of Chicago Press, 1996), 31-75. Other early studies of disability, the Great War, and the male body include Seth Koven, "Remembering and Dismembering: Crippled Children, Wounded Soldiers and the Great War in Britain," *American Historical Review* 99, no. 4 (October 1994): 1167-1202, and Roxanne Panchasi, "Reconstructions: Prosthetics and the Rehabilitation of the Male Body in World War I France," *Differences: A Journal of Feminist Cultural Studies* 7, no. 3 (1995): 109-40.

³² Bourke, *Dismembering the Male*, 210-11. On the debate over modernity and memory in post-war Europe see Paul Fussell, *The Great War and Modern Memory* (Oxford: Oxford University Press, 1975); Modris Eksteins, *Rites of Spring: The Great War and the Birth of the Modern Age* (Boston: Houghton Mifflin, 1989); Adrian Gregory, *The Silence of Memory: Armistice Day, 1919-1946* (Oxford: Berg Publishers, 1994); Jay Winter, *Sites of Memory, Sites of Mourning: The Great War in European Cultural History* (Cambridge: Press Syndicate of the University of Cambridge, 1995).

Bourke's study is best read as a series of provocative essays rather than a comprehensive survey of the war's physical legacy. Nevertheless, as part of an emerging field of scholarship on wartime culture, gender, and post-war memory, her work was instrumental in paving the way for a new generation of historians interested in uncovering how societies responded to crises engendered by war disability, as well as the challenges of healing and re-establishment.³³ Studies of medical and occupational rehabilitation have been especially prominent in recent years. Significant contributions by Jeffrey Reznick and Julie Anderson, for example, explain how the British state's limited intervention in the management of its war disabled galvanized volunteers to take on care-giving roles during and after the war.³⁴ As Anderson's research suggests, the expertise and new approaches introduced by these volunteers were essential to future developments in rehabilitation policy for veterans and civilians alike.³⁵ Importantly, these authors also grant disabled soldiers a substantial degree of agency during rehabilitation, revealing how patients forged their own culture of healing, navigated through the politics of hospital life, and resisted intrusive medical practices.³⁶ Some authors, such as Ana Carden-Coyne,

³³ For a concise survey of current approaches to the study of disabled veterans see the introduction to David Gerber, ed., *Disabled Veterans in History*, 2nd edition (Ann Arbor: University of Michigan Press, 2012).

³⁴ Jeffery Reznick, *Healing the Nation: Soldiers and the Culture of Caregiving in Britain During the Great War* (Manchester: Manchester University Press, 2004); idem, *John Galsworthy and Disabled Soldiers of the Great War*. Manchester: Manchester University Press, 2009); Julie Anderson, *War, Disability and Rehabilitation in Britain: Soul of a Nation* (Manchester: Manchester University Press, 2011), especially chapter 2.

³⁵ Anderson, *War, Disability, and Rehabilitation*, 2-4. Also see Julie Anderson and Neil Pemberton, "Walking Alone: Aiding the War and Civilian Blind in the Inter-war Period," *European Review of History* 14, no. 4 (2007): 459-79.

³⁶ Both Reznick and Anderson provide excellent cases studies of various hospitals, see Reznick, *Healing the Nation*, chapter 6; Anderson, *War, Disability, and Rehabilitation*, chapter 2. For a similar approach in the American context see Beth Linker, *War's Waste: Rehabilitation in World War I America* (Chicago: University of Chicago Press, 2011).

have gone so far as to suggest that veterans took rehabilitation into their own hands, seeking to restore their maimed bodies to a classical masculine aesthetic by embracing new prosthetics, reconstructive surgeries, or finding inventive ways to veil their dissymmetry.³⁷

Though they have added a great degree to our understanding of the Great War's medical and cultural impact, by focusing primarily on physical maiming and healing these studies underemphasize two crucial features of veterans' post-war lives: their evolving relationship with the state, and the impact of disability on family. Of the recent literature, Deborah Cohen's comparative study of disabled veterans in Britain and Germany offers the most useful appraisal of how the politics of entitlement shaped veterans' interactions with state and civil society. Government generosity, as Cohen illustrates, was by no means a guarantor of stability. Britain's meagre system of pension and rehabilitation benefits paled in comparison to Germany's expansive program that included some of the most generous pensions in the world as well as state-mandated employment guarantees for the disabled. In Britain, philanthropy filled in the gaps, promoting a culture of cooperation and reconciliation between the war's victims and broader society, while simultaneously shielding the state from the blowback of its own parsimony.³⁸ In Germany, however, the lavish benefits showered on the disabled caused

³⁷ Ana Carden-Coyne, *Reconstructing the Body: Classicism, Modernism, and the First World War* (Oxford: Oxford University Press, 2009). Also see, idem, "Ungrateful Bodies: Rehabilitation, Resistance and Disabled American Veterans of the First World War," *European Review of History* 14, no. 4 (2007): 543-65; idem, "'Painful Bodies and Brutal Women': Remedial Massage, Gender Relations and Cultural Agency in Military Hospitals, 1914-1918," *Journal of War and Culture Studies* 1, no. 2 (2008): 139-58.

³⁸ Deborah Cohen, *The War Come Home: Disabled Veterans in Britain and Germany, 1914-1939* (Berkeley: University of California Press, 2001), 8-9.

tensions to percolate between veterans and civilians that were eventually mobilized against the state. Whereas British veterans remained mostly conservative and supportive of existing political structures, resentment amongst German veterans made them much more susceptible to radicalization.³⁹ While the Canadian approach to re-establishment paralleled Germany's in terms of scope and generosity, a key observation made throughout this study is that Canada's disabled veterans also bolstered the state in spite of their frequent discontent, seeing it as a conduit to achieve reform rather than an obstacle.

Marina Larsson's recent study of Australia's war disabled, *Shattered Anzacs*, offers a poignant example of how politics extended beyond the public domain to the private sphere. Using kin networks as the focal point of her analysis, Larsson "reads against the grain" of official documents to explore how disability impacted the families and communities that disabled veterans returned home to after the war.⁴⁰ The household politics of disability, contends Larsson, was an instrumental part of the reintegration process, and provides a means to illuminate how disabled Anzacs navigated material hardships, emotional traumas, and familial strife. Importantly, Larsson's study deviates from much of the literature on war and disability by investigating how 'invisible wounds' such as war neuroses, tuberculosis, physical defects, or 'burning out' affected veterans' access to entitlements and familial relationships.⁴¹ Like Morton's studies of Canada's pension authorities, Larsson is critical of pension authorities (in this case, the Repatriation

³⁹ Cohen, 188-92.

⁴⁰ Marina Larsson, *Shattered Anzacs: Living with the Scars of War* (Sydney: University of New South Wales Press, 2008), 24. Also see Larsson's article "Restoring the Spirit: The Rehabilitation of Disabled Soldiers in Australia after the Great War," *Health and History* 6, no. 2 (2004): 45-59.

⁴¹ Larsson, *Shattered Anzacs*, 18-19.

Department) for their parsimony and indifference to veterans, framing disability as a universal tragedy that undermines the basic tenets of the “Anzac myth.”⁴²

In spite of a burgeoning international literature, Canadian historians have remained mostly silent on the subject of war and disability since Morton’s path-breaking work of the 1980s. Contributions from Peter Neary and Lara Campbell on veterans’ unemployment in the 1930s, while not expressly concerned with disability, have shown the limitations of veterans’ citizenship and the federal state’s reluctances to adopt a special program for employment relief.⁴³ A recent survey of Canada’s war blind produced by Serge Durlinger has also made a substantial contribution to our understanding of how vision-loss affected the lives of over 100 Great War veterans, but the study’s narrow focus and tendency to emphasize personal ‘triumphs’ over disability does not speak to the broader challenges that ex-servicemen faced.⁴⁴ The most important Canadian contribution of the last several years is Mark Humphries’ article on the diagnosis and treatment of war trauma during the inter-war period. In it, Humphries explains how state physicians and pension officials sought to delegitimize cases of war trauma by employing gendered medical concepts of heredity. Ex-soldiers who exhibited ‘unmanly’ symptoms and/or had a past history of mental instability were frequently dismissed as ‘hysterical’ rather than being granted the more legitimate—and

⁴² Larsson, *Shattered Anzacs*, 266.

⁴³ Lara Campbell, “‘We who have wallowed in the mud of Flanders’: First World War Veterans, Unemployment and the Development of Social Welfare in Canada, 1929-1939,” *Journal of the Canadian Historical Association* 11, no. 1 (2000): 125-49; Peter Neary, *On to Civvy Street: Canada’s Rehabilitation Program for Veterans of the Second World War* (Montréal and Kingston: McGill-Queen’s University Press, 2011), especially chapters 1 and 2.

⁴⁴ Serge Durlinger, *Veterans With a Vision: Canada’s War Blinded in Peace and War* (Vancouver: UBC Press, 2010).

pensionable—diagnosis of ‘neurasthenia.’⁴⁵ While debates over the nature of war neuroses continued to fixate on whether it was an acquired or innate disorder, fearing exploitation from veterans, Canadian pension authorities chose to abide by a more rigid medical framework in order to guard against abuse of the system.⁴⁶

Trauma was an important feature of the Canadian veterans’ experience, as it was in many of the former combatant nations. The history of shell shock and war-related mental illness is too extensive to examine in detail here, but it is worth noting where this study falls within the broader historiography and how it contributes to existing approaches. The literature on mental illness and the Great War has tended to gravitate towards two general schools of thought. The first approaches these disabilities from a social control perspective, relying on the work of Foucault and historians of the asylum to explain how social constructions of madness broker power relationships within institutional and clinical settings.⁴⁷ In these contexts, treatment is often highlighted as punitive, inhumane, and ineffectual.⁴⁸ Patients are victimized while practitioners represent

⁴⁵ Mark Humphries, “War’s Long Shadow: Masculinity, Medicine, and the Gendered Politics of Trauma, 1914–1939,” *Canadian Historical Review* 91, no. 3 (September 2010): 527-29. Outside of Humphries’ work the only other major study on Canadian approaches to shell shock treatment is Tom Brown, “Shell Shock in the Canadian Expeditionary Force, 1914-1918: Canadian Psychiatry in the Great War,” in *Health Disease and Medicine: Essays in Canadian History*, ed. Charles G. Roland, 308-32 (Toronto: Hannah Institute for the History of Medicine, 1983).

⁴⁶ Humphries, “War’s Long Shadow,” 504-509.

⁴⁷ Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason* (New York: Pantheon Books, 1965).

⁴⁸ See for example Eric Leed, *No Man’s Land: Combat and Identity in World War I* (Cambridge: Cambridge University Press, 1979); Ben Shephard, *War of Nerves* (London: Jonathan Cape, 2000); Joanna Bourke, “Effeminacy, Ethnicity and the End of Trauma: The Sufferings of ‘Shell-Shocked’ Men in Great Britain and Ireland, 1914-39,” *Journal of Contemporary History* 35, no. 1 (2000): 57-69; Leo van Bergen, *Before My Helpless Sight: Suffering, Dying and Military Medicine on the Western Front, 1914-1918*, trans. Liz Waters (Surrey, UK: Ashgate Publishing Limited, 2009); Tracey Loughran, “Shell Shock, Trauma, and the First World War: The Making of a Diagnosis and Its Histories,” *Journal of the History of Medicine and Allied Sciences* 67 no. 1 (2012): 94-119.

the abusive and disciplinarian nature of industrial era institutionalization. A more recent approach calls attention to the complex interactions between soldiers, institutions, medical professionals, and broader society, stressing patient agency, the diversity of treatment regimes, and the malleability of trauma's meaning and implications in various social and institutional contexts.⁴⁹ As Mark Humphries and Peter Leese have both illustrated, Canadian and British approaches to 'shell shock' were informed by prevailing Edwardian ideas toward male nervous illness, with treatment consisting chiefly of rest, special diet, and light occupation. Methods such as psychoanalysis and punitive electrotherapy were applied on small groups of patients by a select few psychiatrists during and after the war, but the evidence available suggests that these were exceptions to the norm, especially in the Canadian case.⁵⁰ The stories of veterans presented in this study confirm the observations of historians such as Humphries and Leese. While vigorous debates certainly unfolded within the medical community on the origins, symptoms, and prevalence of war neuroses in the army, treatment and pensioning practices remained relatively consistent until well into the post-war period. What remained contentious was whether such disorders originated from military service or resulted from hereditary

⁴⁹ Peter Leese, *Shell Shock: Traumatic Neuroses and the British Soldiers of the First World War* (New York: Palgrave Macmillan, 2002); Paul Lerner, *Hysterical Men: War, Psychiatry, and the Politics of Trauma in Germany, 1890-1930* (Ithaca: Cornell University Press, 2003); Peter Barham, *Forgotten Lunatics of the Great War* (New Haven: Yale University Press, 2004); John Weaver and David Wright, "Shell Shock and the Politics of Asylum Committal in New Zealand, 1916-22," *Health and History* 7, no. 1 (2005): 17-40; Mark Osborne Humphries with Kellen Kurschinski, "Rest, Relax and Get Well: A Re-conceptualization of Great War Shell Shock Treatment," *War and Society (Australia)* 27, no. 2 (October 2008): 89-110; Mark S. Micale, *Hysterical Men: The Hidden History of Male Nervous Illness* (Cambridge: Harvard University Press, 2008). For general surveys in the history of war trauma in the twentieth century see Edgar Jones and Simon Wessely, *Shell Shock to PTSD: Military Psychiatry from 1900 to the Gulf War* (New York: Psychology Press, 2005) and Terry Copp and Mark Humphries, *Combat Stress in the 20th Century: The Commonwealth Perspective* (Kingston: Canadian Defence Academy Press, 2010).

⁵⁰ Humphries with Kurschinski, "Rest, "Relax and Get Well," 100-110; Leese, *Shell Shock*, 68-84.

defects and an inherently weak moral constitution, a key question for pension officials to consider.⁵¹

Debates over pension criteria were part and parcel of a burgeoning discourse on disease and disability that dominated veterans' politics from the beginning. Despite a wealth of literature, however, only a select few studies of veterans have investigated the long-term impact of war disability. This dearth of analysis has followed broader trends within the historiography on health and medicine.⁵² Indeed, although medical historians have long studied the effects of disease on society—including its role as a historical actor—for much of the twentieth century disability remained on the fringes of historical scholarship.⁵³ With the exception of some works on psychiatry and 'mad people's history,' until very recently most histories of disability approach the topic from a practitioner-based perspective that framed disabled persons as objects of medical science who necessitated intervention to cure their deficiencies.⁵⁴ Over the previous two decades a new wave of disability historians and critical disability scholars have challenged this "medical pathology" of disability, seeking instead to reclaim the histories of disabled

⁵¹ Humphries, "War's Long Shadow," 504-509.

⁵² For an analysis of how disability can enhance our understanding of the veterans' experience after 1914 see David A. Gerber, "Disabled Veterans, the State, and the Experience of Disability in Western Societies, 1914-1950," *Journal of Social History* 36, no. 4 (2003): 899-916.

⁵³ Charles E. Rosenberg, "Framing Disease: Illness, Society, and History," in *Framing Disease: Studies in Cultural History*, eds. Charles E. Rosenberg and Janet Golden (New Brunswick: Rutgers University Press, 1992), xiii. Also see Alfred W. Crosby, *The Columbian Exchange: The Biological and Cultural Consequences of 1492* (Westport, CT: Greenwood Press, 1972); idem, *Ecological Imperialism: The Biological Expansion of Europe, 900-1900* (Cambridge: Cambridge University Press, 1986); and William McNeil, *Plagues and Peoples* (New York: Anchor Books, 1977).

⁵⁴ For an overview the historical literature on disability in the Canadian context, see Geoffrey Reaume, "Disability History in Canada: Present Work in The Field And Future Prospects," *Canadian Journal of Disability Studies* 1 no., 1 (2012): 35-81. A concise international survey is provided by Ana Carden-Coyne and Julie Anderson, "Enabling the Past: New Perspectives in the History Disability," *European Review of History* 14, no. 4 (2007): 447-57.

persons and grant them agency within in medical and social contexts.⁵⁵ Disability, many argue, has been culturally and scientifically constructed in an effort to justify inequality.⁵⁶

Although this study acknowledges the pivotal role these scholars have played in advancing disability as a social category worthy of analysis, it also recognizes the limitations of a literature that has been principally concerned with distancing disability from a medicalised perspective and the cultural notion of disability as ‘tragedy.’⁵⁷ As this study will illustrate, veterans often used their disabilities as a positive source of identity, mobilizing it to attain benefits and instil pride in their post-war accomplishments. Others, however, suffered greatly—sometimes silently—with few options but to rely on family, charity, or meagre support from the state to eek out a living. That some 10,000 Canadians died between 1919 and 1939 as a result of war disabilities is a testament to the perennial threat disability posed to the longevity of ex-servicemen. A patient-centred perspective presents an opportune means of establishing veterans’ agency, but it must afford

⁵⁵ Paul K. Longmore and Lauri Umansky, “Introduction: Disability History: From the Margins to the Mainstream,” in *The New Disability History: American Perspectives*, eds. Paul K. Longmore and Lauri Umansky (New York: New York University Press, 2001), 8-9; Catherine J. Kudlick, “Why We Need Another ‘Other,’” *American Historical Review* 108, no. 3 (June 2003): 764-65. Early studies in this burgeoning field include Paul K. Longmore, “Uncovering the Hidden History of People with Disabilities,” *Reviews in American History* 15 (1987): 355-64; Lennard J. Davis, *Enforcing Normalcy: Disability, Deafness and the Body* (New York: Verso, 1995); Rosemarie Garland-Thomson, ed., *Freakery: Cultural Spectacles of the Extraordinary Body* (New York: New York University Press, 1996); David T. Mitchell and Sharon L. Snyder, eds., *The Body and Physical Difference: Discourses of Disability* (Ann Arbor: University of Michigan Press, 1997).

⁵⁶ See for example, William Roth, “Handicap as a Social Construct,” *Society* 20 (1983): 56-61; Douglas C. Baynton, “Disability and the Justification of Inequality in American History,” in *The New Disability History: American Perspectives*, eds. Paul K. Longmore and Lauri Umansky (New York: New York University Press, 2001), and Paul K. Longmore, *Why I Burned My Book and Other Essays on Disability* (Philadelphia: Temple University Press, 2003). For a history of the disability rights movement see Duane F. Stroman, *The Disability Rights Movement: From Deinstitutionalization to Self-Determination* (Lanham, MD: University Press of America, 2003).

⁵⁷ Longmore, *Why I burned My Book*, 1-15.

recognition to the centrality of practitioners and medical science many disabled veterans' lives, especially as their health diminished over time.⁵⁸

More importantly, since this dissertation fuses the study of policy with the lived experience of disability, it is essential to uncover how contemporary understandings of ability/disability shaped veterans' identities as well as their relationships with kin, communities, and the state. A war disability was certainly accompanied by personal trepidation and cultural prejudices—especially in the case of psychological trauma—but it was first and foremost a barrier to resuming one's livelihood, a fact that often bred anxiety and despair to a much greater extent than the physical symptoms of the condition itself.⁵⁹ A close examination of pension records reveals this pattern time and again. Most ex-servicemen only had a lay medical understanding of disability; what they cared about most was how a deterioration in their health might affect their economic independence and breadwinner status. It was within this same economic conception of disability that policies were developed, debated and revised, and while an activist approach might reveal to us a great deal about injustices or resistance, as responsible historians we must treat policy-making and the experiences of veterans within the context of the period under examination.⁶⁰

⁵⁸ Roy Porter, "The Patient's View: Doing Medical History From Below," *Theory and Society* 14 (1985): 167-74.

⁵⁹ For a contemporary analysis of the economic consequences of war disability see Garrard Harris, *The Redemption of the Disabled: A Study of Programmes of Rehabilitation for the Disabled of War and Industry* (Toronto: McClelland and Stewart, 1919), and Douglas C. McMurtrie, *The Disabled Soldier* (New York: Macmillan, 1919).

⁶⁰ A recent study that demonstrates this acute sensitivity to historical context is David Wright, *Downs: The History of a Disability* (Toronto: Oxford University Press, 2011). Also see Geoffrey Reaume, *Lyndhurst: Canada's First Rehabilitation Hospital for People with Spinal Cord Injuries, 1945-1998* (Montréal and Kingston: McGill-Queen's University Press, 2007).

Policy-making, however, went beyond simple material considerations. As numerous historians have illustrated, the Great War posed a significant challenge to dominant gender norms. Modern war's effects on the male body, coupled with the economic implications of total or partial disablement (in addition to other upheavals on the home front), fuelled popular fears that a generation of Canadian soldiers would leave military service unable to carry on their masculine roles as breadwinners.⁶¹ That many young, robust soldiers returned with permanent physical scars, missing limbs, or debilitating illnesses also raised difficult questions about the social and moral health of post-war society. While this study does not employ a gender-centric approach to the study of the war and its aftermath, it makes a deliberate effort to incorporate gender analysis where it enhances our understanding of policy-making and experience. Drawing from the work of R.W. Connell and more recent trends in the history of gender and sexuality, it emphasizes how the war produced competing notions of manliness, but also helped entrench dominant modes of Victorian thought towards disablement.⁶² Rehabilitation (which included surgeries, convalescence, and physical activities) as well as vocational retraining, for example, were not only intended to restore soldiers to a state of physical independence, they were also an exercise in fortifying moral character and a strong,

⁶¹ Nancy Christie, *Engendering the State: Family, Work and Welfare in Canada* (Toronto: University of Toronto Press, 2000); Humphries, "War's Long Shadow," 504-509, 529-31.

⁶² R.W. Connell, *Gender and Power: Society, the Person, and Sexual Politics* (Stanford: Stanford University Press, 1987); idem, *Masculinities* (Berkeley: University of California Press, 1995). Also see Joan Scott "Gender: A Useful Category of Historical Analysis," *American Historical Review* 91, no. 5 (December 1986): 1053-1075; Michael Roper and John Tosh, "Historians and the Politics of Masculinity," in *Manful Assertions: Masculinities in Britain Since 1800*, eds. Michael Roper and John Tosh (New York: Routledge, 1991). On approaches to the study of gender and sexuality in the Canadian context see Steven Maynard, "Queer Musings on Masculinity and History," *Labour / Le Travail* 42 (1998): 183-97, and Joy Parr, "Gender History and Historical Practice," *Canadian Historical Review* 76, no. 3 (1995): 354-76.

independent work ethic. Disability was only a badge of honour if a soldier had the determination to overcome it and retain economic independence. Many wilfully strived towards this ideal, though as this study will illustrate, expectations and outcomes varied widely from veteran to veteran. The reality was that few members of the CEF returned the same men they were at the time of enlistment, especially those barely removed from boyhood.⁶³ Whether they survived unscathed, were traumatized, severely maimed, or contracted a chronic illness, many soldiers were forced to reconcile the stark contradiction between their expectations of military service and the horrifying experiences of life on Western Front for the remainder of their lives. If war was the ultimate expression of masculine power, its main folly was that the injuries and disease it imparted on those who served could rob them of their youth, virility, and independence.⁶⁴ Veterans who escaped the horror of combat, despite having done ‘their bit’ in other ways, were faced with the equally difficult challenge of legitimizing their contributions so that they too could assert post-war status and, in certain cases, a pension or other entitlements.

⁶³ Tim Cook, “‘He was determined to go’: Underage Soldiers in the Canadian Expeditionary Force,” *Histoire Sociale / Social History* 41, no. 81 (May 2008): 71-74. On the emotional impact of the war see Michael Roper, “Between Manliness and Masculinity: The ‘War Generation’ and the Psychology of Fear in Britain, 1914–1950,” *The Journal of British Studies* 44, no. 2 (2005): 343–62; idem, *The Secret Battle: Emotional Survival in the Great War* (Manchester, Manchester University Press, 2009); Susan Kingsley Kent, *Aftershocks: Politics and Trauma in Britain, 1918-1931* (New York: Palgrave Macmillan, 2009).

⁶⁴ On masculine expectations of war in the Canadian context see Mike O’Brien, “Manhood and the Militia Myth: Masculinity, Class, and Militarism in Ontario, 1902–1914,” *Labour / Le Travail* 42 (Fall 1998): 115-41; Mark Moss, *Manliness and Militarism: Educating Young Boys in Ontario for War* (Toronto: Oxford University Press, 2001); James Wood, *Militia Myths: Ideas of the Canadian Citizen Soldier, 1896-1921* (Vancouver: UBC Press, 2010). The most comprehensive survey of the war’s impact on masculinity is Jessica Meyer, *Men of War: Masculinity and the First World War in Britain* (Basingstoke: Palgrave Macmillan, 2009).

Whatever their experience, it is clear that Canada's Great War disabled returned home neither as passive victims nor triumphant heroes – successful reintegration depended greatly on a mix of contingency and individual fortitude. The state and a small circle of policy-makers, however, had hoped that the majority would emerge as the latter. In addition to medical treatment overseas, the federal government invested a vast quantity of state resources and volunteer labour into programs intended to facilitate soldiers' civil re-establishment. According to some Canadian historians such as Desmond Morton, the scale of government intervention during the Great War marked a watershed period in the development of the Canadian welfare state and provided a blueprint for social security reforms of the future.⁶⁵ Not only did the state take increasing interest in caring for its citizen soldiers, it also embarked on a new period of unprecedented intervention in the lives of ordinary Canadians through new methods of taxation, surveillance and censorship, public health management, moral regulation, and wealth redistribution.⁶⁶ The introduction of conscription symbolized the ultimate price of Canadian citizenship in wartime, one which few were willing to pay.⁶⁷

⁶⁵ Morton and Wright, *Winning the Second Battle*, 222-25.

⁶⁶ Gregory Kealey, "State Repression of Labour and the Left in Canada, 1914–20: The Impact of the First World War," *Canadian Historical Review* 73, no. 3 (1992): 281–314; Jane Ursel, *Private Lives, Public Policy: 100 Years of State Intervention in the Family* (Toronto: Women's Press, 1992); Craig Heron, ed., *The Workers' Revolt in Canada, 1917-1925* (Toronto: University of Toronto Press, 1998); Veronica Strong-Boag, "'Wages for Housework': Mothers' Allowances and the Beginning of Social Security in Canada," in *Social Welfare Policy in Canada: Historical Readings*, eds. Raymond B. Blake and Jeff Keshen (Mississauga, ON: Copp Clark Ltd., 1995), 82-106; Benjamin Isitt, *From Victoria to Vladivostok: Canada's Siberian Expedition, 1917-19* (Vancouver: UBC Press, 2010); David Tough, "'The rich ... should give to such an extent that it will hurt': 'Conscription of Wealth' and Political Modernism in the Parliamentary Debate on the 1917 Income War Tax," *Canadian Historical Review* 93, no. 3 (2012): 382-407.

⁶⁷ J.L. Granatstein and J.M. Hitsman, *Broken Promises: The History of Conscription in Canada* (Toronto: Copp Clark, 1977); Martin F. Auger, "On the Brink of Civil War: The Canadian Government and the Suppression of the 1918 Quebec Easter Riots," *Canadian Historical Review* 89, no. 4 (2008): 503-40.

The Great War certainly offered Canadians a glimpse of the modern state's capabilities, but federal authorities showed little interest in maintaining costly public expenditures in the absence of a crisis. Social welfare remained the responsibility of the provinces and private charity. A lavish, long-term program of aid to veterans did not align with the post-war imperative of restoring soldiers (disabled or able-bodied) to a life of productive labour. Most ex-servicemen thirsted for a similar outcome, but these hopes were predicated on the belief that they would be welcomed home with open arms and with opportunities abound. The transition from war to peace, however, was a much more complex and messy affair than civil re-establishment's architects had envisioned. Shortcomings in policies coupled with various 'shocks' to the system such as the post-war recession and Great Depression exposed the weakness of programs that were intended to merely provide veterans with a start in civilian life, rather than a permanent safety net.⁶⁸ Indeed, as numerous studies have illustrated, interest in social reform remained alive and well during the inter-war years, though few have made note of how veterans' issues contributed to the broader movement for enhanced social security.⁶⁹ A major objective of the latter chapters in this study is to increase our understanding by

⁶⁸ Dennis Guest, *The Emergence of Social Security in Canada* (Vancouver: UBC Press, 1980); James Struthers, *No Fault of Their Own: Unemployment and the Canadian Welfare State, 1914-1941* (Toronto: University of Toronto Press, 1983); Alvin Finkel, *Social Policy and Practice in Canada* (Waterloo: Wilfrid Laurier University Press, 2005).

⁶⁹ Terry Copp, *The Anatomy of Poverty: The Condition of the Working-Class in Montréal, 1897-1929* (Toronto: McClelland and Stewart, 1974); Doug Owsram, *The Government Generation: Canadian Intellectuals and the State, 1900-1945* (Toronto: University of Toronto Press, 1986); Cynthia Comacchio, *'Nations Are Built of Babies': Saving Ontario's Mothers and Children, 1900-1940* (Montréal and Kingston: McGill-Queen's University Press, 1993); Nancy Christie and Michael Gauvreau, *A Full-Orbed Christianity: The Protestant Churches and Social Welfare in Canada, 1900-1940* (Montréal and Kingston: McGill-Queen's University Press, 1996); Margaret Little, *'No Car, No Radio, No Liquor Permit': The Moral Regulation of Single Mothers in Ontario, 1920-1997* (Toronto: Oxford University Press, 1998).

illustrating how incremental changes to allegedly broken policies influenced future innovation in veterans' benefits and social policy as a whole. It was this combination of failure *and* success—rather than simply the former—that motivated policy-makers to overhaul Canada's system of veterans' benefits when the country went to war again in 1939.⁷⁰

By this time, more than a generation had passed since the first plans for post-war reconstruction were laid down in the summer of 1915. Politicians and military leaders were fully cognizant of the savagery of modern war, as well as the medical resources needed to ensure that the sick and wounded could be cared for efficiently and effectively. No such experience existed in 1914. Instead, military commanders and physicians scrambled to keep pace with shifting medical knowledge and mounting casualties. The first chapter of this study provides a synthesis of the Canadian army's medical effort overseas, as well as a comprehensive overview of the effects of military service on the health of everyday soldiers. Utilizing a diverse range of sources including soldiers' letters and memoirs, unit war diaries, personnel records, and official statistics, it illustrates how disability was a seminal feature of Canada's military experience overseas. The shape and form of disability took on, however, diverged from what many medical experts had anticipated. After the initial shock of the horrible wounding made possible by industrial warfare, military authorities and physicians found themselves in an unrelenting battle to

⁷⁰ As Peter Neary and Desmond Morton have both illustrated, revisions to policy that fuelled innovations during the Second World War were already underway in the 1930s. See Desmond Morton, "The Canadian Veterans' Heritage from the Great War," in *The Veterans Charter and Post-World War II Canada*, eds. Peter Neary and J.L. Granatstein (Montréal and Kingston: McGill-Queen's University Press, 1998), 15-33, and Neary, *On to Civvy Street*, 25-59.

manage the health of soldiers and preserve military manpower. Battlefield wounds, they discovered, were only part of a much larger constellation of health problems endemic throughout the ranks, many of which were only loosely associated with exposure to combat. Though historians often acknowledge this crucial aspect of the ‘medical war’ in passing, this chapter brings to light the complex ways in which soldiers confronted disabilities that ran against the grain of typical war wounds and seeks to establish a broader framework for understanding the full scope of the Great War impact on veterans’ health.

Chapter two examines how these revelations and medical dilemmas spread across the Atlantic and impacted the management of disability on the Canadian home front. Beginning with the establishment of the Military Hospitals Commission in the summer of 1915, it traces the evolution of wartime rehabilitation policy from its nascent stages as a largely volunteer, humanitarian effort, to a fully-fledged national system of post-discharge medical care. Importantly, this chapter shows how rapid transformations in wartime medical knowledge and new fields of expertise such as occupational therapy directly impacted the patient experience, as well as expectations for recovery. Though few soldiers who returned to the Canadian home front could be returned to a state of military fitness, as this chapter will illustrate, home front authorities remained confident that carefully managed treatment regimens could restore most soldiers to a state of physical fitness that would permit them to contribute to the wartime and post-war economy.

But what of the soldiers who could not be fully restored to their former physical state? Chapters three and four offer a comprehensive history of Canada's other core re-establishment initiatives: pensioning and vocational retraining. As with rehabilitation policy, disability pension regulations were crafted and revised based off of scientific measures of disablement. A soldier's class, occupational background, and personal circumstances were irrelevant when deciding an award: what mattered chiefly was his rank when the disability occurred, and the extent to which it prevented him from earning a living in the general labour market. Neither an amputation, chronic bronchitis, nor a heart condition were sufficient to warrant a full pension—any remaining capacity to work would diminish the extent of a disabled soldier's compensation. To ensure that ex-servicemen who could not return to their former occupations would retain their independence, re-establishment planners developed a sophisticated and largely experimental program of vocational retraining. As Chapter four explains, these benefits not only bolstered hopes that all but the most seriously disabled could be saved from a life of idleness, they were also conceptualized as a safeguard against future demands for pension increases.

When waves of casualties reached Canada during late 1917 and early 1918, the three pillars of civil re-establishment (rehabilitation, retraining, and pensions) were already in place. At the peak of demobilization 1919, Canada's Department of Soldiers' Civil Re-establishment, the Board of Pension Commissioners, and various provincial and voluntary organizations were transitioning disabled soldiers back to civilian life by the thousands every month. This combined effort, however, was short-lived. As authorities

sought to rein in expenditures and wartime patriotism gradually waned in the early 1920s, many veterans struggled to reconcile their post-war expectations with the difficulties of returning to civilian life. Chapter five explains how these men and their families experienced this transitional period while also investigating how policy-makers attempted to revise key programs during a period of austerity. Chief amongst veterans' complaints were a lack of stable employment opportunities and rigid pension regulations, both of which spurred a substantial investigation by a Royal Commission, but ultimately resulted in few meaningful changes.

The final chapter of this dissertation follows these themes into a period of dramatic economic upheaval and major efforts to reform the system. By the outbreak of the Great Depression discontent was boiling over and politicians were faced with little choice but to act. Anger with the system emanated not simply from the alleged parsimony of pension regulations, but from a broader contradiction between the humanitarian ideals of civil re-establishment and the administrative state that emerged in the war's aftermath. The latter, I argue, grew out of reluctant necessity. In the absence of widespread voluntarism and in times of crisis, elected officials gradually came to accept that the state was obligated to address the concerns of ex-servicemen who, through no fault of their own, had fallen through the cracks in the system or became destitute as a result of deteriorating health. Importantly, this chapter will show how the 1930s bore witness to a more all-encompassing conceptualization of disability that positioned it as a preeminent social problem, rather than a private medical misfortune. Indeed, the upheaval of the Depression years gradually eroded the notion that the war's disabled were masters of their

own personal fate. The state would have to find new ways of strengthening its relationship with veterans, and after war broke out in September 1939, a new generation of citizen soldiers who had grown up knowing of promises left unfulfilled to the Great War's survivors.

Chapter 1: ‘The Medical War’: Managing Soldiers’ Bodies and Minds in the Great War, 1914-18

William Harry Jennings was one of the first Canadian soldiers to experience the savagery of the Great War. A printer by trade, he enlisted in Andrew Hamilton Gault’s privately financed Princess Patricia’s Canadian Light Infantry (PPCLI) at Ottawa on 25 August 1914. He, along with the rest of the Patricias, arrived in France on 21 December attached to the 80th Brigade of the British Expeditionary Force (BEF). On 6 January 1915 the battalion entered the trenches just outside of a town the Brits dubbed ‘Dickiebush’ (Dickebusch), south of Ypres.¹ In the early morning hours of 24 January Jennings and five other men were hit while carrying ammunition boxes in the open from a well-placed German machine-gun position. Two men, Lieutenant Charles H. Price and Lance-Corporal John H. Murphy, were killed. Jennings was struck in the head just above the ear, and immediately collapsed to the ground. A fellow comrade, also wounded, managed to drag him 50 yards to safety, where he and another man were then able to help Jennings stumble to a dressing station half a mile away. He was soon transported by field ambulance to a nearby stationary hospital where he would undergo surgery.²

¹ War Diary [WD], Princess Patricia’s Canadian Light Infantry, 24 January 1915, RG 9, Department of Militia and Defence [hereafter ‘RG 9’], Series III-D-3, vol. 4911, file 346, Library and Archives Canada [hereafter ‘LAC’].

² Letter, William Harry Jennings to Mother, 9 February 1915, *Canadian Letters and Images Project* <<http://www.canadianletters.ca/letters.php?letterid=2769&warid=3&docid=1&collectionid=197>> (accessed February 20, 2013). Due to the public availability of his letters, Jennings’ name has not been redacted.

In a letter dated 9 February a confounded Jennings remarked to his mother that he was lucky to be alive and had “gotten off the best of the three.” His wounds, however, were severe: a fractured skull and damaged cranial nerve had left him with partial paralysis in his right arm and leg. After his operation and treatment from “the cleverest surgeon in the army,” he was happy to have the feeling return to his extremities. “All I need now is rest and time when I’ll be as good as ever,” he wrote to his mother in an assuring tone. Despite an encouraging prognosis, Jennings did not mince words about what he had experience during his short time in combat. The war, he proclaimed, “is absolutely worse than the people ever imagine.” Battlefield conditions were “raw and miserable” and the trenches “a terror.”³ Following another month in hospital, Jennings returned to Canada where he was discharged on 19 March. He would spend the remainder of the war as a civil servant, struggling to balance the demands of working life with the lingering effects of his war injuries.⁴

“The most important point to be made about the male body during the Great War,” writes Joanna Bourke, “is that it was *intended* to be mutilated.”⁵ It was this gruesome reality of industrialized warfare that Jennings and nearly 350,000 Canadians who saw service on the Western Front were exposed to between 1914-18. In total, 51,310 were killed in combat, and a further 138,166 wounded in action. Nearly half of all

³ Letter, William Harry Jennings to Mother, 22 February 1915, *Canadian Letters and Images Project* <<http://www.canadianletters.ca/letters.php?letterid=2770&warid=3&docid=1&collectionid=197>> (accessed February 20, 2013). Also see, Personnel File, William Harry Jennings, RG 150, Ministry of the Overseas Military Forces of Canada [hereafter ‘RG 150’], Accession 1992-93/166, Box 4825 – 24, LAC.

⁴ *The Calgary Daily Herald*, May 16, 1925, 2.

⁵ Joanna Bourke, *Dismembering the Male: Men’s Bodies, Britain, and the Great War* (Chicago: University of Chicago Press, 1996), 31.

soldiers who survived were hospitalized as a result of combat injuries at least once. Across all theatres, fatal army casualties (including deaths from disease or accident) numbered 59,544. Non-fatal casualties comprising all categories amounted to 172,950, bringing total figures for the army to a staggering 232,494. In a country of approximately eight million, 17 per cent of the male population was either killed, maimed, or fell ill as a result of the war.⁶ The numbers for other combatant nations were even more staggering. Out of a population of around one million, over 100,000 New Zealanders served in the Great War, 60 per cent of whom became casualties (18,166 killed, 41,317 wounded).⁷ France, with 1.3 million military dead and over 4.25 million more sick or wounded (a casualty rate of 67 per cent) witnessed nearly an entire generation of young men vanish.⁸

The physical carnage that the Great War wrought upon its participants was met by an unparalleled effort from medical authorities to contain, manage, and if possible, cure disability. Between 1914 and 1918 advancements in medical science and casualty management allowed millions of men to survive horrific, crippling wounds to one day return home to their loved ones. These same innovations, however, also left countless survivors of the war as ‘partial’ or ‘changed’ men who would struggle with chronic pain,

⁶ A.F. Duguid, *Official History of the Canadian Forces in the Great War, 1914-1919, Vol. 1: From the Outbreak of War to the Formation of the Canadian Corps, August 1914-September 1915* (Ottawa: King's Printer, 1947), and G.W.L. Nicholson, *Official History of the Canadian Army in the First World War: Canadian Expeditionary Force, 1914-1919* (Ottawa: Queen's Printer, 1962), Appendix C. Also see Appendix 1: Methodological Essay.

⁷ Christopher Pugsley, *The ANZAC Experience: New Zealand, Australia and Empire in the First World War* (Auckland: Reed Publishing, 2004), 307-308.

⁸ Nearly 50 per cent of all French fatalities occurred between August 1914 and December 1915. See Leonard Smith, Annette Becker and Stéphane Audoin-Rouzeau, *France and the Great War, 1914-1918* (Cambridge: Cambridge University Press, 2003), 69. On the impact of the Great War on French inter-war society see Antoine Prost, *In the Wake of War: 'Les Anciens Combattants' and French Society*, translated by Helen McPhail (Providence: Berg, 1992. c. 1977), and Eugen Weber, *The Hollow Years: France in the 1930s* (New York: W.W. Norton & Co., 1994).

mental anguish, and diminished vitality for the remainder of their lives. In Canada, the return of disabled soldiers bred widespread anxiety that the war was contributing to an upheaval of traditional masculine norms of behaviour, aesthetics, and identity. Their presence, and the prospect of thousands more returning, raised unanticipated questions about the war effort as a whole.⁹ How would the sight of disfigured and crippled men affect morale? Would they become an object of patriotism, or a deterrent to enlistment? How might the war's wounded be 'cured' or made whole again? Could rehabilitation restore them to military fitness or economic self-sufficiency for both the present and future?

Such questions were central to the broader project of healing and care giving that Canada's military medical authority, the Canadian Army Medical Corps (CAMC), was charged with facilitating during the Great War. This chapter explores the evolution of this project in two distinct ways. First, I contend that in order to understand the complex medical and pensioning dilemmas veterans and re-establishment authorities faced in the post-war years we must take into account how the war impacted body and mind. Battle wounds from shrapnel and bullets were the most horrifying single cause of hospitalization during the war, but army medical personnel also had to contend with challenges posed by lax standards in recruiting, poor sanitation and hygiene, outbreaks of disease, and other health risks that emerged regularly from general service conditions in all theatres. As a large-scale, predominantly volunteer army representing a cross-section of Canada's adult-

⁹ Mark Harrison, *The Medical War: British Military Medicine in the First World War* (Oxford: Oxford University Press, 2010), 12-13, and Jeff Keshen, *Propaganda and Censorship During Canada's Great War* (Edmonton: University of Alberta Press, 1996), 57-59.

male population, the men of the Canadian Expeditionary Force (CEF) varied widely in their pre-enlistment health and abilities to cope with diseases and injuries common to military service. At every stage of the war physicians and military officials had to determine who was physically capable of fighting, how those who were incapable might be utilized elsewhere, and how treatment regimes and preventative techniques might be advanced to eliminate unnecessary wastage and diminish the prevalence of disability.

As Mark Harrison reminds us, though, medicine's prominence in the Great War can only be partly explained by the need to conserve manpower. In Britain and its dominions, humanitarian ideals, volunteerism, and morale all played a vital role in shaping the practice and objective of wartime care giving.¹⁰ Physicians and nurses enlisted their services for varying reasons, but what bound most together was a sense of patriotic duty and a conviction that modern medicine could circumvent the devastating effects of industrial combat.¹¹ "Nothing could illustrate better the spirit of self-sacrifice and devotion which the great war has awakened all over the world," wrote Sir William Osler after touring a British base hospital in 1915.¹² Emboldened by high humanitarian ideals and scientific breakthroughs witnessed on the battlefield and in the laboratories, operating rooms, and special hospitals, the medical services were instrumental in reassuring military officials and a weary public that 'the medical war' was indeed being won.¹³

¹⁰ Harrison, 10-13.

¹¹ J. George Adami, *War Story of the Canadian Army Medical Corps, vol. 1* (London: Colour Ltd., 1918), 232-34.

¹² Sir William Osler, *Science and War* (Oxford: Clarendon Press, 1915), 27.

¹³ Harrison, 10-13.

It is the convergence between the managerial character of military medicine and the humanitarianism of care giving that is the other focus of this chapter, and a persistent theme found within the latter chapters of this dissertation. While sometimes conflicting, neither was mutually exclusive. In wartime the former informed the objective of treatment regimes, while the latter guided the application of care. The interaction between both, I argue, engendered widespread faith in the efficacy of the wartime medicine and plans for post-war rehabilitation. With proper care, retraining and discipline, wounded men could be saved from a life of infirmity and restored to military or economic usefulness. Devotion to this ideal was not confined to the medical profession. As a symbol of the nation, race, and empire, the health of the citizen-soldier was intimately connected to the righteousness of the cause; failure to provide sufficient care thus posed both an unwanted military and moral dilemma.¹⁴ The model of rehabilitation that Canada adopted was met with great enthusiasm principally because it addressed individual and collective anxieties surrounding the negative corporeal and material impact that the war was having on the nation's fighting men, and by extension, the future of the dominion.

Despite the importance of the medical profession to the military and civilian experience of the Great War, we still know relatively little about how treatment regimes

¹⁴ Mark Moss, *Manliness and Militarism: Educating Young Boys in Ontario for War* (Toronto: Oxford University Press, 2001), and Mike O'Brien, "Manhood and the Militia Myth: Masculinity, Class and Militarism in Ontario, 1902-1914," *Labour / Le Travail* 42 (Fall 1998): 115-22.

were rationalized, implemented, and experienced, especially in the Canadian context.¹⁵ This chapter expands our understanding of how Canada's own 'medical war' was waged by drawing together a diverse range of sources, including official statistics, sample group data, wartime medical records, and soldiers' writings. By doing so I hope to illustrate the ways in which the war impacted the health of soldiers, and moreover, how the sick and wounded navigated the frontline treatment system, experienced hospital life, and participated in the broader rehabilitation project. Since it was commonplace for Canada's war disabled to spend a significant period of time within military medical spaces, it is crucial to treat these wartime experiences as a significant moment that shaped the course of their post-war lives.

II. THE CANADIAN ARMY MEDICAL CORPS AND FORWARD TREATMENT

For the majority of Canadian soldiers who served overseas in the Great War, combat conditions posed the most significant threat to their overall health. The majority of physical wounds received in the Great War were the result of shell shrapnel, shell fragmentation, mortar fire, and bullets. According to army medical statistics, as much as 85 per cent of all wounds that required hospitalization were the result of these industrial weapons, either through gunshot and shrapnel wounds, or musculoskeletal traumas. In

¹⁵ Sir Andrew Macphail, *Official History of the Canadian Forces in the Great War, 1914-1919: The Medical Services*. Ottawa: King's Printer, 1925), and Rawling, chapters 3 and 4. Also see Desmond Morton, "Military Medicine and State Medicine: Historical Notes on the Canadian Army Medical Corps in the First World War, 1914-1919," in *Canadian Health Care and the State: A Century of Evolution*, edited by C. David Naylor (Montréal and Kingston: McGill-Queen's University Press, 1992), 38-66. On forward treatment see Heather L. Moran, "Stretcher Bearers and Surgeons: Canadian Front-line Medicine During the First World War, 1914-18" (PhD diss., University of Western Ontario, 2008). For an international study of the patient experience during the Great War see Leo Van Bergen, *Before My Helpless Sight: Suffering, Dying, and Military Medicine on the Western Front, 1914-1918*, trans. by Liz Waters (Surrey, UK: Ashgate Publishing Limited, 2009).

total 38 per cent of all soldiers in the sample group who served in France were hospitalized for these types of wounds. Army medical corps figures suggest a similar rate of wounding, perhaps as high as 43 per cent of all men who served on the Western Front and survived the war.¹⁶ Multiple wounding was also widespread: of 94 men in the sample group wounded by combat weapons, one third were hospitalized for these wounds at least twice. Two men were hospitalized on four separate occasions.

Combat injuries varied widely in severity and complexity. High explosive rounds could be devastating if they hit a trench or fortification, but were much less effective at exerting damage in an open field, especially if they sank into the earth prior to detonation. High explosive shells, bombs, or mines could ‘bury’ a man or toss him like a ragdoll, causing severe contusions, fractures, or head trauma.¹⁷ A single lead ball from a shrapnel shell might superficially graze one soldier while the man beside him absorbed a horrific combination of lead, steel fragments, soil, and other foreign bodies. Writing in the *Canadian Medical Association Journal (CMAJ)* in April of 1917, a CAMC surgeon from No. 3 Canadian General Hospital noted that one patient had recently been admitted with over 80 foreign bodies as a result of a shell burst.¹⁸ Some cases were even more gruesome. After he was severely wounded at Mont Sorrell in June 1916, Private Charles Douglas Richardson of the PPCLI recounted the horrible maiming that he had witnessed in the battle: “As I walked along both front and support lines I came across the most terrible sights. There would be arms or legs lying around with no sign of the rest of the

¹⁶ Derived from Macphail’s battle casualty table (pp. 393), and Nicholson’s Appendix C.

¹⁷ E.J. Williams, “Gunshot Wounds of the Present War,” *Canadian Medical Association Journal* [hereafter *CMAJ*] 6, no. 12 (December 1916): 1057-62.

¹⁸ Donald Hingston, “Notes on War Surgery,” *CMAJ* 7, no. 4 (April 1917): 308.

bodies, and the blood was in pools and spattered over trenches, [illegible] and in fact everything.”¹⁹

The wounds brought on by industrial warfare afforded militaries little time to act when casualties occurred. To keep the machinery of war in motion, the medical care of soldiers was conceived, organized, and administered in such a way as to marshal the wounded from the front lines to sites of healing and recovery in as efficient a manner as possible. To achieve this end battlefield medicine was structured along two principal treatment areas: the collection zone, which included the Regimental Aid Posts (RAPs) and Field Ambulances (FAs), and the evacuation zone, which began at the Casualty Clearing Stations (CCSs) and gave way to much larger base hospitals near the Channel coast. Cases could then be passed on to the extensive military hospital network in the United Kingdom. A severely ill or wounded soldier might spend months, even years navigating through this system, colouring their wartime experience and their encounters with disability and rehabilitation.

In order to illustrate how wartime medicine attempted to obviate the spread of sickness and improve prognoses of physical wounds, we must look carefully at how treatment and rehabilitation schemes were implemented and the challenges to soldiers' health that were encountered daily both on and off the battlefield. For severe combat wounds or sickness early evacuation was vital to diminish the chances of shock, catastrophic infection, or spreading of disease. To care for its sick and wounded, each

¹⁹ Private Charles Douglas Richardson letter to Edna, 15 June 1916, *Canadian Letters and Images Project*, <<http://canadianletters.ca/letters.php?letterid=3964&warid=3&docid=1&collectionid=225>> (accessed June 24th, 2013).

infantry battalion in the Canadian army was assigned a dedicated Regimental Medical Officer (RMO). Normally a junior physician or medical student, these commissioned officers would live amongst the soldiers and serve as the primary caregivers on the battlefield, gaining an intimate knowledge of their habits, vices, and medical histories.²⁰ Each RMO came accompanied by a detail of stretcher-bearers trained in basic first aid and sanitation. In combat situations, bearer parties would clear casualties to the RAP—typically located in close proximity to the front lines—where they would then assist with bandaging, triage, and further evacuations.²¹

Under non-combat conditions, the RMO and his detail were also charged with inspecting the sanitary conditions of the area occupied by the battalion, evacuating and tending to the sick, and promoting the general health of the men. Part of a medical officer's routine was contending with regular 'wastage' in and out of the line. In a 1918 account of his wartime experiences as a battalion medical officer, Captain R.J. Manion spoke bluntly of the moral and disciplinary conundrum MOs regularly faced while examining soldiers on sick parade:

If he is not ill, but is simply sick and tired of the mud, dirt, rats, lice, discipline, and discomfort—as we all get at times—he will have to tax his ingenuity and his acting ability to convince the doctor that his pains in his legs and back are real, not imaginary; or that his right knee is swollen, when the practised eye of the physicians says it is not. If he is an old soldier and knows the game well, he may

²⁰ Macphail, 127-35. A succinct overview of the role of the RMO is provided in a memorandum from the ADMS of 2nd Canadian Division reprinted in the December 1915 issue of the *CMAJ*. See "Casualties," *CMAJ* 5, no. 12 (December 1915): 1122-27. The most comprehensive Canadian account is Harold McGill and Marjorie Norris, *Medicine and Duty: the World War I Memoir of Captain Harold W. McGill, Medical Officer, 31st Battalion, C.E.F.* (Calgary: University of Calgary Press, 2007).

²¹ WD, No. 8 Field Ambulance, January 1917, Appendix, "Plans & Description of a Typical R.A.P.," RG 9-III-D-3, vol. 5030, file 831, part 2, LAC; Macphail, 127-35.

get away with it, sometimes with the tacit consent of a sympathetic medical officer.²²

In addition to serving as the first line of defence against death and severe injury, MOs also performed an important role as disciplinarians of the body and gatekeepers to the military medical chain.²³ Each day they had to carefully balance the prevailing need to minimize personnel wastage, while simultaneously maintaining morale in the unit and preventing legitimately ill men from endangering the health and wellbeing of their comrades. Routine inspections provided both frustrating and amusing examples of soldiers feigning illness and which were often met by equally cunning attempts to expose these maladies as deliberate fabrications.²⁴ Even if only representative of a small minority of men, such cases also brought to bear the treacherous reality of life on the Western Front. Malingering or ‘scrimshanking’ was a common concern for both medical officers and senior commanders, but as Manion wrote with reluctant empathy, it was also understandable: "if at times some officer or man gets tired of the mud, rain, lice, shells, dirt, and dangers that he is daily encountering, and tries to get a few days in civilized surroundings he is but showing a very human side to his nature."²⁵

From the perspective of senior commanders the RMO’s discretion was crucial in distinguishing between the ‘worthy’ and ‘unworthy’ disabled. Unnecessary wastage had to be avoided, a policy that often forced RMOs to prioritize the needs of the battalion

²² Captain R.J. Manion, M.C., *A Surgeon in Arms* (Toronto: McLelland, Goodchild & Stewart, 1918), 105. Born in 1881, Manion served as the medical officer of the 21st Battalion. His memoir, while overtly patriotic and glorifying the Canadian effort, shows little effort to sanitize the complex and gruesome experiences medical officers faced on a daily basis.

²³ Bourke, 92-94.

²⁴ Manion, 105-123.

²⁵ Manion, 122-23.

over the complaints of a particular soldier who, while perhaps suffering from some sort of ailment—and one that might be considered pensionable—could still carry on his duties efficiently. Mass casualty scenarios posed a different challenge. They required fast action many times over. If a soldier was hit or fell seriously ill, he needed to be transferred to a field ambulance immediately, after which he would enter the administrative reach of the medical corps as an official casualty. At its peak, the CAMC was comprised of 16 field ambulances, with at least one for each of the Canadian Corps' 12 infantry brigades, as well as other units to service the corps' level of command. Contrary to its name, the ambulance was both a hospital and a mobile extraction unit. Each consisted of both an Advanced Dressing Station (ADS) and a Main Dressing Station (MDS), with a regular staff of nine medical officers and 283 other ranks divided between each.²⁶

Battalion stretcher-bearers would often be the first to bandage a patient or provide them with morphine, but little treatment was carried out until arrival at the ADS. Although better equipped than an aid post, these stations offered few guarantees of protection, often being located as little as 500 meters from the front lines in a basement cellar or fortified dugout.²⁷ Here medical officers and orderlies could splint a fractured limb, administer antiseptics or anti-tetanus serum, and begin cleaning and excising wounds.²⁸ Coffee, tea, hot water bottles, and blankets were also offered in an attempt to

²⁶ Macphail, 68.

²⁷ WD, No. 8 Field Ambulance, February 1917, Appendix, "Description of an Advanced Dressing Station," RG 9-III-D-3, vol. 5030, file 831, part 2, LAC.

²⁸ As the war pressed on, able-bodied POWs and men assigned to Permanent Base Duty were more heavily relied upon to carry the wounded from the front lines to advanced dressing stations during heavy combat. See for example WD, DDMS Canadian Corps, August 1916, Appendix, "Medical Arrangements for Reserve Army Operations No. 1," RG 9 III-D-3, vol. 5024, file 812, LAC.

maintain body temperatures and guard against shock.²⁹ If transportation lines were clear of danger patients then passed on to the MDS via wheeled stretchers, ambulance cars or light rail. This integral piece of the treatment system was ostensibly a fixed field hospital with facilities that allowed physicians to perform emergency surgeries, splint severe fractures, and provide oxygen and decontamination for gas victims.³⁰ In times of crisis, a thousand patients or more might pass through the ambulance over course of a day. In one exceptional example, a Canadian field ambulance was reported to have attended to 4000 casualties in the span of 30 hours.³¹ Stays, however, were relatively short. A severely wounded patient would have to be transferred quickly to a casualty clearing station, while ‘sitting wounded’ could wait to be examined later by a physician. In either case, a soldier who arrived at the ambulance was noted in its admission and discharge books as a documented casualty.

To ensure that the units further down the line were not overwhelmed by the regular parade of sick or the ‘lightly wounded,’ one field ambulance per division was normally held in reserve to staff a Divisional Rest Station (DRS), as well as a larger one at the corps level. The DRS was essentially a forward convalescent camp where the sick and slightly injured were placed on a regimen of warm food, rest, and light exercise, all under the careful observation of physicians.³² Stays were brief and intended to be

²⁹ Sir William Grant Macpherson, *History of the Great War Based on Official Documents. Medical Services. Surgery of War, vol. I* (London: H.M.S.O., 1922), 73-78.

³⁰ Macphail, 68.

³¹ A.E. Snell, *The C.A.M.C. with the Canadian Corps During the Last Hundred Days of the Great War* (Ottawa: F.A. Acland, 1924), 6.

³² Captain Percy G. Bell, “Notes on Special Work in a Field Ambulance,” *CMAJ* 6, no. 12 (December 1916): 1091-94

‘therapeutic’ rather than curative. Keeping within the medical framework of forward treatment, a stay at the rest station was intended to relieve illness or discomfort while keeping men close to their units. For a soldier suffering from shell shock, trench fever, or rheumatism, even a short stay respite was a welcome one:

I am having a fine holiday at the Rest Station. They don't worry us at all—the idea apparently is to let us forget the war as much as possible—at least to forget our part in it. So we read and eat and go for walks into the country and otherwise amuse ourselves according to our tastes and inclinations.³³

The DRS afforded some soldiers the opportunity for leisure, but men remained under military discipline. If physically capable, they would be responsible for ‘fatigue duty,’ a much-maligned routine involving the upkeep of the station and its facilities.³⁴ “Most of these [rest] camps were anathema to our Fifth men, for the work was monotonous, often disgusting and occasionally repulsive. That word ‘Rest’ was the most misleading word in army vocabulary,” Frederick W. Noyes wrote of his experience.³⁵

But work, according to the Canadian military medical gaze, was essential to expose malingerers, reinforce martial prowess, and assert one’s masculine fortitude in overcoming sickness and injury. Rest stations were designed expressly with this purpose in mind, offering military commanders flexibility in the management of manpower while simultaneously recognizing that removal from the line could serve a soldier’s immediate benefit, even if only for a few short days. If a patient’s condition did not improve, he would be reassigned for service in a non-combat unit, discharged to England, or possibly

³³ Bernard Freeman Trotter to Trotter Family, 9 March 1917, *Canadian Letters and Images Project*, <http://canadianletters.ca/letters.php?letterid=2503&doid=1> (accessed June 27th, 2013).

³⁴ WD, ADMS 1st Canadian Division, December 1915, Appendix C, “1st Divisional Rest Station,” RG 9-III-D-3, vol. 5024, file 814, part 1, LAC.

³⁵ Frederick Walter Noyes, *Stretcher Bearers... At the Double!* (Toronto: Hunter Rose Co., 1937), 65.

removed from the services entirely.³⁶ By keeping soldiers close but separated from the front, these stations occupied a unique middle-space within the broader infrastructure of the CAMC, and while their efficacy for certain disorders (such as shell shock) later came under intense scrutiny, they did much to relieve the burden on more vital units further down the medical chain.³⁷ By the same token, they also ensured that many men with disabilities that could not be treated were retained within a combat theatre for an extended period of time.

After being treated by a field ambulance patients were passed on to the CCS by convoy. Canada fielded four of these clearing stations during the war, each of which was staffed by surgical specialists, nurses, and orderlies. Originally intended as a marshalling point between frontline medical units and base hospitals, within the first few months of the Great War the CCS rapidly evolved into the crucial lynchpin between collection and evacuation zones of the military medical chain. Severe physical maiming and the dangers imposed by ‘shock’ left the British Army with few options but to move surgical treatment as far forward as possible—as close as 5-6000 yards in certain cases.³⁸ Here a CCS would be established in a nearby town where patients were held in a combination of permanent

³⁶ WD, ADMS 1st Canadian Division, December 1915, Appendix C, “1st Divisional Rest Station,” RG 9-III-D-3, vol. 5024, file 814, part 1, LAC.

³⁷ Edgar Jones and Simon Wessely, *Shell Shock to PTSD: Military Psychiatry from 1900 to the Gulf War* (New York: Psychology Press, 2005), 26-31.

³⁸ Kim Pelis, “Taking Credit: The Canadian Army Medical Corps and the British Conversion to Blood Transfusion in WWI,” *Journal of the History of Medicine and Allied Sciences* 56, no. 3 (July 2001): 250-51.

and temporary buildings.³⁹ Under ideal circumstances a patient might reach the CCS only a few hours after being wounded or falling ill. In mass casualty scenarios, however, the severely wounded—men with abdominal wounds, skull fractures, or mangled limbs—were prioritized, even if their condition was rapidly becoming moribund. Those suffering from shock were sent immediately to the resuscitation ward, where “every appliance is used which can possibly tend to restore his vitality” so that lifesaving operations could later be performed.⁴⁰ To ensure that wounded could be efficiently evacuated the CCS was normally positioned alongside a rail line so that ambulance trains could transfer waves of patients to base hospitals in coastal towns like Boulogne, Camiers, or Étaples, a journey often spanning over 100 miles.⁴¹

Base hospitals were the most expansive and intricate component of the medical infrastructure in France. The largest could care for over 2000 patients and contained specialized wards where particular wounds were treated by highly trained medical officers, orderlies and nursing sisters.⁴² If a patient could reasonably be expected to recover within a few weeks, the base hospital usually marked the end point of their journey through the medical system. Private Edward S., for example was admitted to No. 24 General Hospital (Étaples) on 8 November 1917 with minor shrapnel wounds to his

³⁹ The first Canadian CCS in France, for example, was established at Fort Gassion, a military prison that had been previously occupied by a field ambulance. See WD, No. 1 Casualty Clearing Station, March 1915, Appendix, “Record of 1st Canadian Casualty Clearing Station, C.A.M.C.,” RG 9-III-D-3, vol. 5032, file 838, part 1, LAC.

⁴⁰ WD, No. 3 Casualty Clearing Station, February 1918, Appendix, *The CCS Review*, “A C.C.S. During a Push,” (January 1918), 2, vol. 5033, file 840, part 2, LAC.

⁴¹ For a list of Canadian base hospitals and their changing locales see Macphail, 210-214.

⁴² W. Rankin, “Work at a Base Hospital: Impressions After Six Months as a Surgical Specialist,” *BMJ* 1, no. 2880 (March 11th, 1916): 371-73. For an account of the work of a Canadian base hospital see *A History of No. 7 (Queen’s) Canadian General Hospital, March 26th, 1915 – Nov. 15th, 1917* (London: C.W. Faulkner, 1917).

left arm, only requiring a few days' treatment and rest before being returned to duty.⁴³ Severe cases like Sergeant Thomas G., who was admitted to No. 20 General Hospital (Camiers) in December 1916 with a compound fracture to his right leg, spent nearly three months on the 'Dangerously Ill' list before being stabilized and evacuated for further treatment in England.⁴⁴

Military medical practice emphasized that healing for the benefit of military efficiency should guide the treatment and administration at every stage of the medical chain. RMOs arbitrated sickness and illness in and amongst the men, promoting the sanitary upkeep of the unit, and privileging certain classes of disability over others for the common good. At field ambulances, casualty clearing stations and base hospitals the main objective was the preservation of life and the maintenance of manpower. If a patient could be retained close to the front, every effort was expended to ensure this end was achieved.⁴⁵ As medical authorities quickly realized, however, countless men required periods of long convalescence, as well as physical and psychological rehabilitation to be made militarily efficient or economically independent once more. In 1915 the CAMC was not yet prepared for this task: as of 1 June, its hospitals in the United Kingdom could only accommodate 624 patients and a further 770 in convalescent homes. By 1916 conditions had improved to a bed total of 7170 shared between general, special, and convalescent hospitals. At the war's end, the expansive Canadian system had beds for over 23,000

⁴³ Personnel File, Edward S., RG 150, Accession 1992-93/166, Box 8904 – 19, LAC. Edward was only out of the line eight days, five of which were spent at the base hospital.

⁴⁴ Personnel File, Thomas G., RG 150, Accession 1992-93/166, Box 3804 – 45, LAC. Thomas would later have his leg amputated.

⁴⁵ Rawling, 70-71.

patients, a stark indication of the brutal injuries and complex illnesses that confronted soldiers and the medical services as the campaign intensified.⁴⁶

III. REHABILITATING ‘WAR’S WASTE’ IN CANADIAN OVERSEAS HOSPITALS

To this point few specifics have been mentioned with respect to the injuries, illnesses, and other impediments to the maintenance of health that the CAMC and Canadian soldiers confronted during the Great War. In an effort to explain how disability grew as a military medical problem to be ‘solved’ by forward treatment or specialized care, the remainder of this chapter elaborates on both the most common and most problematic sources of disability that Canadians encountered between 1914-18. Having described the overall function and rationale of forward treatment, it places particular emphasis on the scale of disability during the war, its chief causes, the medical response, and the patient experience. Of particular significance in this discussion are the special hospitals and convalescent homes, for which the best records are available and rehabilitation practices figured most prominently.

Mangled bodies put the most strain on the resources and personnel of the army medical services. Due to the nature of the fighting on the Western Front wounds to the upper and lower extremities were the most common. Shrapnel shells were designed to burst only a few meters above their targets, raining down hundreds of lead balls and shell fragments to inflict as much damage as possible.⁴⁷ As Table 1.1 illustrates, shrapnel shells, machine-guns, and rifles inflicted non-fatal wounds to the arms, legs, and face or

⁴⁶ All figures taken from Macphail, 247.

⁴⁷ Tim Cook, *At the Sharp End: Canadian Fighting the Great War, 1915-1916, vol. I* (Toronto: Viking, 2007), 260-61.

neck with the most frequency. These patterns were also present within the sample group, as indicated by Table 1.2.

TABLE 1.1 – NON-FATAL WOUNDS TREATED BY THE CANADIAN ARMY MEDICAL CORPS, 1914-19

WOUND TYPE	OFFICERS	OTHER RANKS	TOTAL	TOTAL (%)
Head and Neck	907	21,377	22,284	15.4%
Chest	230	3,550	3,780	2.6%
Abdomen	78	1,317	1,395	1.0%
Pelvis	10	43	53	0.1%
Upper Extremities	1,895	49,615	51,508	35.6%
Lower Extremities	1,809	41,843	43,652	30.2%
Wounded, remained at duty	904	6,698	7,602	5.3%
Wounds, accidental	107	2,140	2,247	1.6%
Wounds, self-inflicted	6	723	729	0.5%
Effects of gas fumes	368	10,988	11,356	7.9%
Total	6,312	138,294	144,606	100%

Source: Macphail, Official History of the CAMC, 393.

TABLE 1.2 – BREAKDOWN OF GUNSHOT AND SHRAPNEL WOUNDS IN SAMPLE GROUP BY TOTAL CASES AND NUMBER OF WOUNDS, 1914-19

WOUND AREA	NUMBER OF CASES	% OF HOSPITALIZATIONS	NUMBER OF WOUNDS	% OF ALL ILLNESSES AND INJURIES
Head and Neck	25	4.5%	32	5.1%
Chest and Back	10	1.8%	10	1.6%
Multiple	1	0.2%	1	0.2%
Trunk	4	0.7%	4	0.6%
Upper Extremities	36	6.4%	37	5.9%
Lower Extremities	50	8.9%	54	8.7%
Total	125	22.4%	137	22.0%

Shrapnel wounds varied drastically in severity and prognosis. Private James C., for instance, was sprayed by German shrapnel along the length of his right arm and on his back during the Battle of Mont Sorrel in June 1916. While undoubtedly painful, his

wounds were only superficial—he spent only seven days at a divisional rest station before returning to duty.⁴⁸ Another soldier, Private Frederick Y., a farmer from Moose Jaw, Saskatchewan, received a similar wound to his right arm on 9 April 1917 at Vimy Ridge. In this case the shrapnel had caused the bone to splinter, leaving his arm “badly smashed.” Infection quickly set in and on 18 April, an operation was performed to amputate the arm 3½ inches below the shoulder.⁴⁹

If not treated quickly, a wound to the leg could lead to debilitating or fatal complications from both haemorrhaging and infection. Fragmentation or the shattering of bones easily severed the aortal or femoral arteries and cause a man to bleed out before stretcher-bearers arrived to evacuate him. Experiments with blood transfusion had been successfully completed as early as 1916, but these methods were not introduced in the CAMC until very late into the war. Instead, surgeons generally relied on established methods of injecting saline solutions to compensate for the loss of blood from haemorrhage, a practice that could do little to prevent shock, especially under battlefield conditions.⁵⁰ Even if bleeding was under control, soldiers still faced the risk of infection growing for every minute they remained on the battlefield. Septicaemia, tetanus, and other contagions could all result from even limited exposure to the manure-rich, debris-laden landscape of the Western Front. If antiseptic agents were not rapidly administered

⁴⁸ Personnel File, James C., RG 150, Accession 1992-93/166, Box 1788 – 15, LAC.

⁴⁹ Personnel File, Frederick Y., RG 150, Accession 1992-93/166, Box 10649 – 35, LAC.

⁵⁰ Pelis, 258-60.

and dead or dying flesh tended to, a patient might slip into shock and die or lose portions of a limb from gangrene.⁵¹

In cases where antiseptic measures could not prevent the spread of infection in an extremity, battlefield surgeons stationed at CCS' needed to act quickly, usually resorting to excision or amputation in an effort to prevent the wound from turning moribund. These decisions were most often made at a clearing station or base hospital, sometimes within as little as 12-24 hours. The more insidious bacterial infections afforded even less time. "Gas infection" or "gas gangrene" (unrelated to poison gas) was particularly feared. As one Canadian surgeon described, "besides the filthy odour of putrefecation" the infection was characterized by a "special sour smell" which would be followed by a rapidly spreading necrosis. If the tissue was not removed, the infection could become fatal.⁵²

Wounds to the extremities accounted for two-thirds of all Canadian battle casualties, but amputations were still comparatively rare. While exact figures are uncertain, post-war pension data suggests that probably 4000 to 4500 Canadians received a major amputation due to combat wounds between 1914 and 1920.⁵³ Both the Canadians and their British counterparts spent much of the war grappling with ways to prevent the

⁵¹ The problem of 'wound shock' plagued forward treatment units for much of the conflict. See *Injuries and Diseases of War: A Manual Based on Experience of the Present Campaign in France. January, 1918* (London: H.M.S.O., 1918), 23-44, and Macpherson, *Surgery of War, vol. I*, chapters 3 and 4.

⁵² Hingston, "Notes on War Surgery," 308-309.

⁵³ Macphail's official history lists the total amputees up to 31 August 1919 as 2780 of all varieties. However, the Board of Pension Commissioners annual report for 1920/21 lists the number of amputee pensioners as 4060. This discrepancy may be partly explained by the fact that some men received amputations while under the care of the Department of Soldiers' Civil Re-establishment (a civilian authority) after 1918. It may also be due to the fact that some patients received their treatment under the care of British units and consequently their medical information was not accounted for in the official CAMC statistics. The larger figure is also proportionately comparable to the number of British soldiers who received amputations during the war (approximately 40,000). See Macphail, 393-94, and *Report of the Work of the Board of Pension Commissioners for Canada* (Ottawa: King's Printer, 1921), 27. Hereafter cited as *BPC Report*.

need for amputation. Minor success was achieved in healing major fractures of bones through a combination of splinting and drainage via perforated tubes and antiseptic agents that would be used to ‘flush out’ contaminated flesh. Such methods, however, required careful monitoring and re-bandaging, something that was not always possible on long journeys from the front, or when medical staff were overburdened by extensive casualties. As a result, many of these cases went septic and resulted in the limb being lost regardless.⁵⁴ If deemed necessary, the most common approach to amputation adopted by surgeons was the ‘guillotine’ method. This involved sawing through the bone of a dying limb at a perpendicular angle while leaving flaps of skin and flesh exposed to form the stump. In carrying out this gruesome task the most thorough surgeons would also take into consideration the position of the arteries in relation to the amputation, how deep the necrosis had crept into the limb, and whether the position of the stump might require future operations to make it suitable for artificial appliances.⁵⁵ Post-operation infections were common—especially when carried out in forward treatment areas—often necessitating multiple surgeries and extensive post-operative hospitalization. While techniques improved over the course of the war it was not uncommon for a severe case to require a year or more of operations, convalescence and rehabilitation before they could begin utilizing their limb once again.⁵⁶

⁵⁴ Macphail, 109-110. The problems of poor amputation practices and the fitting of artificial limbs were laid out in a 1916 memorandum from the British War Office entitled “Memorandum on Amputations and Amputation Stumps.” For a summary see “Amputations and Amputation Stumps,” *BMJ* 1 no. 2884 (April 8th, 1916): 534-35.

⁵⁵ Macpherson, *Surgery of the War*, vol. I, 146-47.

⁵⁶ E. Muirhead Little, “Modern Artificial Limbs and their Influence Upon Methods of Amputation: General Considerations,” *BMJ* 2, no. 2965 (October 27th, 1917): 550-53.

Gunshot or shrapnel wounds to the abdomen required immediate intervention to prevent haemorrhaging and shock, especially those to the lower regions of the bowels where sepsis was almost guaranteed. The same was true of severe wounds to the trunk. Because of the high risk of infection these patients were prioritized for transfer to a casualty clearing station, where they could undergo emergency surgery within as little as four hours after being wounded.⁵⁷ If morbid infection could be prevented, observed one Canadian surgeon, it was possible that upwards of 30 to 35 per cent of cases could be saved.⁵⁸ In an era before the advent of antibiotics, anti-septic measures (described earlier) and timely treatment were seen as the best methods for preventing the rapid spread of infection. Injuries to the head, face, and neck were unquestionably the most terrifying, but were also more commonly survived. As with wounds to the upper extremities, these injuries were predominantly caused by exploding artillery shrapnel. Helmets, which were not introduced into the CEF until March of 1916, helped reduce the prevalence of skull fractures and damage to the cranial region from shrapnel, but they could do little to protect a soldier's face and neck. Writing in September 1915 from No. 1 General Hospital, Nursing Sister Clare Gass recounted her experience of seeing two patients with facial wounds:

War news from the front very good but the losses are dreadful—and such terrible wounds. Harold Begbie's talk of wounds as "scratches & pink marks" is a trifle out of place in the face of these shattered limbs & great areas of lacerated flesh.⁵⁹

⁵⁷ Edward Archibald, "Abdominal Wounds as seen at a Casualty Clearing Station," *CMAJ* 7, no. 4 (April 1917): 299-300.

⁵⁸ Archibald, 306.

⁵⁹ Gass is referring to Edward Harold Begbie, the noted author, poet, and journalist who took on an active role in the recruiting effort on the English home front during the Great War.

One of our men such a nice lad of 21 has the whole of his lower jaw, tongue included—gone. Another boy next him in almost the same condition. Feed them with a rubber tube. Fortunately they cannot see their disfigurement—& in the ordinary course of events they will get well.⁶⁰

The prospect of ‘getting well’ was of little consolation to a man who had been horribly (and likely permanently) disfigured. Even so, medical pioneers like Harold Gillies offered some soldiers hope through the advent of radical new techniques in reconstructive surgery.⁶¹ Speaking before a meeting of the Canadian Nursing Association in February 1917, a Mrs. Henderson spoke of the veritable miracles that medical science could achieve in restoring these men to their original aesthetic form. She noted in particular one man

whose face had been shattered, the lower jaw gone, and four teeth hanging from part of his upper jaw. Part of a rib had been used to replace the jaw bone, and the face had been built up gradually from that until the work of restoration was so perfect that the man could show with great pride a photo of himself taken before the war, to let one see how wonderfully like his former self he really was.⁶²

As Kerry Neale has illustrated in her work on facially disfigured soldiers in Britain and the Dominions, such resounding success was relatively uncommon.⁶³ While skin and bone grafts could partially restore a man with less severe injuries, it was usually the most successful cases that were photographed and presented as an exercise in both medical

⁶⁰ See entry for 28 September 1915 in *The War Diary of Clare Gass, 1915-18*, ed. Susan Mann (Montréal and Kingston: McGill-Queen’s University Press, 2000), 65.

⁶¹ For a full account of Gillies’ work during the Great War see Harold D. Gillies, *Plastic Surgery of the Face: Based on Selected Cases of War Injuries of the Face including Burns* (London: Hodder and Stoughton, 1920). Also see Reginald Pound, *Gillies, Surgeon Extraordinary: A Biography* (London: Joseph, 1964), and Murray Meikle, *Reconstructing Faces: The Art and Wartime Surgery of Gillies, Pickerill, McIndoe, and Mowlem* (Dunedin, NZ: Otago University Press, 2013).

⁶² H.A. DesBrisay, “The Canadian Nurses Association and Register for Graduate Nurses, Montréal,” *The Canadian Nurse* (March 1917): 155.

⁶³ Kerry Neale, “Scarred by War: Medical Responses to Facially Disfigured Soldiers of the Great War,” in *War Wounds: Medicine and the Trauma of Conflict*, edited by Ashley Ekins and Elizabeth Stewart (Wollombi, NSW, Australia: Exisle Publishing Limited, 2011), 60-73.

pedagogy and propaganda.⁶⁴ Military medicine ultimately provided no objective ‘cure’ for disfigurement.⁶⁵

Though they were a gruesome reflection of war’s ravaging power, cases of disfigurement minor in scale compared to the tens of thousands of Canadian soldiers with severe physical wounds who required long periods of convalescence and physical retraining. Writing to his romance Lulu, Thomas William Johnson gave a representative account of how many severely wounded soldiers reacted to treatment after first arriving in hospital:

I am making good progress. I have been up three half days now, & tomorrow I start getting up for the whole day. My arm is supported in a sling, or hangs helplessly by my side. Each day a nurse massages it for an hour, & slowly I am regaining its use. You are dreadfully mistaken, Lulu dear when you think I bear pain bravely; I am like a baby. But thank God I dont have very much now.⁶⁶

Johnson’s words reflect a common emotional response to the initial shock of hospital life articulated by countless wounded and permanently disabled soldiers during the Great War. The resolve to overcome one’s wounds was anchored by the helplessness, anxiety, and melancholy inherent to long periods of immobility and physical pain. Thoughts of loved ones back home, or the fear of losing one’s livelihood also weighed heavily on a

⁶⁴ Sandy Callister, “‘Broken Gargoyles’: The Photographic Representation of Severely Wounded New Zealand Soldiers,” *Social History of Medicine* 20, no. 1 (2007): 112-15.

⁶⁵ The total number of permanently facially disfigured Canadian soldiers is unknown, largely because specialized units treated both disfigurements, ophthalmological, and dental cases. Macphail notes that some 2000 cases passed through the Canadian service, but it is unclear how many of these men were left with irreversible damage. The Board of Pension Commissioners report for 1920/21 states that 188 men were receiving pensions for ‘disfigurements,’ most of which were probably to the face. See *BPC Report* (1921), 27.

⁶⁶ Thomas William Johnson letter to Lulu, 1 June 1917, *Canadian Letters and Images Project*, <<http://canadianletters.ca/letters.php?letterid=11717&warid=3&docid=1&collectionid=438>> (accessed July 5th 2013).

soldier's mind. While many men wished for their chance to land a 'Blighty,' the hospital, for all its allure, could quickly turn into a confusing purgatory between the fear and excitement of combat and the comforts of home.⁶⁷ It also presented a medical and social paradox for army and civilian authorities alike. Bed rest and forced inactivity were a necessary component of effective treatment, but this process also bred concern that idleness would permanently damage a patient's mentality towards work, rendering him militarily and industrially inefficient, or worse, a lifelong burden to the state. "Are the lives of our wounded being conserved for future usefulness—for the upbuilding of Canada—or, on the contrary, are they are lives being saved for existence alone," pondered one editorialist in the *CMAJ*.⁶⁸ If rehabilitation was to be successful, it needed to both restore a patient's confidence in his physical abilities (both objectively and subjectively) and instil a masculinising mentality of self-sufficiency and industriousness.

If standardization was to be achieved, the scheme also had to be managed and administered by units of the CAMC. Investigations by Canadian officials into the practices of French and Belgian hospitals in 1915 had illustrated the utility of occupation and specialized exercises in rehabilitating what contemporaries broadly termed 'orthopaedic cases'—men whose disabilities resulted primarily from the effects of gunshot wounds or other musculoskeletal injuries.⁶⁹ Limited room in Canadian hospitals

⁶⁷ A 'blighty' was a common term used amongst soldiers to denote a wound that was severe enough to necessitate treatment and convalescence in England.

⁶⁸ "Orthopaedic After-Treatment of Canadian Wounded," *CMAJ* 6, no. 4 (April 1916): 330.

⁶⁹ For a more extensive summary see Sessional Paper No. 35a – "The Provision of Employment for Members of the Canadian Expeditionary Force on their Return to Canada," in *Sessional Papers of the Dominion of Canada* (Ottawa: King's Printer, 1916). For a more extensive summary of French efforts see J.L. Todd, *The French System for the Return to Civilian Life of Crippled and Discharged Soldiers* (New York: Red Cross Institute for Crippled and Disabled Men, 1918).

had made it necessary to admit patients into the Royal Army Medical Corps (RAMC) military hospital system during the first two years of the war; but even there few opportunities existed for patients who required lengthy periods of rehabilitation or retraining due to a lack of resources and limited expertise.

The Canadian program began in earnest with the establishment of Granville Canadian Special Hospital at Ramsgate in September 1915 (later moved to Buxton in October 1917). Granville was Canada's largest overseas orthopaedic hospital, treating over 17,000 patients during the war, including some 2500 amputees.⁷⁰ Although originally intended to treat cases of "shell shock, nerve diseases and lesions, and injuries of bones and joints," from a medical perspective the most promising advancements related to the latter category of patient. Indeed, Granville was increasingly relied upon as a proving ground for new or experimental treatment and rehabilitation techniques adopted in other hospitals throughout England and Canada.

Upon admission patients at Granville and other institutions were strictly regimented in their daily activities. The severely wounded were most often confined to their wards, but ambulatory patients were expected to spend their days divided among treatment, physical exercise, and light occupations around the hospital.⁷¹ Physical therapy commenced in the morning and varied depending on the nature of the wound. Massage, radiant heat, faradic and galvanic electrotherapy, and various forms of hydrotherapy were the most common treatments administered to orthopaedic cases in an effort to restore

⁷⁰ Macphail, 204.

⁷¹ WD, Granville Canadian Special Hospital, Untitled summary of activities to July 1916, RG 9-III-D-3, vol. 5040, file 877, part 1, LAC.

nerve flow, improve circulation, and stimulate dormant muscles.⁷² Physiotherapy rooms and the gymnasium were equipped with specially designed apparatuses for mimicking natural movements and building strength. These mechanical therapies were complimented by Swedish drill and isolation exercises carried out under the supervision of trained NCOs and physical instructors—some of them former patients whose injuries were too severe to allow them to return to the front lines.⁷³

Few personal accounts are available from Granville patients, but reactions by Canadian soldiers to these treatments in similar hospital settings help to illustrate how these medical practices were experienced and interpreted. In a letter to his hometown newspaper, the *Dutton Advance*, ‘Private Macfarlane’ wrote enthusiastically of the “truly marvelous...modern appliances they have for the wounded. Electric massage and radio heat are doing wonders for me.” Although the treatment left his leg “covered with perspiration and red as a half-cooked beef steak,” Macfarlane was confident that this fascinating therapy was a “do[ing] a power of good.”⁷⁴ Other patients were less receptive to the process of physiotherapy, finding it painful, tiresome, and in the presence of more able-bodied men, emasculating. Stoicism tempered the comportment of many soldiers

⁷² WD, Granville Canadian Special Hospital, July 1917, Appendix B, Table F, RG 9-III-D-3, vol. 5040, file 877, part 2, LAC. The breakdown of the over 26,000 treatments administered to patients during this busy month is as follows: Massage – 7886; Eau Courante Baths – 2001; Spinal Massage Baths – 255; Contrast Baths – 186; Radiant Heat & Arc Baths – 2663; Vapour & Turkish Baths – 100; Douches – 856; French Pomade – 59; Galvanism & Faradism – 3176; Ionization – 937; Electric Water Baths – 162. Added to these were x-ray examinations and several thousand ‘treatments’ (exercises primarily) administered in the gymnasium.

⁷³ WD, Granville Canadian Special Hospital, Untitled summary of activities to July 1916, RG 9-III-D-3, vol. 5040, file 877, part 1, LAC.

⁷⁴ Private McFarlane to Robert Affleck, 1 March 1917, *Canadian Letters and Images Project*, <<http://canadianletters.ca/letters.php?letterid=4976&warid=3&docid=1&collectionid=281>> (accessed July 7th, 2013).

while in the presence of practitioners, but privately they were not shy in expressing their discomfort.⁷⁵ Writing to his mother in December 1916, John ‘Jack’ Row summed up the feeling of many patients when he described his treatment as a combination of “massage and physical torture.”⁷⁶ While recovering from severe leg wounds Private Gordon Rae Mackay shared a similar opinion: “They have begun the torture business on my legs now & believe me I did not know what pain was, before they get after me with massage. It sure is cruel treatment but of course it is necessary to bend these stiff legs.”⁷⁷

Even if they did so grudgingly, patients generally accepted that physical discomfort was a necessary component of healing. Most welcome were the opportunities to engage in activities away from the therapeutic wards, especially organized play and recreation. Billiards, marksmanship competitions, and craftwork were available to patients at many military hospitals and convalescent homes. ‘Ward occupations’—a nascent form of occupational therapy explored in more detail in a later chapter—also provided patients that were confined to their beds or wards with a mental and physical distraction from the ennui of convalescence.⁷⁸ Discipline, however, needed to be maintained: recreation could not merely serve the self-indulgence and enjoyment of the

⁷⁵ Christine E. Hallett, *Containing Trauma: Nursing Work in the First World War* (Manchester: Manchester University Press, 2009), 175-77.

⁷⁶ John ‘Jack’ Row to Mother, 21 December 1916, *Canadian Letters and Images Project*, <<http://canadianletters.ca/letters.php?letterid=9088&warid=3&docid=1&collectionid=360>> (accessed July 7th, 2013).

⁷⁷ Gordon Rae Mackay to Mother, 2 September 1917, *Canadian Letters and Images Project*, <http://canadianletters.ca/letters.php?letterid=1674&warid=3&docid=1&collectionid=131> (accessed July 7th, 2013).

⁷⁸ The fullest account of occupational therapy during the Great War within the Canadian and international literature is Judith Friedland, *Restoring the Spirit: The Beginnings of Occupational Therapy in Canada, 1890-1930* (Montréal and Kingston: McGill-Queen’s University Press, 2011), especially chapters 7-10.

patient. Hospitals required extensive upkeep to operate efficiently, and staff were often overburdened by the care of the sick and severely wounded. As a duty to the hospital, patients were expected to tend to light chores around their wards and the grounds. At Granville, for instance, capable patients would be employed in the manufacturing of splints, X-Ray frames, and even artificial limbs (primarily ‘peg legs’). Some even assisted physicians with other patients undergoing physical therapy.⁷⁹ Part utilitarian, part curative, occupation was a common approach implemented throughout the CAMC’s military hospitals during the war. Writing in 1915, Granville’s war diarist summed up both the medical and economic rationale behind hospital work: “It has been felt for some time that the sooner a patient became convinced that he was not merely a patient but also a MAN, capable to do something, the more rapid his cure became.”⁸⁰

Sport and routine physical exercise were equally important to the Canadian rehabilitation project. Almost every unit in the CEF participated in organized team events from the earliest days of the campaign, often as a means of dissuading men from giving into moral and carnal vices. Its ‘curative powers,’ however, were not widely recognized by military physicians until the mid-point of the war. Having already established that ‘activity’ (especially occupational) was necessary for men to overcome disabilities, the CAMC extended this approach to treatment by incorporating the pioneering work of physical educator R. Tait McKenzie into their rehabilitation scheme. A Canadian by birth, McKenzie joined the ranks of the RAMC in 1915 and helped to introduce standardized

⁷⁹ WD, Granville Canadian Special Hospital, April 1918, Appendix I, RG 9-III-D-3 vol. 5040, file 878, part 1, LAC.

⁸⁰ WD, Granville Canadian Special Hospital, Untitled summary of activities to July 1916, RG 9-III-D-3, vol. 5040, file 877, part 1, LAC.

physical exercise regimens into both the Canadian and British military medical systems.⁸¹ His approach emphasized active treatments such as gymnastics and military drill, each of which served to “reeducate control, alertness, accuracy, speed, and strength in men who have lost them through neglect, injury, or the enforced idleness of hospital life.”⁸² Patients were to maintain military discipline and participate in exercise routines collectively, irrespective of their disabilities—if a soldier could not carry out the task, he would stand fast until able to rejoin the routine once again.⁸³ Games like tennis, baseball, football or croquet allowed disabled men of all abilities to work on coordination while also emphasizing a competitive spirit and camaraderie with their fellow patients. Indeed, it was even common for the patients to play against the able-bodied members of the hospital staff.⁸⁴

By the war’s end both physicians and military authorities alike had seen extensive evidence of modern medicine’s curative power. Even before fully implementing McKenzie’s program of physical therapy, at the beginning of 1917 the staff of Granville could boast that they had returned nearly 55 per cent of their patients to full or light duty, with only 17.5 per cent discharged to Canada.⁸⁵ Monthly returns provided in the

⁸¹ Fred Mason, “Sculpting Soldiers and Reclaiming the Maimed: R. Tait McKenzie’s Work in the First World War Period,” *Canadian Bulletin of Medical History* 27, no. 2 (2010): 366.

⁸² R. Tait McKenzie, *Reclaiming the Maimed: A Handbook of Physical Therapy* (New York: Macmillan, 1918), 92.

⁸³ McKenzie, 92-94.

⁸⁴ Hospital newspapers and histories often are the best source for summaries and photographic accounts of sporting competitions within hospital system. See for example *The Canadian Convalescent Hospital, Bear Wood, Workingham, Berkshire, 1915-18* (London: 1918).

⁸⁵ Robert Wilson, “On the Role of Physiotherapy in the Treatment of the Returned Invalided Soldier,” *CMAJ* 8, no. 8 (August 1918): 701.

hospital's war diaries suggest that these rates continued throughout the war.⁸⁶ At St. Dunstan's Hostel, Sir Arthur Pearson's imaginative and meticulous approach to the re-education of blinded ex-servicemen captivated the public's imagination as disabled men traditionally thought to be 'hopeless' were expertly taught Braille and occupational skills such as typewriting, boot repair, or poultry raising, all within the span of six to eight months.⁸⁷ "She is home for me," wrote one former patient: "I was born again and nurtured into a new manhood by her, led by her from stygian darkness to mental and spiritual light, and my heart turns with longing towards her."⁸⁸ Modern medicine, it was proposed, was not simply rehabilitating disabled soldiers: it was 'remaking' them.⁸⁹ In truth, the published, uplifting tales were unduly rosy.

Some of the war's most horrible injuries were not caused by weapons that tore flesh or shattered bones. While it is generally acknowledged that military medicine made advances in the treatment and rehabilitation of certain orthopaedic cases—at least from a physical standpoint—it had less certain answers for some of the other mechanisms and consequences of industrial killing. The most notorious of these was poison gas. The war witnessed the development of numerous varieties of this menacing weapon, however three principle forms were experienced most frequently by Canadian units—chlorine,

⁸⁶ For instance the March 1918 report for Granville's surgical department shows that of 339 patients discharged during the month (most of whom suffered from gunshot wounds or related nerve damage), 8 per cent ($n=24$) were returned to full duty, 45 per cent ($n=153$) to light duty, 6 per cent ($n=20$) to Canada, and 41 per cent ($n=142$) to other institutions. See WD, Granville Canadian Special Hospital, March 1918, Appendix F, "Disposal of Patients Discharged During March 1918," RG 9-III-D-3, vol. 5040, file 878, part 1, LAC.

⁸⁷ Serge Durlinger, *Veterans with a Vision: Canada's War Blinded in Peace and War* (Vancouver: UBC Press, 2010), 26-27.

⁸⁸ James H. Rawlinson, *Through St. Dunstan's to Light* (Toronto: Thomas Allen, 1919), 86.

⁸⁹ "Remaking the Disabled," *BMJ* 2, no. 2959 (September 15th, 1917): 363.

phosgene, and mustard gas. Canadians' first encounter with chemical warfare came on 22 April 1915, when the Germans emptied 5730 canisters of chlorine gas along a 7000-yard front as part of an offensive operation in the Ypres Salient.⁹⁰ Men of the 1st Canadian Division were fortunate to escape the worst of the first cloud on 22 April only to face a second more devastating attack on the 24th. Some soldiers were able to diminish the gas's effects by urinating on cloths (the ammonium would dull the effect of the gas) or later by soaking them in a bicarbonate of soda mixture, but many were wholly unprepared. The creeping greenish-yellow cloud stayed close to the ground, causing severe burning and scarring to the eyes, throat, and lungs. Acute cases drowned internally as bile filled their respiratory system. Oxygen therapy had not yet been widely adopted by the RAMC or its counterparts, so patients often continued to suffer from burning and inflammation for days after being poisoned. This was typically followed by the onset of chronic dyspnoea, bronchitis, and a high fever, which could lead to further complications as the patient's immune system weakened, necessitating prolonged treatment and convalescence.⁹¹

Like chlorine, phosgene gas, which the Canadians first experienced in December of 1915, was most damaging if ingested through the lungs. What made phosgene far more insidious was that it was scarcely visible, its smell was far less potent, and the symptoms of poisoning were usually not noticeable for several hours. Mild ingestion would result in only slight irritation of the throat or general fatigue. Some soldiers might carry on for

⁹⁰ Tim Cook, *No Place to Run: The Canadian Corps and Gas Warfare in the First World War* (Vancouver: UBC Press, 2000), 19-21.

⁹¹ Leonard Hill, "An Address on Gas Poisoning," *BMJ* 2, no. 2866 (December 4th, 1915): 801-804.

hours or even days unaware that they were affected.⁹² In other cases the gas could cause mass hysteria amongst entire battalions who feared they had all been poisoned, putting significant strain on medical officers and stretcher-bearers who had to determine whether to prioritize *potential* gas casualties over those suffering from shrapnel or gunshot wounds. When acute symptoms of phosgene poisoning finally set in the experience was similar to chlorine: dyspnoea, inflammation of the bronchi, and secretion of fluid into the lungs, especially upon physical exertion.⁹³ Cases that required immediate care were usually sent to base hospitals where they were treated with rest, warmth, a fluid heavy diet and, if available, oxygen. Until late 1917, many doctors also used venesection (blood-letting) in the belief that it would relieve pressure on the heart and help diminish respiratory oedema, albeit with little effect on patient outcomes.⁹⁴

Fatal casualties from poison gas were proportionately high during the early stages of its use in the Great War, but its effectiveness as a tactical weapon was largely dependent on surprise and chance. The advent of respirators and anti-gas measures quickly negated early successes. The wholesale introduction of gas shells in the summer of 1916, however, re-established chemical weapons as a major part of the German and allied arsenals for the duration of the conflict. Following the Somme, gas shells of all varieties were utilized in almost every major engagement, producing a steady stream of

⁹² For a full account of lung irritant gas symptoms see Sir William Grant Macpherson, *History of the Great War Based on Official Documents. Medical Services. Diseases of the War, vol. II* (London: H.M.S.O., 1923), 383-424.

⁹³ Cook, *No Place to Run*, 58-62.

⁹⁴ Major G.B. Peat, "The Effects of Gassing as seen at a Casualty Clearing Station," *CMAJ* 8, no. 1 (January 1918): 17-24. For a general overview of respiratory treatment see Macpherson, *Diseases of the War, vol. II*, 505-508.

casualties and causing unquantifiable psychological strain.⁹⁵ Gas shelling was particularly suited to mustard gas, the most insidious and contaminating poison employed on a large scale. Even slight exposure to the gas caused painful blistering—especially around the armpits, stomach, and groin—conjunctivitis, vomiting, burning of the throat, and tracheal haemorrhaging.⁹⁶ Gas vapours were easily absorbed into the soil or clothing, allowing the contaminant to spread even with slight contact. The Canadian Corps' first experience with the gas came at the Battle of Hill 70 in August 1917. Patients were transported immediately to the nearest dressing station where they were stripped of all clothing and bathed from head to foot in a soda solution. Eyes were then flushed, covered in gauze, and a second dose of soda bicarbonate was administered internally before being transferred through the evacuation chain to a base hospital.⁹⁷ Unlike phosgene or chlorine, which required lengthy treatment and convalescence, most mustard gas casualties could potentially be returned to the line within a few weeks. Pulmonary complications, however, were still common, and could extend a patient's stay in hospital. Private David B. for example was exposed to a mustard gas shell on 13 November 1917, receiving slight burns to his hands. Shortly after exposure he developed inflammation in his lungs and difficulty breathing. While his hands healed quickly, he was forced to undergo prolonged treatment at Woodcote Park Military Convalescent Hospital in Epsom,

⁹⁵ Cook, *No Place to Run*, 212-17.

⁹⁶ "Mustard Gas," *BMJ* 2, no. 2956 (August 25, 1917): 266.

⁹⁷ WD, ADMS 1st Canadian Division, August 1917, Appendix, "Brief Summary of Medical Arrangements and Operations during Hill 70 Offensive," RG 9 III-D-3, vol. 5025, file 815, LAC. Also see Macpherson, *Diseases of War, Vol. II*, 508-512.

England before finally being discharged on 8 February 1918, 87 days after initial exposure.⁹⁸

Unlike shrapnel or gunshot wounds, the military medical services had few answers to the problem of poison gas. While laboratory science and clinical experimentation offered some clues on how the deadly effects of exposure might be mitigated, chronic secondary conditions such as bronchitis, emphysema, or conjunctivitis frustrated practitioners. Most patients immediately required sedatives, chemical therapy (including ammonia), stimulant and fluids, followed by a prolonged period of rest and special diet. Since patients frequently remained idle while in hospital, graduated exercises and physical drill were required to ascertain whether they could withstand a return to combat.⁹⁹ Prognoses varied widely depending on the time and place exposure occurred, as well as the type of gas used. For instance, one 1917 British army report on phosgene casualties found that while 40 per cent could be returned to duty in the span of five weeks and a further 25 within eight weeks, 35 per cent were never able to return to duty.¹⁰⁰ An even more sobering Canadian study of gas victims from Second Ypres found that of 332 who were evacuated to England, 188 (56.6 per cent) were discharged to Canada.¹⁰¹ Of 14 soldiers in the sample group that were gassed during the war, only three were discharged with gas poisoning or related complications as their primary disability, an attrition rate of 21 per cent. Concrete figures can never be known, but some scholarship suggests that gas

⁹⁸ Personnel File, David B., RG 150, Accession 1992-93/166, Box 744 – 8, LAC.

⁹⁹ Macpherson, *Diseases of the War*, vol. II, 495-517.

¹⁰⁰ Cook, *No Place to Run*, 155.

¹⁰¹ J.C. Meakins and J.G. Priestly, "The After-Effects of Chlorine Gas Poisoning," *CMAJ* 9, no. 11 (November 1919): 968-74.

accounted for upwards of a million casualties during the Great War.¹⁰² At least 11,356 of these were Canadians—7.9 per cent of all Canadian battlefield casualties—but the number of men actually *exposed* likely was much higher.¹⁰³ The extent of fatal casualties from gas can never be known.

More troubling for both medical authorities and soldiers was the unpredictability of long-term damage and inadequate practice of wartime recordkeeping. At the time of discharge a gas victim might exhibit no significant symptoms or lesions, compelling medical examiners to dismiss a man's alleged disability as functional or neurotic. That gas also exacerbated conditions typical of poor pre-enlistment health only complicated matters further.¹⁰⁴ Minor gas casualties not evacuated beyond the field ambulance could also lack the appropriate documentation in their service records to support a pension claim, especially if they were treated in a mass casualty scenario. In the years following the Armistice, gas victims would become central to debates over the question of attributability, as a steady stream of veterans came forward claiming that exposure had left them susceptible to chronic respiratory illness, heart complications, or diseases of the nervous system. Military medicine gradually developed standard procedures for treating exposure to these deadly poisons, but little was known about the long-term physiological consequences.

¹⁰² Numbers have varied widely, in large part due to poor recordkeeping on the part of particular belligerents, especially Russia. For more on the problem of accounting for these see L.F. Haber, *The Poisonous Cloud: Chemical Warfare in the First World War* (Oxford: Oxford University Press, 1986), 239-48.

¹⁰³ Macphail, 393.

¹⁰⁴ J.C. Meakins, "Note on the Handling and After History of Heart Affections of in Soldiers," *CMAJ* 8, no. 5 (May 1918): 397.

Not all wounds of the Great War were physical in nature. War trauma has long captivated the imaginations of writers, poets, and scholars, leading to the development of an extensive literature that has given ‘shell shock’ (as it is most commonly referred) a degree of cultural resiliency unknown to any other medical aspect of the Great War. The limited research on the Canadian experience suggests that the CAMC’s physicians tended to frame shell shock and related nervous disorders as an acquired or ‘organic’ condition, often labelling it as neurasthenia.¹⁰⁵ As Mark Humphries notes, this was primarily due to the fact that most CAMC doctors were civilian practitioners with little clinical experience to guide their encounters with the complex array of symptoms exhibited by these casualties. Clinical specialists at Canadian special hospitals tended to reinforce this view, preferring to treat the somatic symptoms of nervous illness (such as poor appetite, fatigue, insomnia, tremors, or irritability) through a combination of rest, special diet, and graduated exercise.¹⁰⁶ As the war progressed, these approaches were augmented by the introduction of physiotherapy and occupational therapy.¹⁰⁷ In the case of the former hydrotherapy and electrotherapy were relied upon extensively at hospitals like Granville as way of inducing physical relaxation and increasing nerve-flow in patients. Galvanic and faradic electrotherapy, contrary to popular post-war accounts that emphasized their

¹⁰⁵ Humphries with Kurschinski, 109-110. Also see Humphries’ master’s thesis, “The Treatment of Evacuated War Neuroses Casualties in the Canadian Expeditionary Force, 1914-1919” (MA Thesis, Wilfrid Laurier University, 2005) and Tomas E. Brown, “Shell Shock in the Canadian Expeditionary Force, 1914-1918: Canadian Psychiatry in the Great War,” in *Health, Disease, and Medicine: Essays in Canadian History*, edited by Charles G. Roland (Hamilton: Hannah Institute/Clarke-Irwin, 1984), 308-32. For a re-evaluation of the British approach to the treatment of war neuroses see Peter Leese, *Shell Shock: Traumatic Neurosis and the British Soldiers of the First World War* (New York, Palgrave, 2002).

¹⁰⁶ Humphries with Kurschinski, 94, 99-100.

¹⁰⁷ On physical therapy and exercise see McKenzie, 1-9, 94. For occupational therapy see Friedland, 148, 154-55.

sinister application by some military psychiatrists, were not designed to induce severe pain or serve as a form of physical discipline for unruly cases.¹⁰⁸ Instead, they served as an important component in illustrating to the patient that, when empowered by modern medicine, the somatic manifestations of their illness could be reduced and eventually cured.

The diagnosis and treatment of shell shock in the Great War was also complicated by a growing inventory of other disorders thought to be connected with the phenomenon of war neuroses. Conditions such as ‘disordered action of the heart’ (DAH), ‘nervous debility’ or ‘valvular disease of the heart’ (VDH) mimicked the symptoms of traumatic neuroses—nervousness, elevated pulse, insomnia, dyspnoea and dizziness—but they often afflicted soldiers who had never been close to shell fire or in intense combat.¹⁰⁹ More confounding was that many patients lacked a history of coronary disease or other illnesses that may have precipitated their symptoms. Canadian hospitals also appear to have treated such cases on the basis of rest cure. Nevertheless, just as with shell shock, anxieties over malingering were ever-present. In a September 1916 article in the *CMAJ*, one CAMC physician wrote sceptically of the DAH cases he had encountered: “the psychic poise of these patients is all against a quick recovery, and in few diseases does

¹⁰⁸ Stefanie C. Linden, Edgar Jones, and Andrew J. Lees, “Shell Shock at Queen’s Square: Lewis Yealland 100 Years On,” *Brain* 136, Part 6 (June 2013): 12, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3673538/> (accessed October 19th, 2013).

¹⁰⁹ A contemporary overview of the problem of classification and diagnosis is given in J.C. Meakins, “After History of Heart Affections in Soldiers,” 394-400. Meakins was one of many senior medical officers who argued that the majority of DAH cases had been misdiagnosed and lacked objective symptoms of heart affliction.

the psychic poise play a greater part than in the unstable heart of soldiers.”¹¹⁰ The somatic features of DAH, he implied, might be entirely functional, or worse, cleverly feigned.

Over time army physicians shared a similar wariness towards cases of neuroses, even if treatment practices rarely took on a punitive or disciplinarian form. Cowardice could not be tolerated, nor could the CEF afford unnecessary wastage from soldiers self-identifying with illnesses that were often diagnosed inconsistently and inaccurately.¹¹¹ In an effort to stem the tide of ‘illegitimate’ nervous casualties, after 1917 the British army began utilizing the expression ‘Not Yet Diagnosed (Nervous)’ in lieu of shell shock. These cases were typically admitted to specialized forward treatment centres instead of being evacuated to ordinary base hospitals or rest stations as had previously been practiced.¹¹² Canadian forward treatment records have not yet been sufficiently examined to determine the impact these changes had on diagnosis and treatment, but evidence from the war diaries of divisional medical officers suggests that Canadian units adopted British practices.¹¹³

Special hospitals such as Granville, Buxton, or Moore Barracks, however, remained relatively consistent in treatment practices, irrespective of the label attached to

¹¹⁰ Robert Dawson Rudolf, “The Irritable Heart of Soldiers (Soldier’s Heart),” *CMAJ* 6, no. 9 (September 1916): 799.

¹¹¹ The British press played a significant role in popularizing the phenomenon and accelerating military concerns over its widespread usage. See Leese, 55-65.

¹¹² Jones and Wessely, 26-31. Harrison, 110-18.

¹¹³ During the Winter of and 1917 and Spring of 1918, for example, 3rd Canadian Division sent all of its NYD(N) cases to No. 39 Stationary hospital either directly, or via rest station staffed by No. 8 Field Ambulance. WD, No. 8 Field Ambulance, April 1918, Appendix, “3rd Canadian Division Medical Arrangements while in Forward Area,” RG 9-III-D-3, vol. 5030, file 831, part 3, LAC.

the patient's illness upon admission.¹¹⁴ By early 1917 these institutions were also complimented by facilities like the King's Canadian Red Cross Hospital at Bushey Park, which was created specifically to treat shell shock and 'heart cases.'¹¹⁵ Characterized by its winding paths and "horticultural grandeur," Bushy Park resembled a "veritable Garden of Eden."¹¹⁶ Here patients spent much of their day at the hospital's gymnasium, workshop, and recreation room, the latter furnished with a piano and other instruments provided by local donors. As with other special hospitals, treatment primarily consisted of graduated exercise in the mornings, occupational retraining in the afternoons, along with recreational sports and carefully managed rest, leisure, and diet.¹¹⁷ Medical authorities made a more concerted effort to identify patients with 'acquired illnesses' and 'innate defects' as the war pressed on, but there is little evidence to suggest that the CAMC's overall approach to treating chronic cases of neuroses was systematically revised. Such distinctions had a far greater bearing on the decision to evacuate as well as the future pensioning responsibilities of the state, a unique problem associated with conceptualizing trauma that appears frequently throughout this study.

The wide range of diagnoses that were utilized throughout the war to identify and classify cases of war neuroses makes the task of determining its prevalence in statistical terms nearly impossible. Trauma could easily be hidden within other diagnostic

¹¹⁴ Humphries with Kurschinski, 109-110.

¹¹⁵ WD, King's Canadian Red Cross Hospital, Bushey Park, November 1916, Appendix, "Historical Narrative," RG 9-III-D-3, vol. 5041, file 880, LAC.

¹¹⁶ WD, King's Canadian Red Cross Hospital, Bushey Park, November 1916, Appendix, "Historical Narrative," RG 9-III-D-3, vol. 5031, file 880, LAC.

¹¹⁷ WD, King's Canadian Red Cross Hospital, Bushey Park, February 1918, Appendix "Monthly Report of Quartermaster." Also see March 1918, Appendix, Untitled monthly report of heart clinic and "Standing Orders for Remedial Exercise," all in RG 9-III-D-3, vol. 5041, file 880, LAC.

categories, or might never be mentioned at all. Soldiers might find other coping mechanisms including humour, spirituality, aggression, or even brutalization to confront and make sense of their trauma. Because of the complex etymology of male nervous illness during this period official statistics are especially elusive. The CAMC official history notes that it treated 8513 cases of “nervous disease” and 1683 cases of insanity during the war. If we cast a wider net and include the 4675 cases of DAH that were treated, it is reasonable to presume that upwards of 15,000 Canadians may have been treated for some form of trauma or related illness between 1914-18.¹¹⁸ This accounts for roughly 2.7 per cent of all war survivors, or 8.7 per cent of all non-fatal casualties across all categories.¹¹⁹

The sample group for this dissertation yields revealing figures. In total 8.6 per cent of the sample ($n=33$) were hospitalized for a condition that could be considered trauma or mental illness under a broad swath of wartime labels. There were 39 separate instances of hospitalization, accounting for 7.0 per cent of all admissions.¹²⁰ Only 2.6 per cent of the sample ($n=10$) was diagnosed with shell shock ($n=6$) or neurasthenia ($n=4$).¹²¹ Only 11 soldiers treated for a nervous condition were discharged, nine of which were deemed attributable to service.

¹¹⁸Macphail, 269. Also see J.P.S. Cathcart, “The Neuro-Psychiatric Branch of the Department of Soldiers’ Civil Re-establishment,” *Ontario Journal of Neuro-Psychiatry* 8 (1928): 46.

¹¹⁹ Figure derived from total of 172,950 non-fatal casualties, all categories, as given in Nicholson’s Appendix C.

¹²⁰ Diagnoses often changed as a soldier made his way through the medical system and encountered different specialists and medical officers. To make the data useful the last diagnosis before discharge to duty or out of the service was used as the primary diagnosis.

¹²¹ Admission breakdown is as follows: Arteriosclerosis ($n=2$); Disordered Action of the Heart ($n=3$); Debility ($n=10$); Delusional Insanity ($n=1$); Epilepsy ($n=1$); Neurasthenia ($n=4$); Nervous Debility ($n=2$); Neuralgia ($n=2$); Neuritis ($n=2$); Shell Shock ($n=5$); Tachycardia ($n=1$); Valvular Disease of the Heart ($n=5$).

What is most striking about the sample data is that the majority of cases were not diagnosed based on prevailing wartime nomenclature for trauma. However inadequate these diagnoses may have been, physicians ultimately preferred to rely on physical explanations for nervous conditions. That nine (of 11) cases discharged were ruled attributable to military service also indicates that this tendency was mirrored at CAMC medical boards. Indeed, contrary to the wishes of psychiatric specialists, medical officers based their decisions on the perceived somatic link between nervous disability and service conditions. Irrespective one's predisposition to such maladies, it was more commonly treated as a form of 'injury' than a hereditary or moral inadequacy.

IV. DISEASE AND THE CANADIAN EXPEDITIONARY FORCE

Shell shock, gas warfare, and the industrial maiming of combat understandably dominate the medical memory of the Great War, but to characterize them as the common medical experience shared by Canada's soldiers is misleading. According to Macphail's official history, the CAMC admitted 395,048 cases of non-combat illness to hospitals overseas and 221,945 in Canada during the war. These cases account for 81 per cent of all admissions.¹²² Unfortunately, we do not know the total number of soldiers who were hospitalized for illness or injury because Macphail's figures are an aggregate of admissions. These figures also exclude minor illnesses—treated on or near the front lines—or cases that were cared for by non-CAMC units.¹²³ Evidence from the sample group provides a corroborating glimpse of the scale of sickness during the war. Of 256

¹²² Macphail, 242, 246. According to Macphail the total non-combat admissions were 616,993. The total for all theatres was 761,635.

¹²³ Based on a rounded figure of 560,000 war survivors.

patients hospitalized, 83.2 per cent ($n=213$) were treated for a non-combat condition. These cases represent roughly 55 per cent of the sample, which extrapolated to the population of all CEF survivors represents about 310,000 men.¹²⁴

We may never know exactly how many Canadians were hospitalized in the Great War, but both the official statistics and sample group figures confirm that illness and disease were widespread, although related deaths were rare. In total, only 3825 Canadians died of disease, roughly 6.4 per cent of all fatal casualties.¹²⁵ If deaths caused by Spanish Influenza and related complications are omitted, disease accounted for only around 5 per cent of all military deaths.¹²⁶ Inoculations, prophylactics, quarantining, and an emphasis on sanitation and preventative medicine went remarkably far in eradicating the deadly effects of bacterial contagions. Compared to previous campaigns, this aspect of the medical war was a remarkable achievement, one which senior authorities were eager to point out as evidence of modern medicine's efficacy. "It may be confidently asserted that this war would long ere this have been prematurely terminated, as has been the case in previous wars, by infectious diseases and the ideals for which we are fighting would have thus been sacrificed, had we not learned and practised effective means for the control and prevention of disease," Colonel A. Primrose, President of the Toronto Academy of Medicine boasted shortly after the war's end.¹²⁷ Indeed, the most common illnesses, while unpleasant for those who fell ill, could normally be treated with a high

¹²⁴ These calculations include men who were also hospitalized for combat wounds.

¹²⁵ Macphail, 243.

¹²⁶ Macphail, 266. On the impact of the Spanish Flu on the Canadian military and the home front, see Mark Humphries, *The Last Plague: Spanish Influenza and the Politics of Public Health in Canada* (Toronto: University of Toronto Press, 2013).

¹²⁷ A. Primrose, "War Activities in Medicine and Surgery," *CMAJ* 9, no. 1 (January 1919): 3.

probability of a return to combat. An exhaustive study of the many afflictions soldiers experienced and their implications on long-term health is not possible here, but a few deserve special mention for the unique way they impacted both the Canadian medical effort during the war and questions over pensioning in the post-war period. Table 1.3 offers an overview of major illnesses that Canadian soldiers faced during the war.

TABLE 1.3 – COMMON DISEASES TREATED BY THE CANADIAN ARMY MEDICAL CORPS, 1914-19

DISEASE	TOTAL CASES	% OF TOTAL CASES TREATED	SAMPLE GROUP CASES	% OF SAMPLE CASES TREATED
Influenza	45,690	6.0%	56	10.0%
Mumps	9664	1.3%	12	2.1%
Tonsillitis	10,473	1.4%	10	1.8%
PUO/Pyrexia-NYD	20,342	2.7%	31	5.5%
Scabies	9559	1.3%	13	2.3%
Respiratory Conditions	n/a	n/a	36	6.4%
Total	95,728	12.6%	158	28.3%

Source: Macphail, Official History of the CAMC, chapter 21.

Poor sanitation was one of the chief causes of infectious disease and placed significant strain on the resources of the medical services. Even with the advent of sanitary sections and mobile laboratories, the filth of the trench system was impossible to circumvent. Much to the chagrin of medical officers, soldiers regularly relieved themselves within the trench networks or near water supplies. One 1st Canadian Division sanitation test carried out in 1915 found that only 121 of 286 (42 per cent) water carts tested for purity were properly treated.¹²⁸ In light of the devastating impact microscopic

¹²⁸ Quoted from Rawling, 72.

pathogens could have on the health of frontline soldiers, this lack of standards drew a stern response from the division's medical director, a reaction that was certainly justified. Paratyphoid, dysentery, gastrointestinal infections and other maladies spread through contaminated food or water had wreaked havoc on armies in past wars, and the terrain of the Western Front was certainly conducive to their proliferation. Reported infections, however, were generally low. Typhoid, for example, affected an “infinitely small” 422 men, while only 1124 cases of dysentery were reported.¹²⁹

The unique conditions experienced on the Western Front also spawned less well-understood illnesses. ‘Trench Fever’—also labelled ‘Pyrexia Unknown Origin’ (PUO) or ‘Pyrexia Not Yet Diagnosed’ during the early stages of the war—was a particularly frequent sickness soldiers contracted while at the front. Acute symptoms usually lasted for several days and were characterized by a sudden onset of high fever, headache, and deep pains in the back and legs.¹³⁰ While almost never fatal, complications could arise, leaving soldiers debilitated or susceptible to other sequelae such as DAH, rheumatism, or debility.¹³¹ Influenza was the most common cause of sickness and also corresponded with a comparatively high morbidity rate due to respiratory complications. 776 fatalities, most resulting from the pandemic of 1918, occurred as a result of flu or secondary infections.¹³²

¹²⁹ Macphail, 250-52. In the Boer War Macphail notes that typhoid was responsible for some 57,684 casualties and 8022 deaths amongst the Imperial Forces.

¹³⁰ Macpherson, *Diseases of the War*, vol. II, 362-68.

¹³¹ Macpherson, *Diseases of the War*, vol. II, 368-71.

¹³² Macphail, 266.

Respiratory disease also plagued Canadian soldiers. Overall statistics for the CEF are not available, but within the sample group there were 43 instances of hospitalization for respiratory illness shared among 36 patients, making it the third highest source of non-combat wastage next to influenza and venereal disease.¹³³ While certain conditions such as bronchitis or pleurisy could be treated with bed rest and special diet, military medicine had few answers for illnesses that became chronic or were in an advanced state upon hospitalization.¹³⁴ These advanced cases broached difficult questions surrounding attributability, a core theme found throughout this study that highlights the growing divide between the managerial and humanitarian approaches to medical rehabilitation and the realities of pensioning. Military physicians might rule that a disability such as chronic bronchitis or emphysema was the result of ‘service conditions’ by the mere fact that the symptoms emerged while in uniform. But if a man had not been gassed, or there was not a clear link between the onset of symptoms and an acute primary condition (influenza or diphtheria, for instance), pension medical officials were more hesitant to attribute these disorders to ‘exposure.’ More problematic were cases that developed after service—was it plausible for symptoms of chronic pulmonary disease to remain dormant for five, even ten years after being exposed? To the sceptical pension examiner post-war lifestyle and living conditions surely would have had some effect on the genesis of the illness, but to what degree, if any, did war service contribute?

¹³³ In total the CAMC treated 66,083 cases of venereal disease overseas, more than 10 per cent of all casualties unrelated to battle. See Macphail, 287. Within the sample group a total of 36 patients were hospitalized during the war for some form of venereal disease, many of them on multiple occasions.

¹³⁴ Katherine McCuaig, *The Weariness, the Fever, and the Fret: The Campaign Against Tuberculosis in Canada, 1900-1950* (Montréal and Kingston: McGill-Queen’s University Press, 1999), 37-39.

Even if we only account for soldiers who went on to receive a pension award, the incidence of respiratory disability amongst CEF veterans is still striking. By 1939, 12,533 ex-servicemen—15.6 per cent of all disability pensioners—held a pension award for some form respiratory disease, second only to disabilities for gunshot wounds.¹³⁵ More indicative of the severity of these cases was the sheer cost to the public: the annual liability (excluding medical treatment) for an average respiratory pensioner in 1939 was \$495.71. The gross annual liability for the two categories of gunshot wounds plus amputees—some 32,795 veterans—was \$370.60 per pensioner.¹³⁶

Pulmonary tuberculosis was the most troubling of all of these sources of disablement. As an affliction popularly associated with poverty and unsanitary living conditions, and generally treated by voluntary organizations and charities, military authorities were largely indifferent to the possibility that young, fit, Anglo-Canadian men would carry the infection with them into the army. The increasing presence of the ‘white plague’ amidst early waves of recruits, however, began to cast doubt on the superior health of Canada’s fighting men and the ability of modern medicine to screen, contain, and manage the disease. Enlistees who showed no physical signs of TB were easily passed as ‘fit,’ only to later break down under the strain of training, or in less advanced cases, after months of overseas service.¹³⁷ Yet military physicians were largely uncritical of this reality:

¹³⁵ *Report of the Work of the Department of Pensions and National Health* (Ottawa: King’s Printer, 1939), 66. Hereafter cited as *DPNH Report*.

¹³⁶ *DPNH Annual Report* (1939), 66.

¹³⁷ Bill Rawling, 107-109

Far be it from me to cast any reflection upon the medical officer who may have passed these men as fit, for the physical examination of the recruits, while it is as thorough as possible to make in the time at one's disposal, obviously does not include an examination of either the urine or sputum. Even were either of these accessible, it is a very easy matter to overlook these items when the physical signs do not arouse suspicion.¹³⁸

Service conditions rather than negligence, concluded this physician, were probably more to blame than anything for the mounting scale of the problem.¹³⁹ This uncertainty about when, how, or why someone contracted tuberculosis would continue to perplex pension officials and prove to be one of the most difficult questions facing veterans' authorities in the years after the war.

Fears that infection might spread amongst men living in close quarters led many physicians to take an overly vigilant approach to the diagnosis of potentially tubercular soldiers. One investigation discovered that some 38 per cent of suspected TB cases returned to Canada were later found to be non-tubercular as a result of misdiagnosis.¹⁴⁰ It was not until late in the war that standardized testing and treatment criteria were established, initiated primarily by the Military Hospitals Commission and later adopted by the CAMC in England.¹⁴¹

If a tubercular soldier had entered the service as a result of medical error, however, the state was obligated to provide treatment and a pension.¹⁴² Given this reality, proper diagnosis and care were absolutely essential to limit the frequency of relapse. In

¹³⁸ Hobart Reed, "End Results of the Various Disabilities of the Returned Soldier," *CMAJ* 7, no. 3 (March 1917): 209.

¹³⁹ Reed, 210.

¹⁴⁰ C.D. Parfitt and D.W. Crombie, "The Classification of the So-Called Tuberculous," *Medical Quarterly (Department of Soldiers' Civil Re-establishment)* (April 1919), 61.

¹⁴¹ McCuaig, 40-45.

¹⁴² A.T. Bond, "Principles of Pensioning in Cases of Tubercle of the Lung," *Medical Quarterly (Department of Soldiers' Civil Re-establishment)* (January 1919), 49-51.

November 1917 the CAMC opened its first dedicated hospital for TB cases, a 150-bed facility at Lenham, Kent.¹⁴³ But whereas other special hospitals had to contend with the ebb and flow of heavy casualties, Lenham received a steady trickle of patients who would be promptly sent before the pension authorities for final ruling on their condition before being discharged to Canada. Treatment varied depending on the severity of infection: active cases of TB were given rest and fresh air so as not to aggravate the illness, while those in a ‘passive’ or ‘arrested’ state were placed on a regimen of graduated outdoor exercise to help restore strength and vitality.¹⁴⁴ On the home front, where a more complex scheme of rehabilitation emerged under the direction of the MHC, patients were admitted to civilian and military sanatoriums where similar approaches to physical therapy, and increasingly occupational therapy were administered.¹⁴⁵ In either context, medical authorities ultimately faced the familiar yet unpleasant reality that TB ‘treatment’ was about symptom relief rather than facilitating a cure.

The number of soldiers who developed TB either prior to enlistment or as a result of aggravation is elusive principally because of the disease’s morbidity and progressive character. Within the sample group there were five cases of infection identified while in service. Nine other soldiers developed the disease after being discharged, making the overall infection rate 3.6 per cent. In total the CAMC treated 3123 cases of TB during the

¹⁴³ *Report of the Ministry, Overseas Military Forces of Canada, 1918* (London: Overseas Military Forces of Canada, 1919), 399.

¹⁴⁴ “The Treatment of Soldiers Suffering From Pulmonary Tuberculosis,” *CMAJ* 6, no. 11 (November 1916): 1010-12.

¹⁴⁵ McCuaig, 38-39.

Great War, 176 of whom died in military hospitals.¹⁴⁶ As of 1928 there were 4957 veterans receiving a pension for TB, but the actual number of former CEF members who carried a latent form of the disease with them through their service, and developed symptoms afterwards, is probably much higher.¹⁴⁷ Many TB pensioners were never treated by the CAMC, but the morbid nature of the disease—not to mention the medical politics of attributability—also means that pension statistics can only provide a crude snapshot of its prevalence.

V. MILITARY ‘UNFITNESS’

The incidence of incipient diseases like tuberculosis within the ranks of the CEF was as much the result of lax medical screening standards as it was a reflection of poor living conditions on the front lines. While many studies of disability and war focus on the maiming effects of combat, few have meaningfully appraised how ‘unfitness’ before enlistment contributed to the proliferation of disability. Canada’s citizen army attracted a diverse cross-section of men of military and non-military age. The process by which these soldiers were selected for military service involved an obligatory medical examination carried out by a medical officer (almost always a civilian practitioner) when the recruit reported for duty. In addition to assessing the recruit’s age, the examiner measured weight, height, and chest size, documented their appearance (including any visible scars,

¹⁴⁶ Macphail, 268.

¹⁴⁷ *BPC Report* (1928), 10.

marks or physical deformities), and performed a dental assessment.¹⁴⁸ Beyond standard tests indicated on medical examination forms, MOs would have to consider additional medical history provided by the man or his kin to determine eligibility for service.¹⁴⁹

Initial mobilization orders specified that recruits were physically fit for service in the infantry if they were between the ages of 18 and 45, a minimum of 5' 3" tall, and had a chest measurement of 33 inches.¹⁵⁰ These standards were progressively lowered as the war continued and manpower needs became more pressing. Even so, figures compiled by the Department of Militia and Defence in 1916 suggested that perhaps 20 to 25 per cent of voluntary enlistees failed to meet even the most basic physical standards necessary to be taken on strength of the CEF.¹⁵¹ Scattered reports from disgruntled medical officers overseas suggested that a similar proportion of 'undesirables' were being discovered regularly within combat units, adding significant strain to an overburdened medical system.¹⁵²

¹⁴⁸ For an example, see attestation record for #2293553 Private John Donald McKenzie available through Library and Archives Canada's "Soldiers of the First World War: 1914-1918" database: <http://data2.archives.ca/cef/gpc012/529360b.gif> (accessed July 17th, 2013).

¹⁴⁹ Nic Clarke, "'You will not be going to this war': The Rejected Volunteers of the First Contingent of the Canadian Expeditionary Force," *First World War Studies* 1, no. 2 (October 2010): 163-67. Also see his dissertation "Unwanted Warriors: The Rejected Volunteers of the Canadian Expeditionary Force" (PhD diss., University of Ottawa, 2009).

¹⁵⁰ "Mobilization Order – Qualifications for Service," 17 August 1914, cited in *General Orders, Militia Orders and Precis of Headquarters Letters Bearing Upon The Administration of the Canadian Army Medical Service Published Between August 6 1914 and December 31, 1916* (Ottawa: Militia Council, 1917), 14. Hereafter cited as *CAMC Orders*.

¹⁵¹ Clarke, "'You will not be going to this war,'" 162. The total estimate does not include the 105,000 conscripts taken on the strength of the CEF between August 1917 and November 1918, nor does it include the unknown number of soldiers who were rejected at recruiting stations.

¹⁵² Desmond Morton and Glenn Wright, *Winning the Second Battle: Canadian Veterans and the Return to Civilian Life, 1915-1930* (Toronto: University of Toronto Press, 1987), 24-25.

Age proved a superficial barrier to successful enlistment. In one reported case a 14-year-old soldier, standing 4'11" and weighing a mere 95 pounds, managed to find his way into the frontline trenches.¹⁵³ At least 7 per cent of the sample group joined the CEF between the ages of 15 and 17; most were not identified as underage until the war was over.¹⁵⁴ One of Canada's oldest enlistees, a 79-year-old Guelph, Ontario man, was able to navigate his way to England before he was reported to military physicians who found him "in an advanced state of senility" and subsequently returned him to Canada.¹⁵⁵ Other cases of physical defects were more confounding. Soldiers with missing digits, partial amputations, and the 'mentally deficient' were all present within the First Canadian Contingent and subsequent waves of reinforcements.¹⁵⁶ One striking example was revealed in January 1916 when the Assistant Director of Medical Services (ADMS) of 1st Canadian Division discovered a soldier with a clubfoot during a routine inspection of a reinforcement draft. Much to the dismay of the ADMS, four separate medical officers had given the private from Vernon, British Columbia a clean bill of health before his arrival in France.¹⁵⁷

¹⁵³ On underage soldiers see Tim Cook, "He Was Determined to Go': Underage Soldiers in the Canadian Expeditionary Force," *Histoire Sociale / Social History* 41, no. 81 (May 2008): 73.

¹⁵⁴ There were 27 cases in total, seven of which were discharged as a result of being underage. Pension records are the best source for revealing a soldier's true age, however, since only 50 per cent of the sample returned a pension record, it is plausible that this number is in fact much higher – perhaps as many as 10 per cent of war survivors. As Tim Cook explains, however, the true number can never be known; it is a matter of scholarly guesswork. See Cook, "Underage Soldiers," 71-74.

¹⁵⁵ Morton and Wright, 25.

¹⁵⁶ Morton and Wright, 24-25.

¹⁵⁷ WD, ADMS 1st Canadian Division, 21 January 1916, RG 9-III-D-3, vol. 5024, file 814, part 1, LAC.

The physical deficiencies found among CEF recruits should not have been surprising. Eligible men of military age came primarily from working-class backgrounds and had been exposed to innumerable health risks inherent to turn-of-the-century industrial labour.¹⁵⁸ In 1915, travelling CAMC medical boards were introduced to examine all members of the services at routine intervals.¹⁵⁹ Each division's ADMS and the DDMS of the Canadian Corps also took an increasing role inspecting men classified as 'Temporarily Unfit,' or 'Permanent Base,' both to guard against malingering and to determine their usefulness elsewhere. When possible, medical boards were instructed to identify the name of the MO who had originally passed the medically unfit man into the service.¹⁶⁰ It was hoped that fear of discipline would dissuade over-zealous or neglectful officers from allowing unsuitable recruits to travel overseas.

Despite the army's best efforts, the endemic poor health of among recruits continued. By mid-1916 recruitment efforts had grown desperate after months of steady decreases and several waves of heavy casualties. Enlistees fell steadily from a high of 33,960 in March to a mere 4930 in December.¹⁶¹ For the whole year of 1917 they only reached a total of 63,611.¹⁶² To fill the growing needs of the CEF many recruiters began recklessly accepting overage men who had come forward in the hope of receiving a steady paycheque and doing 'their bit.' Private John L., a teamster from New

¹⁵⁸ David Silbey, "Bodies and Cultures Collide: Enlistment, the Medical Exam, and the British Working Class, 1914–1916," *Social History of Medicine* 17, no. 1 (2004): 61-76. On the poor health of recruits in the American context see Beth Linker, "Feet for Fighting: Locating Disability and Social Medicine in First World War America," *Social History of Medicine* 20, no. 1 (April 2007): 91-109.

¹⁵⁹ "No. 107 – Discharge of Recruits Not Medically Fit," in *CAMC Orders*, 87-88.

¹⁶⁰ "No. 107 – Discharge of Recruits Not Medically Fit," in *CAMC Orders*, 87-88.

¹⁶¹ Nicholson, Appendix C.

¹⁶² Nicholson, Appendix C.

Westminster, British Columbia, for example, enlisted on 8 June 1916 at the age of 51, but stated that he was just 44. Like many older enlistees coming from a life of heavy labour, John was not in perfect health. He suffered from chronic foot problems that caused him “considerable pain” when walking long distances, showed signs of arteriosclerosis, and even had one of his toes amputated shortly after enlistment. Despite his poor record of health, John L. would serve over 900 days in the CEF, including 14 months in France as a member of the 4th Canadian Railway Troops.¹⁶³ Private Joseph B., another questionable recruit, joined the CEF on 5 April 1917 at the age of 57, also giving a stated age of 44. A bushman by trade, Joseph’s pre-discharge medical examination showed that he had “malformed little fingers,” was suffering from defective vision, debilitating varicocele, as well as “partial loss of function of cardio-vascular system [and] muscular system.”¹⁶⁴ A final medical board ruled that while both the varicocele and cardio-vascular were pre-enlistment conditions, each had been aggravated while serving with the Forestry Corps in France.¹⁶⁵

These are just two typical examples of soldiers recruited to satisfy the pressing manpower needs of the CEF before conscription was introduced in August 1917. Canada’s army needed men and, even with threat of punitive action from senior military officials, recruitment medical officers—and perhaps many middle-level medical authorities overseas—were either wilfully turning a blind eye, or lacking the competency to determine what impact pre-existing conditions might have on a man’s military

¹⁶³ Personnel File, John L., RG 150, Accession 1992-93/166, Box 5809 – 36, LAC.

¹⁶⁴ Personnel File, Joseph B., RG 150, Accession 1992-93/166, Box 746 – 43, LAC.

¹⁶⁵ Personnel File, Joseph B., RG 150, Accession 1992-93/166, Box 746 – 43, LAC.

efficiency and future health. Much to the vexation of pension authorities, they were also inadvertently adding men to the pension roll: both John L. and Joseph B. were granted pensions for aggravation of pre-enlistment conditions following the war.¹⁶⁶

The circumstances these men faced were not unique. Over 10 per cent of the sample group was discharged as a result of being overage, underage, ‘undesirable,’ or unfit for further service due to pre-existing medical conditions. Overage soldiers ($n=7$) accounted for 6.3 per cent of all soldiers prematurely discharged as ‘medically unfit,’ serving an average of 613 days, most of them on duty overseas. Nearly 20.7 per cent of all medically discharged soldiers ($n=23$) had a documented pre-enlistment disability. As authorities would discover after the war, the proportion was in fact much greater. As Figure 2.1 in this dissertation’s statistical appendix shows, the frequency of ‘invisible wounds,’ including respiratory diseases, nervous conditions (traumatic and otherwise) as well as ‘special senses’ (defective vision and hearing) comprised a substantial portion of all pensioned disabilities.

Combat wounds, as many military medical authorities (but not necessarily the public or politicians) had come to expect, were not the dominant source of disability. Although nearly 85 per cent of pensions awarded were held by men who served in France, the numbers indicate that many disabilities came from uncertain origins, and were often much different than military and civilian medical authorities had previously

¹⁶⁶ Pension File, Joseph B., Veterans Affairs Canada [hereafter ‘VAC’], and Pension File, John L., VAC.

anticipated.¹⁶⁷ ‘Invisible wounds’—disease, internal damage to the physiological systems of the body, and aggravated pre-war conditions such as flat feet—in their totality were as commonplace, if not more endemic than weakened limbs, disfiguring scars, blindness, or amputations. The male body in the Great War was certainly intended to be mutilated (as Joanna Bourke poignantly observes) but in many respects disability and its prevalence was also a matter of neglect, accident, or predestination. In other words, to see the full extent of the war’s impact on veterans’ health, *we must look everywhere* to uncover the genesis of disability.

VI. CONCLUSION

The preceding analysis confirms that the medical experience of the Great War is more complex than is often acknowledged within both the military historiography and the burgeoning literature on the bodily impact of the war.¹⁶⁸ From recruitment to discharge, soldiers and practitioners encountered one another in nearly every aspect of military life. Medical care was not isolated to the confines of the hospital; it was a pervasive feature of military management with its own distinct approach and culture. Military medicine stressed efficiency, but within a framework of corporeal and institutional discipline there

¹⁶⁷ *BPC Report* (1922), 16. Statistics are not available for 1921, however, a perusal of the annual reports for both the BPC and Department of Pensions and National Health shows that the rate remained relatively consistent throughout the inter-war period.

¹⁶⁸ Recent examples have focused in particular on the aesthetic implications of maiming and disfigurement and its relationship with rehabilitative medicine. See Ana Carden-Coyne, “Ungrateful Bodies: Rehabilitation, Resistance and Disabled American Veterans of the First World War,” *European Review of History* 14, no. 4 (2007): 543-65; Sandy Callister, “Broken Gargoyles,” 111-30; Suzzannah Biernoff, “The Rhetoric of Disfigurement in First World War Britain,” *Social History of Medicine* 24, no. 4 (2011): 666-85; Beth Linker, “Shooting Disabled Soldiers: Medicine and Photography in World War I America,” *Journal of the History of Medicine and Allied Sciences* 66, no. 3 (2011): 313-46; idem, *War’s Waste: Rehabilitation in World War I America* (Chicago: University of Chicago Press, 2011).

was also compassion, humanitarianism, and above all, a progressive belief that medical science had the power to heal for the betterment of the patient, the army, and the nation. In a number of respects the war witnessed remarkable achievements in attaining these ends. Disease, once far more devastating to armies than the actual battles, was responsible for only 1 of 21 military deaths. Less than 1 in every 100 hospitalizations for sickness/disease resulted in a fatality.¹⁶⁹ Severely wounded men who in past wars would have succumbed to shock, tetanus, sepsis, or gangrene all had a more promising prognosis thanks to innovations in military surgery and the management of secondary infections. Ironically, these life-saving techniques also added more men to the growing population of permanently disabled—men whose bodies needed to be healed then ‘reclaimed’ through reconstruction and rehabilitation. This requirement of military medicine made the Great War a watershed for the professionalization of nursing, orthopaedic surgery, and physical and occupational therapy.¹⁷⁰ It also fuelled patriotic calls for Canadians to support the disabled man as they returned. With gumption, opportunity, and masculine comportment, the harshest economic effects of disability could be overcome.

But if we are to understand how the war truly impacted the lives of those who served, we must move beyond the military medical gaze, its achievements, and its shortcomings. The scale of disability, how soldiers and medical authorities constructed

¹⁶⁹ Macphail, 243.

¹⁷⁰ On the relationship between war and modern medical innovation see Roger Cooter, “Medicine and the Goodness of War,” *Canadian Bulletin of Medical History* 7 (1990): 147-59; idem, *Surgery and Society in Peace and War: Orthopaedics and the Organization of Modern Medicine, 1880-1948* (London, Macmillan Press, 1993); Mark Harrison, “The Medicalization of War – the Militarization of Medicine,” *Journal of the Society for the Social History of Medicine* 9, no. 2 (August 1996): 267-76; Roger Cooter, Mark Harrison and Steven Sturdy, eds., *War, Medicine and Modernity* (Stroud, UK: Sutton Publishing, 1998); idem, eds., *Medicine and Modern Warfare* (Amsterdam: Rodopi, 1999).

these conditions, and how they were experienced all interacted to inform the wartime discourse on disability. Men's bodies were not mere objects of medical science to be prodded, evaluated, or discarded. At every stage of the treatment chain soldiers exercised agency. Some worked against the grain of the military-medical bureaucracy, feigning injury or malingering to escape combat. Others, seemingly helpless at the hands of physicians and nurses, sought comfort and reassurance from their caretakers or through letters home to loved ones. Many faced a lengthy, frustrating period of recovery weighted by devastation over their altered physical abilities and the anxiety of not knowing how their kin or friends might react. Wartime experiences would have a significant bearing on how soldiers constructed memories of their service and navigated the politics of pensions, health, disability and citizenship in the post-war period.

War engendered hyper-masculinised expectations of martial ability, and correspondingly, compelled the male-dominated medical profession to idealize rehabilitation as a holistic process of physical, mental, and occupational reconstruction. Real men could overcome disabilities, irrespective of their temporary or permanent limitations. But the disabled that the medical profession encountered were more diverse and in greater numbers than was anticipated. Soldiers entered the ranks in varying states of health. In the drive for army recruitment tens of thousands of Canadians, some mere boys, others too elderly, and many suffering from deformities or chronic disease, were taken on strength of the CEF, thereby gaining access to the state's medical resources and the possibility of a pension. It was ultimately the responsibility of military medical authorities to serve as gatekeepers: if injury or illness occurred during service, or if a pre-

existing condition was aggravated in any credible way, it became the state's responsibility. That obligation had serious post-war consequences for veterans seeking compensation. As policy-makers and pension authorities quickly discovered, men who may have appeared otherwise healthy upon enlistment could easily break down under the strain of persistent physical drill and camp life. Even more sojourned to the front lines only to report ill with conditions that confounded and frustrated senior medical authorities.

Numbers and scale also matter, and while we should be cautious about speaking of disability in strictly quantitative terms—many who suffered are not found in the 'official' statistics for varying reasons—they suggest why we must reconfigure our understanding of the war's impact on the human body and mind. 'Invisible wounds' were more common than those caused by shrapnel or bullets. That a significant proportion of Canada's military-aged men were simply unfit to continue fighting for their country, or even fight in the first place, were facts that few within civilian or military circles entertained in the Fall of 1914. Disability raised uncomfortable questions about the competence of army officials, the efficacy of military medicine, as well as the health of a young and presumably virile dominion. The state of health of men in their prime might not have been worthy of public concern and attention in normal times, however, the upheavals experienced on the home front and medical crisis that gradually preoccupied the nation ensured that soldiers' health took centre stage as a pivotal question for post-war reconstruction. As we shall see, developments in 1915, including the first wave wounded from Ypres and the 'undesirables' who were returned after succumbing to the harsh

winter conditions on the Salisbury Plain forced the government authorities to begin radically altering their approach to the care of Canada's Great War disabled.

Chapter 2: ‘A Rude Awakening’: Managing the Crisis of the Disabled on the Canadian Home Front, 1914-19

William Harry Jennings, who we met in the previous chapter, returned to Canada on 28 March 1915 aboard the transport ship *Scandinavian*.¹ Among the ship’s 800 passengers were some of the first soldiers invalided back to Canada from the First Canadian Contingent. The long trans-Atlantic voyage had been miserable. Jennings along with 22 other soldiers, almost all suffering from “rheumatism,” had spent their entire journey crammed into steerage class below deck.² The food was poor and the weather bitterly cold. When they arrived at Halifax there was little pomp and circumstance—a set of cheap clothes and a coach-class train ticket were the limits of the nation’s generosity.³

After arriving in Toronto by train Jennings travelled in a slat-seated car to his hometown of Forest, Ontario, a distance of over 250 kilometres, to reunite with his parents. Early into his stay he fell severely ill with an acute case of pleurisy, a debilitating inflammatory infection of the lungs characterized by a heavy cough, high fever, short and shallow breath, and rapid pulse.⁴ With no military hospitals nearby, Jennings was only able to receive treatment from a local civilian practitioner. In July two Canadian Army

¹ Personnel File, William Harry Jennings, RG 150, Overseas Military Forces of Canada [hereafter ‘RG 150’], Accession 1992-93/166, Box 4825 – 24, Library and Archives Canada [hereafter ‘LAC’].

² “Injured Canadians Return,” *The Edmonton Bulletin*, March 29th, 1915, 1.

³ Desmond Morton, *When Your Number’s Up: The Canadian Soldier in the First World War* (Toronto: Vintage, 1993), 253.

⁴ Pension File, William Harry Jennings, VAC.

Medical Corps (CAMC) physicians visited Jennings from the local military district headquarters, granting him pay and allowances while he continued to convalesce at home, though no treatment was provided. The pleurisy, medical evidence would later show, was contracted overseas but had evidently gone unnoticed by military physicians in England.⁵

Looking to take up his former occupation as a compositor for the *Calgary Daily Herald*, Jennings left Forest in December 1915. His health, however, continued to deteriorate. For the remainder of the war the lingering effects of pleurisy and recurrent paralysis in his right arm from the neurological effects of a gunshot wound to the head plagued him on a daily basis. No longer able to write effectively, he was assigned to a reader's desk and carried out proofreading duties for the *Herald*. Friends and co-workers claimed that Jennings often lost time at work due to illness and frequently complained about severe pain in his right side. He was simply not as "robust" as he had been before the war.⁶ His pension, originally granted at a rate of 20 per cent, had been discontinued for a one-time gratuity of \$600.00 after medical authorities convinced the veteran that his disability would be 'negligible' once he learned to write with his left hand. The more crippling condition was his susceptibility to illness as a result of his lung troubles. With no opportunity for retraining and no access to medical resources available, the veteran struggled to make ends meet until he was hospitalized with bronchopneumonia in April 1925. Tragically, Jennings passed away a few weeks later at the age of 36.⁷

⁵ Personnel File, William Harry Jennings, RG 150, Accession 1992-93/166, Box 4825 – 24, LAC.

⁶ Pension File, William Harry Jennings, VAC.

⁷ Pension File, William Harry Jennings, VAC.

Like hundreds of Canadian soldiers who returned home from the Great War in its early stages, Jennings had fallen through the cracks of a predominantly voluntary treatment system that remained ill-prepared to take on the monumental task of rehabilitating and restoring the sick and wounded to civilian life. Canadians had little experience dealing with veterans when they went to war in 1914. In the aftermath of previous conflicts such as the 1885 Rebellions or the Boer War, compensation for disability typically consisted of a meagre pension or gratuity and a parcel of land.⁸ In a nation with only a tiny permanent force and a volunteer militia there seemed to be little need for profligate, American-style ex-soldiers' benefits. Indeed, the rising costs of Civil War pensions and the excessive political influence of the Grand Army of the Republic served as cautionary tales for Canada's politicians as they contemplated pension reform in the aftermath of the Boer War.⁹ Private charity and individual resolve were much-preferred alternatives to a complex system of state support that would be prone to corruption and would quickly drain vital public revenue. On the eve of the Great War benefits for disabled and deceased soldiers had changed little from the meagre scheme of compensation created for aging War of 1812 survivors some 40 years prior.¹⁰

The Great War quickly rendered this approach to the treatment of the disabled obsolete. In a matter of a few months Sir Sam Hughes' national recruiting campaign had

⁸ Desmond Morton and Glenn Wright, *Winning the Second Battle: Canadian Veterans and the Return to Civilian Life, 1915-1930* (Toronto: University of Toronto Press, 1987), 14.

⁹ On the history of the GAR and the politicization of pensions see Stuart McConnell, *Glorious Contentment: The Grand Army of the Republic, 1865-1900* (Chapel Hill: University of North Carolina Press, 1992), and Larry M. Logue and Peter Blanck, *Race, Ethnicity, and Disability: Veterans and Benefits in Post-Civil War America* (Cambridge: Cambridge University Press, 2010).

¹⁰ Desmond Morton, "Resisting the Pension Evil: Bureaucracy, Democracy, and Canada's Board of Pension Commissioners, 1916-1933," *Canadian Historical Review* 68, no. 2 (1987): 199-200.

raised more troops than in all of Canada's previous wars combined. Upon arriving at Valcartier thousands were immediately rejected due to poor health. Hundreds more passed through lax medical screening only to break down under the strain of training overseas. The horrendous conditions experienced by the first troops who entered the trenches in early 1915 compounded the problem. As the scale of the medical calamity facing the Canadian Expeditionary Force (CEF) grew more alarming, military authorities and policy-makers were forced to ask difficult questions that had been ignored since the war's outbreak. What did the state owe to men who served by their own volition? How might the treatment of the disabled impact popular morale and support for the war? What long-term economic and social consequences would disability entail for post-war society? Could advances in modern medicine restore a man's capacity to work, thereby diminishing the state's future financial obligations?

This chapter explores how the state responded to the unprecedented task of caring for tens of thousands of disabled soldiers on the home front during the Great War. At the centre of this discussion are the Military Hospitals Commission (MHC) and its successor, the Department of Soldiers' Civil Re-establishment (DSCR). Formed in June 1915, the MHC began as a modest initiative organized by the Department of Militia and Defence and patriotic volunteers to acquire convalescent homes for disabled men and provide them with ongoing treatment. By the war's end Canada had one of the most sophisticated and extensive treatment networks of any combatant nation, spanning every province, and staffed by thousands of nurses, orderlies, physicians and specialists. The work of medically rehabilitating the disabled was a crucial first step in Canada's tripartite

approach to re-establishment. Pensions (explored in Chapter 3) and vocational retraining (explored in Chapter 4) could not function to their desired effect if a soldier's health was not first restored to the highest degree permitted by modern medicine. In a similar fashion to their military medical counterparts overseas, the MHC and DSCR were easily allured by scientific approaches to rehabilitation, fortifying their confidence that with the right treatment and mindset, any disability could be 'overcome.'

Conceiving and implementing a system of rehabilitation that could accommodate the unique needs of Canada's largely volunteer army was not without tribulation. Throughout its short history the MHC faced an uphill battle for access to resources and was often criticized by military authorities for its alleged lack of professional competence. As a civilian organization, critics could easily point out that in spite of its noble intentions the commission lacked the expertise and discipline to handle the sometimes uncooperative and unruly soldier-patient. This rivalry between civilian and military authorities led to a deepening crisis of identity within the Canadian treatment system as the humanitarian ideals of civilian volunteers increasingly clashed with the managerial pragmatism of military medical officials. In a final attempt to establish a line of separation between civilian medicine and military medicine, in early 1918 the MHC was amalgamated into the newly established DSCR and a majority of its facilities temporarily transferred to the army medical corps.

The conflict between civilian and military medical authorities was emblematic of a wider process of renegotiation and reinvention that took place in Canada during the Great War, one in which the state's role went through rapid and often abrupt changes.

Rehabilitation began as a largely volunteer effort, spearheaded by well-to-do citizens who wanted to do ‘their bit’ by offering compassionate support to the returning wounded. As these civilian efforts grew more formalized and recognizable, their practices began to clash with established military medical structures and a growing body of ‘expert’ opinion on how best to re-establish returning disabled soldiers. If rehabilitation was to succeed, the war disabled could not be left to their own devices: they had to be imbued with a desire to regain their physical vitality and return to a life of productive labour. This had always been the MHC’s ideal, but as this chapter will illustrate, pressures from within and outside of the organization compelled the state to take a more active role in cultivating medical expertise and managing the patient experience. The emergence of occupational therapy, reconstructive surgery, orthopaedics, and neuropsychiatry only bolstered expectations that the MHC and DSCR’s modern approach to healing would be unprecedented in its efficacy and totality.

Disability was nothing new to Canadians who had worked in the nation’s factories, mines, or railyards for several generations and experienced the dangers of an industrialized economy firsthand. But for the state, both the poor overall health of recruits and the physical toll the war exacted on men who went overseas precipitated a heightened awareness of the threat that disablement posed to the economic, social, and moral strength of Canadian society. Tackling this unprecedented social crisis—what I term the ‘crisis of the disabled’—necessitated a major reconfiguration of the government’s role in the lives of its citizens, a process that as numerous historians have shown, characterized the home

front experience throughout the war.¹¹ With the future health of the nation at stake, responsibility for the war's disabled could not be left solely to patriotic organizations or private charity. Citizen soldiers would demand certain rights as a condition of their service and Canada had to do better than previous generations in caring for its disabled.

Granted, there was also marked continuity with the pre-war period. Re-establishment and its key tenets—rehabilitative medicine, pensioning, and retraining—were informed by the prevailing ideologies and social attitudes of the day. Disability was still framed first and foremost as an economic impediment, meaning a soldier was effectively 'cured' when he was liberated from the financial burdens of disease or injury.¹² Pensions, treatment allowances, or retraining would help alleviate any lingering material hardships, but it was the responsibility of the disabled to make the most of the modern treatment and benefits granted to him.

As Joanna Bourke and others have pointed out, the Great War also stoked popular fears that dominant norms of masculinity were in a state of crisis.¹³ Canadians were not immune to such anxieties, and like other nations, rehabilitation and its promising objective of remaking broken men into self-sufficient breadwinners offered reassurance that the dominion's manhood would remain strong, industrious, and virile in the face of

¹¹ Robert Craig Brown and Ramsay Cook, *Canada 1896–1921: A Nation Transformed* (Toronto: McClelland and Stewart, 1974), especially chapters 11, 12, and 15; Jeff Keshen, *Propaganda and Censorship During Canada's Great War* (Edmonton: University of Alberta Press, 1996); Desmond Morton, *Fight or Pay: Soldiers' Families in the Great War* (Vancouver: UBC Press, 2004);

¹² J.L. Biggar, "State Medicine and Rehabilitation," *Canadian Medical Association Journal* [hereafter *CMAJ*] 9, no. 11 (November 1919): 1013-15.

¹³ Joanna Bourke, *Dismembering the Male: Men's Bodies, Britain and the Great War* (Chicago: University of Chicago Press, 1996), 11-13, 29-30. A more recent study is Ana Carden-Coyne, *Reconstructing the Body: Classicism, Modernism, and the First World War* (New York: Oxford University Press, 2009).

modernity.¹⁴ These dominant virtues of Victorian era manliness were imparted on soldiers during each stage of the rehabilitation process, from the hospital ward to the gymnasium, and finally the shop floor. Canada's post-war prosperity would hinge not only on the generosity displayed towards her returned soldiers, it would also be a reflection of their virtue and, as one popular re-establishment poster proclaimed, their commitment to achieve "victory over wounds."¹⁵ Those who failed did so because they lacked the patriotic zeal and masculine fortitude to do what was best for their families, communities, and above all, the nation. A grateful country would do its utmost to show them the light, but the state's long-term obligations were to be minimized as much as possible.

II. THE BIRTH OF THE MILITARY HOSPITALS COMMISSION

With the exception of the Princess Patricia's Light Infantry, few Canadian volunteers saw extensive combat until April of 1915 at the Second Battle of Ypres. In the aftermath of the gas attacks on 22 and 24 April, the press was inundated with stories of heroism, as well as outrage at Germany's barbaric disregard for 'civilized warfare.'¹⁶ Over 6000 soldiers were casualties, a full third of the 1st Canadian Division's fighting

¹⁴ Mike O'Brien, "Manhood and the Militia Myth: Masculinity, Class, and Militarism in Ontario, 1902-1914," *Labour / Le Travail* 42 (Fall 1998): 115-41; Mark Moss, *Manliness and Militarism: Educating Young Boys in Ontario for War* (Toronto: Oxford University Press, 2001), 15-16 and 110-15. The question of whether the Great War ushered in a new understanding of modernity in Canada is explored most fully in Jonathan F. Vance, *Death So Noble: Memory, Meaning, and the First World War* (Vancouver: UBC Press, 1997). For a recent contribution to this debate with an emphasis on the changing nature of the state see David Tough, "'The rich... should give to such an extent that it will hurt': 'Conscription of Wealth' and Political Modernism in the Parliamentary Debate on the 1917 Income War Tax," *Canadian Historical Review* 93, no. 3 (September 2012): 382-407.

¹⁵ "Victory Over Wounds, The Soldiers Return," War Records Survey Posters, Accession No. 1983-28-697, Box A158/X1, LAC.

¹⁶ Much of the early accounts were the result of Max Aitken, See "Canadians' Bravery Will Ever Occupy Prominent Place Among Glorious Deeds of British Army," *The Edmonton Bulletin*, May 1st, 1915, 1; and "Deeds That Stirred the British Empire: The Glorious Stand of the Canadians at Ypres," *Crossfield Chronicle*, August 6th, 1915, 6.

strength.¹⁷ Discussion of how these men might be cared for, especially those permanently disabled, garnered little public interest. The Department of Militia and Defence had appointed a committee of officers to look into the matter of providing convalescent homes for returned soldiers, but most of the CAMC's medical work and resources were tied up in recruitment or already overseas.¹⁸

The scale and severity of the casualties experienced at Ypres illustrated that the provision of long-term treatment was, at least for the time, beyond the capacity of Canada's army medical services. Following recommendations put forth by Red Cross Colonel George Sterling Ryerson, the Borden government finally responded to the question of caring for returned men by establishing the Hospitals Commission (later renamed Military Hospitals Commission) through order-in-council on 30 June 1915.¹⁹ Appointed to preside over the new organization was Conservative leader of the Senate James A. Lougheed, a Calgary real estate mogul who had also recently taken on the role of Acting-Minister of Militia and Defence in Sam Hughes' absence. Assisting Lougheed was a cast of well-known 'public men' drawn from the business and political world.

¹⁷ Tim Cook, *At the Sharp End: Canadians Fighting the Great War, 1914-1916* (Toronto: Viking, 2007), 165-66. For an overview of 1st Canadian Division's experience in 1914-15, see Andrew Iarocci, *Shoestring Soldiers: The 1st Canadian Division at War, 1914-15* (Toronto: University of Toronto Press, 2008).

¹⁸ "Statement of President of the Military Hospitals Commission," RG 38, Department of Veterans Affairs, Military Hospitals Commission fonds [hereafter 'RG 38'], Series B-1, Minutes, Memoranda, and Reports, vol. 287, [hereafter 'MHC Minutes'], LAC.

¹⁹ Morton and Wright, 7.

Ironically, the original membership contained only one doctor, a certain indication of the MHC's philanthropic underpinnings.²⁰

Lougheed showed little interest in his new appointment, instead devoting much of his time over the summer and early fall of 1915 attempting to manage the chaos of Hughes' militia department. With few resources and little expert guidance, the commission eagerly began to accept offers from wealthy citizens and patriotic organizations to provide bed space for returning wounded. Mining tycoon A.J. Moxham, for example, donated his Sydney mansion 'Moxham Castle' with accommodation for 100 patients. Founding MHC member W.M. Dobell and his wife were one of the first offers accepted, opening the doors of their Québec City home in the summer and autumn of 1915. In Hamilton, Ontario Mrs. P.D. Crerar along with several local ladies opened a small home with room for just 10 patients in September 1915.²¹ By October, the MHC had established 11 convalescent homes across Canada capable of caring for 530 patients, with dozens of additional offers remaining on the table.²²

When commission members reconvened for their second formal meeting on 18 October they could congratulate themselves on doing a great service to the war effort. For the time being, the MHC had helped military authorities find desperately needed beds for the sick and wounded. Soon, however, hundreds of new casualties incurred during the spring and summer months would be making the transatlantic voyage back to Canada. In

²⁰ *Report of the Work of the Military Hospitals Commission* [hereafter cited as *MHC Report*] (Ottawa: King's Printer, 1917), 18. The physician in question was Lt.-Col. Thomas Walker of Saint John. In addition, the Director General of Medical Services for the Department of Militia and Defence was also included on the roster as a permanent medical advisor and liaison.

²¹ *MHC Report*, 20-21, 27.

²² Morton and Wright, 19.

November 1915, with barely a week's notice, military authorities in England dispatched nearly 600 invalids aboard the steamer *Metagama*, catching the MHC completely off guard.²³ The '*Metagama* Incident,' as it came to be known, quickly deteriorated into a public embarrassment. Sick and wounded men arrived to find convalescent homes full to capacity, forcing many to return to their homes on derelict passenger cars requisitioned by the commission at the last minute.²⁴

The *Metagama* debacle brought into sharp focus both the limitations of the commission's resources and the need for further planning and communication with military medical officials at home and overseas.²⁵ Many returning casualties required artificial limbs, physical therapy, financial assistance, and training for future employment before they could be re-established. Facilitating this transition required the commission to both expand the scope of its work and also to take a more active role in the administration of care. For much of 1915 and early 1916 convalescent homes had been managed by a disparate collection of civilian physicians, nurses, and patriotic volunteers. Treatment consisted primarily of rest and leisure—few opportunities existed for convalescent patients to make 'productive' use of their time towards a full recovery.²⁶ Frequent inspections of the homes raised concerns within the leadership of the MHC that complacency was becoming endemic amongst patients. A new model was needed.²⁷

²³ Morton, *Fight or Pay*, 136-37.

²⁴ "Broken Men Back from War are Turned Into Cars Unfit for Horses," *The Edmonton Bulletin*, November 24th, 1915, 6.

²⁵ Morton, *Fight or Pay*, 136-37.

²⁶ Untitled Report, RG 38, MHC Minutes, LAC.

²⁷ Military Hospitals Commission, *Military Hospitals Commission: Special Bulletin, April 1916* [hereafter *MHC Special Bulletin*] (Ottawa: King's Printer, 1916), 5.

It was not the British, but the Belgians and French whose approach to rehabilitation that the commission found to be most compatible with its own fledgling program.²⁸ Overseas investigations throughout late 1915 and early 1916 uncovered the path-breaking work of Dr. Jules Amar and the treatment scheme in force at the Anglo-Belgian Hospital in Rouen. A well-known French physiologist and social reformer, Amar quickly emerged during the Great War as one of the world's leading authorities on the rehabilitation of disabled soldiers.²⁹ His system was particularly revered for its scientific methods and specialized devices that allowed physicians to assess the degree of a man's incapacity on a percentage-based scale, offer a detailed prognosis, and, if necessary, make pension recommendations. In order to restore the disabled to their full economic capacity, under the 'Amar system' (as Canadians came to call it) patients first underwent a strict routine of functional retraining where they were emancipated from their physical handicaps to greatest extent that modern medical science would allow. To enhance the functionality of amputation cases, Amar had also developed groundbreaking new prostheses, including a fully moveable artificial work-arm with detachable hooks and grabbers that amputees could use to grasp hand tools or operate complex machinery.³⁰

²⁸ A detailed overview of the French approach to rehabilitation of the disabled is given in J.L. Todd, *The French System for Return to Civilian Life of Crippled and Discharged Soldiers* (New York: The Red Cross Institute for Crippled and Disabled Men, 1918), and Dr. Bourillon, "Re-education of Disabled Men," in *Proceedings of the Inter-Allied Conference on the After-Care of Disabled Men* (London: H.M.S.O., 1918), 111-23.

²⁹ For a first-hand account of Amar's approach to rehabilitation during the Great War, see Jules Amar, *La rééducation professionnelle des mutilés de guerre* (Paris: Renouard, 1917). Also see Jules Amar, Bernard Miall, and Albert Kent, *The Physiology of Industrial Organization and the Re-employment of the Disabled* (New York: Macmillan, 1919).

³⁰ Todd, *The French System*, 9-10.

At the Anglo-Belgian hospital in Rouen Canadians witnessed Amar's miraculous system in full flight. Here hundreds of patients underwent a series of rigorous therapies including radiant heat, electricity and radiology (for healing scar tissue) hydrotherapy, and various forms of electrotherapy intended to stimulate nerves and restore function to paralytic muscles. As patients progressed through their treatment regimen they were also introduced to mechanotherapy, a form of passive and active physical exercise aided by apparatuses specially designed to replicate natural movements.³¹ Whenever possible active exercises were preferred for orthopaedic cases and amputees: "The advantage is that he attacks his disability directly, watches his improvements from day to day, and aims at consistent recovery."³²

As a patient regained confidence in his movements, hospital staff introduced him to more rigorous exercises under the broad label of 'medical gymnastics.'³³ Resistance and natural movement were essential to the rehabilitation process because they helped a patient witness an appreciable change in his physical abilities while also allowing physicians to assess his degree of permanent incapacity.³⁴ The object of healing was to minimize the financial impact of disability for the sake of the soldier, his family, and his country. Patients who responded well to therapy, however severe their injuries had been, could be relied upon to further contribute to the war effort by undertaking retraining and rejoining industry. The most eager patients would use these opportunities to advance

³¹ *MHC Special Bulletin*, 53-72.

³² "Functional Re-education," *Reconstruction* (March 1918): 13-14.

³³ *MHC Special Bulletin*, 61-64.

³⁴ Todd, *The French System*, 5-6.

themselves occupationally over their pre-war status. Those who chose not to seek out a ‘cure’ were guilty of shirking their patriotic duty.³⁵

Having recognized that a pedestrian approach to the care of its disabled soldiers might have dire consequences for the war effort and post-war society, the Military Hospitals Commission was quick to incorporate the ethos underpinning the French and Belgian systems into its own work. Disabled men required discipline, physical activity, and moral guidance in order to ward off the psychological effects of injury and facilitate rehabilitation; something Canada’s military hospitals overseas did not always have the space or resources to provide. Indeed, as MHC member Senator J.S. McLennan pointed out in a 1916 special bulletin:

The wounded man returns to Canada with only part of his treatment completed. He is eager for the sight of his home, the prospect of which has often sustained him in irksome hours, he is eager to meet his kinsfolk and friends, conscious that he has deserved well of his country, but he is weakened by wounds or disease, his initiatives slackened by enforced idleness, his fibre softened by experiences which are enervating so that only in exceptional cases can he have the outlook and the self-dependence of a man in normal health and vigour, and thus he looks forward in an uncertain future with grave anxiety, springing from these bodily and mental disabilities.³⁶

The MHC, McLennan confidently professed, was up to the task. But the soldiers themselves needed to approach rehabilitation with the right mindset as well:

The aim of the Commission is to do its best for the physical and economic well-being of the man, and to bring to bear on him such influences that he may perform for his country a service not less important than those of the firing line, namely, that, instead of being an idle ward of the State, he becomes a shining example to the young, of self-dependence, of courage and perseverance in overcoming disabilities.³⁷

³⁵ On shirking and malingering in the Great War, see Bourke, 76-123.

³⁶ *MHC Special Bulletin*, 6.

³⁷ *MHC Special Bulletin*, 9.

To achieve this end, the MHC needed to rethink the compassionate and philanthropic treatment approach adopted in its voluntary institutions. It also needed to consider whether these convalescent homes could realistically be expected to provide the apparatuses and medical expertise necessary for Amar's system of functional re-education to flourish. Most existing facilities simply lacked space for physical recreation or vocational retraining. "There is an absolute unanimity of opinion that the influence of convalescent homes is bad," proclaimed founding member of the MHC and firsthand witness to Amar's methods, W.M. Dobell.³⁸ At best, they offered a comfortable space for men who might otherwise have been sent home in poor physical condition. At worst, critics charged that volunteer staff showered patients with unwarranted affection and unfamiliar luxuries. These extravagancies fostered indolence and apathy towards recovery. Lax discipline, authorities feared, had led some patients to imbibe, gamble, and lose their interest in returning to a life of labour.³⁹ Canada's homes, Dobell recommended, should be closed down (his own included) in favour of military hospitals with qualified personnel able to regulate the leisure time and activities of patients under their care. The underlying principle of this revamped system would be to restore men to physical fitness as efficiently as possible so that they could return to their former occupations or, if not capable, begin training for a new one.⁴⁰

Dobell's recommendations resonated with the commission. Patriotism and philanthropy had proven a powerful tool for the mobilization of voluntary resources, but

³⁸ *MHC Special Bulletin*, 26.

³⁹ *MHC Special Bulletin*, 6.

⁴⁰ *MHC Special Bulletin*, 28.

compassionate spirit and the lack of formality inherent to convalescent treatment could be detrimental to the recovery of patients. Jurisdictional responsibility for ‘active treatment’ of returned soldiers, however, still remained an unresolved issue. The MHC’s original powers had been conceived upon the faulty premise that the vast majority of soldiers returning to Canada during active hostilities would be convalescent cases. Long-term treatment patients including soldiers with TB were a simple matter since the CAMC had little space or patience to care for them. But what of amputees or orthopaedic cases who might require further surgery and treatment upon their return to Canada? What was to be done with the growing number of men suffering from shell shock, rheumatism and other chronic ailments in need of specialized therapies and close observation?

In an effort to extend the commission’s power over these men, an order-in-council introduced in July 1916 established the Military Hospitals Commission Command, a quasi-military branch of the MHC which all returned soldiers undergoing active treatment would be attached to upon their return to Canada.⁴¹ On the surface, the new arrangement seemed to resolve lingering doubts about the purpose and scope of the commission. In addition to gaining full access to the personnel and resources of the CAMC, the order-in-council also classified the MHCC as a sub-unit of the Canadian Expeditionary Force, giving its staff additional authority to direct military physicians and, more importantly, maintain discipline amongst the patient population. The old model of small volunteer-run convalescent homes was rapidly jettisoned in favour of modern and purportedly more

⁴¹ Untitled Report, RG 38, MHC Minutes, LAC.

efficient centralized institutions featuring specialized staffs and a much wider array of amenities to expedite the healing process.

III. REHABILITATION AND MODERN MEDICINE: THEORY AND PRACTICE ON THE CANADIAN HOME FRONT

Throughout 1917 the MHC undertook a massive program of expansion as it sought to modernize its facilities and professionalize its staff. In addition to acquiring more competent physicians and veteran nursing sister, the MHC partnered with the University of Toronto to establish the Military School of Orthopaedic Surgery and Physiotherapy, the first professional program of its kind in Canada. Hosted at the newly constructed Hart House, the school offered VADs, nursing sisters, and even some former soldier-patients intensive six-month courses in massage, physiotherapy (including mechanotherapy), physical training, and occupational therapy. By the war's end nearly all of the 250 graduates from the program had served in Canadian hospitals caring for disabled soldiers.⁴²

Hospitals also began to take on a different character. In 1917 the MHC began construction of the largest hospitals in its network, a 1500-bed facility just outside of the small Lake Ontario town of Whitby, Ontario. Located only a short drive from Toronto, the idyllic rural setting of the hospital presented a welcome alternative for authorities

⁴² Ruby Heap, "Training Women for a New 'Women's Profession': Physiotherapy Education at the University of Toronto, 1917-40," *History of Education Quarterly* 35, no. 2 (Summer 1995): 140-41. In her study of Canadian VADs in the Great War, Linda Quiney has pointed out that the presence of VADs in MHC institutions and their involvement in specialized training programs also hastened calls from the military nursing establishment to seek out further professionalization. See Linda Quiney, "'Assistant Angels': Canadian Women as Voluntary Aid Detachment Nurses during and after the Great War, 1914-1930" (PhD diss., University of Ottawa, 2002), 309-310.

concerned over the potential ‘distractions’ and vices of city life. With an auditorium capable of seating 1200, 300 acres of waterfront land, and “the most perfect dietic system in Canada,” MHC officials were confident that Whitby could be a shining example for other hospitals to strive towards, offering the ideal combination of rest, work, and play to push disabled soldiers towards a return to self-sufficiency.⁴³

For all of its splendour and promise, however, the Whitby model was poorly suited for many types of patients. Its facilities, while vast, catered specifically to convalescing soldiers whose disabilities required less intensive medical intervention and, consequently, much shorter stays, sometimes no more than a few weeks. For the majority of the MHC’s in-patient population, specialized treatment centres and sanatoriums were the primary sites of rehabilitation and recovery. Of these institutions, the MHC’s crown jewel was the Toronto Orthopaedic Hospital.⁴⁴ Able to accommodate up to 500 patients at a time by 1917, the hospital was equipped with the latest medical technology to aid in restoring function to patients with amputations and other crippling injuries. Routines were strictly regimented to maintain discipline and promote a healthy attitude towards recovery. Following breakfast and fatigue duties, each day’s activities began at 9 a.m. with parading and light physical exercise for half an hour. Soldiers requiring active treatment were then expected to report to the appropriate ward, while more physically fit

⁴³ *MHC Report*, 24.

⁴⁴ During the course of the war the hospital was moved several times, eventually being established permanently as Christie Street Hospital in the northern reaches of the city (present day Christie Street and Lambert Lodge Avenue).

men attended occupational workshops or light duties around the hospital.⁴⁵ Recreational activities including concerts, lectures, automobile rides, moving pictures, and for those capable, organized sporting events, were made available to patients based on a carefully crafted schedule.⁴⁶ Like its CAMC counterparts overseas, the MHC quickly learned that participation in sport was one of the best ways of warding off the negative psychological effects of lengthy hospitalization. Each hospital had its own approach and amenities based on the needs and abilities of its patients, but it was not uncommon for many of the larger facilities to have tennis courts, baseball diamonds, and bowling greens on their grounds in addition to a large indoor gymnasium.⁴⁷

The MHC also had to equip and train a growing number of men in the use of prosthetics and other orthopaedic appliances. Shortages of permanent limbs had been experienced throughout England during the early stages of the war, compelling the commission to establish its own Toronto factory in July 1916. By 1917, it was producing 90 per cent of the limbs used by Canadian amputees.⁴⁸ The decision to take over complete control of the manufacture and fitting of limbs seemed self-evident to Canadian authorities. Experience had shown that amputees who were left too long in convalescent

⁴⁵ *Returned Soldiers; Proceedings of the Special Committee Appointed to Consider, Inquire into and Report upon the Reception, Treatment, Care, Training and Re-education of the Wounded, Disabled and Convalescent who have Served in the Canadian Expeditionary Forces, and the Provision of Employment for those who have been Honourably Discharged who are Unable to Engage in their Former Occupation* (Ottawa: King's Printer, 1917), 157. Hereafter cited as *Special Committee (1917)*.

⁴⁶ "Two Feet off but won't Need Crutches," *Toronto Daily Star*, July 21st, 1917, 4. For an overview of the orthopaedic hospital's daily activities upon opening at Christie Street see "Standing Orders: Dominion Orthopaedic Hospital," in *Illustrated Souvenir: Dominion Orthopaedic Hospital* (Toronto: Saturday Night Press, 1920). vii.

⁴⁷ "How the Wounded Soldier is Returned to Civil Life," *Reconstruction* (November 1917), 7.

⁴⁸ Untitled report, RG 38, MHC Minutes, LAC.

homes overseas frequently experienced a significant depreciation in their condition.⁴⁹ Stumps healed slower, patients became more apathetic, and if fitted too early, a limb could actually do more harm than good. Fearing that private manufacturers would not be able to produce the quantity necessary or might sacrifice quality for profit, the MHC took on the burden of covering all costs related to the manufacture, fitting, maintenance, and replacement of prostheses and other appliances, an obligation that the state continued to fulfil for the remainder of a veteran's life.⁵⁰

In an era when Canadians were accustomed to seeing workers crippled by industrial accidents with no other option but a life of pauperism, the MHC's work offered hope that horribly maimed men could be restored with the aid of modern prosthetics and physiotherapy. Writing in the *Toronto Daily Star*, one reporter documented the impressive work being carried out by staff at the Toronto Orthopaedic Hospital:

Many crippled soldiers were seen making their way about in invalid chairs. They appeared very cheerful, indeed, perhaps because they witness constantly the progress of others. Pte. Moulson, of Winnipeg, who lost his two feet from frost, hopes to be able to walk without crutches at all. Many were in the wards trying to get used to their artificial limbs.⁵¹

The MHC's own publication, *Reconstruction*, painted a similarly rosy picture of the wonders scientific rehabilitation could do for the amputee. One early 1918 article told the uplifting story of a man who, with the aid of a modern prosthetic, was able to "run, box, dance, and walk as well as a proficient exponent of any of these arts who may have two

⁴⁹ "Amputations and Amputation Stumps," *British Medical Journal* 1, no. 2884 (April 8th, 1916): 534-35.

⁵⁰ Untitled report, RG 38, MHC Minutes, LAC. Costs ranged between \$80 and \$90 for a leg, and \$60.00 to \$90.00 for an arm.

⁵¹ "Two Feet off but won't Need Crutches," *Toronto Daily Star*, July 21st, 1917, 4.

sound legs.”⁵² Another bi-amputee from Chicago had sceptics in awe after running 100 yards in under 15 seconds.⁵³ Examples of personal triumph over disability were seemingly everywhere, and MHC propaganda wasted few opportunities to highlight them.

These exceptional cases were just that: exceptional. Many patients who were uncertain of how their disability might continue to affect their lives when their treatment came to an end offered a more reticent appraisal of their new artificial appendages:

I think the leg is as good as they can make it except that the ankle has a little too much movement so that the foot makes too much of a bump when I put it down flat. Perhaps that is because I am not quite got on to the way of putting down properly. Anyway if they alter it it wont take them long & I can wait in the shop until its done. it's a little bigger around the ankle than my good foot is too, but I dont think they can improve on that much as its rather difficult for them to get them exactly alike except its a rubber foot and they have no ankle movement. Then again I have a pretty small foot (swank). I think on the whole I have a pretty good limb though and am getting pretty well used to it now. I can walk as well as some that have had their legs for a month or two & have longer stumps that I have. I am practising now to see what I can do without the cane. Of course I shall have to use a cane for walking any distance but will be able to manage around the house without it.⁵⁴

Modern medicine indeed had its limits. Despite the MHC's optimism, artificial limbs could never fully restore the functionalities of flesh and bone. Temporary peg legs given to most soldiers while they were still in hospital offered maximum ease of use but little in the way of aesthetic appeal. More complex legs with moveable joints fitted by specialists came with additional comfort but could also be heavy and cumbersome

⁵² “Canada’s Method of Facing Debt to Soldiers who have Lost Limbs in Battle is Described,” *Reconstruction* (January 1918), 8.

⁵³ “Canada’s Method of Facing Debt to Soldiers who have Lost Limbs in Battle is Described,” *Reconstruction* (January 1918), 8.

⁵⁴ John (Jack) Davey letter to Kitty, 11 February 1917, *Canadian Letters and Images Project* <<http://canadianletters.ca/letters.php?letterid=14449&warid=3&docid=1&collectionid=421>> (accessed September 25th, 2013).

depending on the extent of the amputation. Men also found orthopaedic shoes clumsy and unattractive. Much to the dismay of orthopaedic staff, some amputees went so far as to shave down the feet of their prosthetic legs so that they could fit into the latest designer men's footwear.⁵⁵ Though fewer in numbers, arm amputees proved to be the most difficult to accommodate, with many often preferring more simplistic 'bras de travail' stump attachments than the more complex mechanical apparatuses like the American 'Carnes Arm.'⁵⁶ In an effort to engage men in sports and games, government limb-makers even began producing specialized attachments for use with tennis and squash racquets, pool cues, or croquet mallets.⁵⁷ If a man could grasp a mallet or racquet, surely he could learn to utilize a hammer, wrench, or saw.

Despite an abundance of wartime propaganda citing miraculous advances in medical technology, even the most enthusiastic of physiotherapists or orthopaedic surgeons understood that the best artificial limbs could not replace the natural functions of a healthy man's arm or leg. There was widespread confidence, however, that when combined with proper training orthopaedic medicine could restore a man to his full economic (rather than physical) capacity. The notion that some soldiers might be 'incurable' and would require life-long support from the state was a possibility that, with

⁵⁵ "RE: Artificial Feet: Fashionable Pointed Shoes are Inadvisable," *Reconstruction* (September 1918), 7.

⁵⁶ Department of Soldiers' Civil Re-establishment, *Canada's Work for Disabled Soldiers* (Ottawa: Department of Soldiers' Civil Re-establishment, 1920), 41. Also see *Pensions, Insurance and Re-establishment. Proceedings of the Special committee appointed by resolution of the House of Commons, on the 10th of March, 1921, to consider questions relating to the pensions, insurance and re-establishment of returned soldiers, and any amendments to the existing laws in relation thereto which may be proposed or considered necessary by the committee etc* (Ottawa: King's Printer, 1921), 341-44.

⁵⁷ *Report of the Invalided Soldiers' Commission* (Ottawa: King's Printer, 1918), 22. Hereafter cited as *ISC Report*.

few exceptions, the MHC and military medical authorities throughout the belligerent powers were simply unwilling to accept. In total war, every ounce of manpower needed to be mobilized and preserved.

Nonetheless, there were numerous medical conditions the MHC encountered for which there was no cure. Despite significant advances in surgery during the war, medical science still had no way of reversing paralysis caused by injuries to the spine or brain. In response the MHC established its only permanent home for ‘incurables,’ a 40-bed facility located at Euclid Hall on Jarvis Street in Central Toronto.⁵⁸ Patients suffering from severe facial injuries were a special challenge. By prevailing economic-oriented definitions of disability these men were not ‘incurable,’ but the severity of certain cases exposed the limitations of modern medicine’s restorative powers. Patients had to contend with both the physical impact of their disability and the emotional devastation of knowing that their appearance had been irreparably damaged. Although severe disfigurements were comparatively rare, medical authorities on the home front treated over 2500 patients requiring facial or dental surgery resulting from combat wounds.⁵⁹ The extent of permanent damage varied wildly from patient to patient. Private William B. for example, was left with scars on his left cheek and lost a portion of his nasal septum and right nostril after a rifle bullet grazed his face in 1918.⁶⁰ Photographs contained in his pension file revealed that while the injuries sounded severe, his general appearance was not altered

⁵⁸ *Report of the Work of the Department of Soldiers’ Civil Re-establishment* (Ottawa: King’s Printer, 1920), 16-17. Hereafter cited as *DSCR Report*.

⁵⁹ *DSCR Report* (1921), 52-53.

⁶⁰ Personnel File, William B., RG 150, Accession 1992-93/166, Box 410 – 36, LAC.

significantly.⁶¹ Private Percy M., on the other hand, lost seven teeth and suffered a fractured left jaw after receiving a severe gunshot wound to the face at the Battle of Amiens on 9 August 1918.⁶² He required reconstructive surgery and specialized dentures to retain use of the left side of his mouth.⁶³ In addition to dental prosthetics Canadian authorities also designed and fitted specialized masks, artificial eyes, and other orthopaedic aids through the Toronto Orthopaedic Hospital. Most often these aides could help partly restore or ‘hide’ the full extent of a patient’s disfigurement, but little could be done to assuage the emotional turmoil that emanated from the loss of one’s physical symmetry.⁶⁴

The war blind, once thought to be a category of disabled that were helpless in a sighted society, held much more promise. A special arrangement made by the MHC permitted all blinded Canadian soldiers to undertake free treatment and retraining at Sir Arthur Pearson’s vaunted St. Dunstan’s Hostel in Regent Park, London.⁶⁵ As Serge Durflinger has shown, the influence of St. Dunstan’s was instrumental in facilitating the growth of blind education and advocacy in Canada, ensuring that a great majority of war blind were able to subsist in the post-war period on their own terms. A key development occurred in 1918, when Captain Edwin Albert Baker, a former engineer and enthusiastic

⁶¹ Personnel File, William B., RG 150, Accession 1992-93/166, Box 410 – 36, LAC.

⁶² Personnel File, Percy M., RG 150, Accession 1992-93/166, Box 6193 – 43, LAC.

⁶³ Personnel File, Percy M., RG 150, Accession 1992-93/166, Box 6193 – 43, LAC.

⁶⁴ *DSCR Report* (1921), 52-53. For a brief overview of masking facial disfigurements during wartime see R. Tait McKenzie, *Reclaiming the Maimed: A Handbook of Physical Therapy* (New York: Macmillan, 1918), 117-24. On the stigma of facial disfigurement medical professionals sought to alleviate see Kerry Neale, “Scarred by War: Medical Responses to Facially Disfigured Soldiers of the Great War,” in *War Wounds: Medicine and the Trauma of Conflict*, ed. Ashley Ekins and Elizabeth Stewart (Wollombi, NSW, Australia: Exisle Publishing Limited, 2011), 60-73.

⁶⁵ Untitled report, RG 38, MHC Minutes, LAC.

St. Dunstan's graduate joined forces with six blind comrades to establish the Canadian National Institute for the Blind (CNIB) along with a retraining facility at Pearson Hall in Toronto.⁶⁶ Following the same philosophy of self-sufficiency found at St. Dunstan's, the CNIB would grow to offer an important network of support for men whose vision was lost during or shortly after the war.

Of all 'incurables,' patients with tuberculosis posed the most complex medical and administrative challenge for Canadian authorities. To contemporaries the 'white plague' was effectively a disease without cure, but recent developments in the treatment and management of all but the most advanced cases carried with it hope that most patients would not only survive, but also be able to manage the effects of the disease on their own accord. As Chapter 1 illustrated, TB was rampant within the first waves of men recruited for the CEF.⁶⁷ By the time the MHC was established, hundreds of 'undesirables' with TB had already been uncovered, either during routine medical examinations or after breaking down while training overseas. Some men had enlisted knowingly. One MHC investigation found that as many as 65 recruits carrying active infections were all patients who had left on their own volition from a single sanatorium.⁶⁸ Most, however, had little idea that they carried the deadly disease. Alexander M., for instance, enlisted in 1915 with an active infection, but did not experience serious symptoms until March 1917 after being

⁶⁶ For a concise discussion of Edwin Albert Baker and the treatment of the blind during the Great War see Serge Durlinger, *Veterans with a Vision: Canada's War Blind in Peace and War* (Vancouver: UBC Press, 2010), 32-63. For a general overview of Baker's contribution to the CNIB see Marjorie Wilkins Campbell, *No Compromise: The Story of Colonel Baker and the CNIB* (Toronto: McClelland and Stewart, 1965).

⁶⁷ "Canada's War Problem in Relation to Tuberculosis," *Bulletin of the Association of Medical Officers Caring for Tuberculous Soldiers in Canada*, no. 5 (November 1917): 8-14, RG 38, Series B-3, Circulars and Bulletins, vol. 371, LAC. Hereafter cited as *TB Bulletin*.

⁶⁸ "Statement of President of the Military Hospitals Commission," RG 38, MHC Minutes, LAC.

in the trenches for eight months.⁶⁹ Lt. Harry L., who appeared to be in poor physical condition when he enlisted in October 1914, showed no signs of the disease until he returned to Canada in 1919 in an advanced state of infection. Medical examinations showed that his health had deteriorated significantly while overseas, and further, that he also had a family history of TB that had gone undocumented.⁷⁰

Failure on the part of recruiting physicians to effectively screen patients had the effect of placing the onus of care on the state. Unless the infection had been discovered prior to embarkation, there were reasonable grounds to suspect that ‘service conditions’—whether the tight quarters of barracks life, inclement outdoor weather during training, or the terrible conditions faced in the trenches—could cause incipient infections to advance over time. The scale of the problem required the MHC to decide quickly on the approach it would take to manage the TB problem. Treatment was lengthy and expensive, and the probability of future recurrences of the disease made the prospect of constructing a few larger, centralized institutions unrealistic.⁷¹ Requiring soldiers to travel long distances to receive treatment would not only come at significant cost to the government, it might also dissuade men from entering a sanatorium in the first place, leading to a higher pension bill and possible spread of the disease.⁷² Throughout 1915-16 the TB problem was also compounded by the poor state of existing civilian institutions, many of which were chronically under-equipped and in disrepair.⁷³ To maximize the reach of its rehabilitation

⁶⁹ Personnel File, Alexander M., RG 150, Accession 1992-93/166, Box 6343 – 23, LAC.

⁷⁰ Personnel File, Harry L., RG 150, Accession 1992-93/166, Box 5686 – 52, LAC.

⁷¹ *MHC Report*, 32-36.

⁷² *MHC Report*, 32-36.

⁷³ *ISC Report*, 26.

efforts and save on capital expenditures the MHC opted to take a piecemeal approach to the acquisition of bed space for tubercular soldiers. In addition to providing its own facilities—including the Laurentide Inn at St. Agathe, Québec—Lougheed's commission struck agreements with several civilian institutions to host TB soldiers at the government's expense.⁷⁴ As the war progressed, the MHC also began working with municipal and provincial authorities to enhance existing institutions and build new ones, with the commission agreeing to cover 50 per cent of the capital expenditures on all new construction.⁷⁵

Although it was able to provide adequate space, the MHC experienced a steep learning curve in the treatment of TB. Soldier-patients were much different than their civilian counterparts. Men who wanted nothing more than to return home to their loved ones found it difficult to adjust to long periods of forced rest, boredom, and mental inertia. Unlike the civilian, the soldier-patient also faced no financial liability because treatment was furnished at the government's expense. Apathy and disorder was common, especially in civilian facilities that emphasized bed rest and lacked the authority to enforce military discipline. In the first six months of 1916, for instance, 15 per cent of patients at the Laurentide Inn were discharged for drunkenness or subordination, while a further one-third signed waivers refusing further treatment so they could return to their homes.⁷⁶ Since most TB patients entered sanatoriums after they were discharged from the army, there was little recourse for sanatorium staff. Wartime pension regulations, which

⁷⁴ *Special Committee (1917)*, 18.

⁷⁵ *MHC Report*, 36.

⁷⁶ Katherine McCuiag, *The Weariness, the Fever, and the Fret: The Campaign Against Tuberculosis in Canada, 1900-1950* (Montréal and Kingston: McGill-Queen's University Press, 1999), 39.

only guaranteed a TB patient a full disability pension for six months after his discharge from a sanatorium, also contributed to antipathy towards lengthy treatment. Indeed, if a subsequent medical board found that the patient's symptoms had significantly diminished, their pension could be reduced by as much as 75 per cent.⁷⁷

The MHC and pension officials were nonetheless committed to the notion that if soldiers were properly educated and afforded the best care possible they could overcome the debilitating effects of the disease and, in many cases, become self-sufficient once again. The primary object of treatment for ex-servicemen, wrote pension commissioner Dr. J.L. Todd, is to “assist men to assist themselves in their own homes.”⁷⁸ Successful treatment would not only bring a patient's infection into arrest, it would also teach him to manage his health in civilian life, thereby limiting the long-term burden imposed on the state and potential hardships on his family.

Such an approach required a substantial reimagining of TB treatment. Prior to the war, treatment in private facilities emphasized a combination of fresh air, a robust diet filled with rich and often fatty foods, and lengthy periods of rest and idleness. Regimentation was limited, and discipline lax. In sum, treatment was intended to prolong a patient's life, rather than restore them to economic independence.⁷⁹ As more and more CAMC medical officers entered the MHC's institutions, they brought with them the experience of working with soldier-patients in other settings and a first-hand knowledge of the purported curative benefits of regular routine and carefully monitored activity. By

⁷⁷ *DSCR Report* (1920), 15. Also see “Standards for Estimation of Disability at Discharge of Tuberculous Patients,” *TB Bulletin*, no. 6 (December 1917): 13-14.

⁷⁸ *MHC Report*, 34.

⁷⁹ “Dr. Etlinger's Work at Pinewood Sanatorium,” *TB Bulletin*, no. 1 (July 1917); 6.

1917, wholesale changes were underway. With the help of dedicated dieticians the overfeeding of patients was abandoned in favour of three simple meals a day filled with nutritious, high protein foods known to help build lean muscle. Exposure to fresh air was maximized in all settings. Rest, too, was gradually reduced in favour of graduated exercise, ward occupations, recreation, and light sports and games. Swedish gymnastics, which required men to undertake various physical movements on verbal command, was particularly revered for its therapeutic effect in offsetting the slowing of mental response common in patients with active TB infections.⁸⁰ A full night's sleep and one hour's rest before or after meals, argued Dr. Kincaid Etlinger of the Pinewood Sanatorium in Workingham, UK, was more than sufficient to help expedite the recovery process in all but the most advanced cases.⁸¹

As treatment methods evolved so too did the amenities at the MHC's sanatoriums. Sun galleries, verandas, reclining chairs, workshops, and recreation halls were added to many facilities to promote a positive mentality towards recovery amongst the patients.⁸² The Balfour Sanatorium in British Columbia went so far as to construct a six-hole golf course designed by the patients themselves.⁸³ The commission also began equipping several facilities with the latest x-ray and laboratory equipment to aid specialists and bacteriologists in diagnosing cases and monitoring their progress in a more scientific manner. These were especially important in discerning genuine TB cases from other

⁸⁰ "Dr. Etlinger's Work at Pinewood Sanatorium," *TB Bulletin*, no. 1 (July 1917): 6.

⁸¹ "Dr. Etlinger's Work at Pinewood Sanatorium," *TB Bulletin*, no. 1 (July 1917): 5.

⁸² Lt.-Col. Alfred Thompson, "What the Military Hospitals Commission is Doing for the Tuberculous Soldier," *TB Bulletin*, no. 3 (September 1917), no pagination.

⁸³ "Balfour Military Sanatorium," *TB Bulletin*, no. 5 (November 1917): 4-8.

respiratory illnesses such as emphysema, pleurisy, or chronic bronchitis, disorders commonly misdiagnosed by rushed or inexperienced medical boards.⁸⁴ Believing it to be an extreme benefit to the treatment of the disease, routine dental work was arranged through the Director General of Dental Services in each military district.⁸⁵ Instruction in management of the disease was given regularly to patients, with emphasis placed on healthy eating habits, regular rest, and careful selection of occupations and working conditions so as not to aggravate one's condition.⁸⁶

At the beginning of 1918 the commission had treated 3648 cases of tuberculosis, more than any other medical condition amongst returned men. Of these, 242 had died, 1619 were still undergoing treatment, and 1787 were discharged to their homes.⁸⁷ By 31 March 1919 that number had grown to 5831 patients, of whom 487 died while under treatment.⁸⁸ Over 70 per cent of patients had served for a period overseas, an indication of both lax medical standards and the number of incipient cases which could not be detected.⁸⁹ Faced with this reality, the MHC—and by extension the federal government—was forced to take a more active role in the management and treatment of the disease for the long term. The Great War, Katherine McCuaig has contended, was a watershed moment in the anti-TB movement, illustrating the importance of state intervention into

⁸⁴ C.D. Parfitt and D.W. Crombie, "The Classification of the So-Called Tuberculous," *Medical Quarterly (Department of Soldiers' Civil Re-establishment)*, no. 2 (April 1919): 61-71.

⁸⁵ "Dr. Etlinger's Work at Pinewood Sanatorium," *TB Bulletin*, no. 1 (July 1917): 5-6.

⁸⁶ *Canada's Work for Disabled Soldiers* (1920), 15-19.

⁸⁷ *ISC Report*, 26.

⁸⁸ Lt.-Col. F. McKelvey Bell, "History and Development of the Medical Branch, Department of Soldiers Civil Re-establishment," *Medical Quarterly (Department of Soldiers' Civil Re-establishment)*, no. 2 (April 1919): 138.

⁸⁹ McKelvey Bell, "History and Development of the Medical Branch," 138.

matters of public health.⁹⁰ With proper education, modern methods of treatment, and a sympathetic public, all but the most severe tubercular veterans could overcome their disabilities.

Post-war statistics show that carefully structured treatment could indeed improve the prognoses for many cases. As table 2.1 illustrates, only 7.3 per cent of patients who underwent sanatorium treatment through the MHC showed no signs of improvement in their condition, and nearly 63 per cent of patients showed signs of improvement or stabilization in their condition.

TABLE 2.1 – PROGNoses AT DISCHARGE FROM SANATORIUM OF APPROXIMATELY 6000 TB PATIENTS UP TO 31 MARCH 1919

Condition	Percentage of Cases
Apparently Arrested	12%
Quiescent	9.3%
Improved	41.5%
Not Improved	7.3%
Refused Treatment	6.3%
Non-Tuberculous	4.6%
No Record	17%
Away without Leave	2%

Source: Lt.-Col. F. McKelvey Bell, "History and Development of the Medical Branch, Department of Soldiers Civil Re-establishment," Medical Quarterly (Department of Soldiers' Civil Re-establishment), no. 2 (April 1919): 137-39.

It should come as no surprise that sanatorium treatment did a great deal to improve the health of patients. But for many TB sufferers, the story was more complex. Morbidity rates among TB patients remained high throughout the late stages of the war until finally

⁹⁰ McCuaig, 55.

decreasing in the mid 1920s.⁹¹ More troubling for authorities and veterans' organizations were the large number of ex-servicemen who developed active infections long after the fighting had stopped. Could this deadly disease have remained dormant even after experiencing years of terrible conditions at the front, or was heredity and post-war lifestyle the ultimate determinant? Such questions were central to the debate over the legacy of TB in the Great War, one which would be a major theme of the veterans' experience in the post-war period as hundreds of new cases came forward each year seeking treatment and pension benefits for a disease which, they claimed, was directly attributable to service conditions.

TB sufferers were not alone in the struggle to gain recognition for the legitimacy of their condition. Throughout the war the high incidence of mental disability amongst Canadian troops posed an uncomfortable medical and public relations challenge for authorities on the home front and the architects of rehabilitation policy. By 1916 'shell shock' had been widely adopted into the public lexicon. Even with wartime censorship, the press was inundated with stories of soldiers who had returned from the front and broken down and were unable to carry on.⁹² What had began as a military medical curiosity reported in French and British medical journals in late 1914 and early 1915 quickly evolved into a popular obsession throughout Canada and the British Empire.⁹³ As

⁹¹ F.S. Burke, "Deaths Among War Pensioners," *CMAJ* 41, no. 5 (November 1939): 457-65.

⁹² Terry Copp and Mark Humphries, *Combat Stress in the 20th Century: The Commonwealth Perspective* (Kingston: Canadian Defence Academy Press, 2010), 8-13.

⁹³ Copp and Humphries, 8-9. Early accounts include C.S. Meyers, "A Contribution to the Study of Shell Shock," *Lancet* 185, no. 4772 (February 13th, 1915): 316-20; Frederick Mott, "The Lettsomian Lectures on the Effects of High Explosives on the Central Nervous System," *Lancet* 187, no. 4824 (February 13th, 1916): 331-38.

Terry Copp and Mark Humphries suggest, the widespread presence of the disease seemed to confirm contemporary perceptions that modernity was inherently traumatic.⁹⁴ To Canadians, shell shock was an expected outcome of modern industrial warfare, and the public's awareness of its peculiar effects challenged the medical community's monopoly on discourse surrounding it.⁹⁵ Nevertheless, an air of scepticism still lingered throughout medical circles and the chain of military command: were these patients suffering from real injuries, were they innately defective, or were they simply malingering?

Chapter 1 illustrated how when confronted with male nervous illness, Canada's military medical practitioners tended to rely on organic explanations for the unusual constellation of symptoms exhibited by patients. Men who were otherwise healthy but had broken down under the strain of combat or in the aftermath of a traumatic event could easily be explained by diagnoses such as neurasthenia, shell shock, soldiers heart, or nervous debility because each label suggested that some physical lesion or phenomenon had precipitated the onset of symptoms. The challenge the MHC faced was separating these 'legitimate' patients from the scores of other 'mental defectives' that had entered the ranks and, in some extreme cases, had also seen front line action. Making such distinctions was remarkably difficult without prolonged periods of observation and numerous therapies to test a patient's response. The symptoms of shell shock and

⁹⁴ Copp and Humphries, 14.

⁹⁵ Copp and Humphries, 14-15.

neurasthenia were as varied as the patients who exhibited them, and moreover, easily overlapped with those of other common mental illnesses.⁹⁶

In effect, the commission had to establish a clear distinction between those whose minds were ‘worthy’ of the state’s generosity, and those who were not. To accomplish this the MHC set up a multi-level system of treatment. As with all disabled men, mental casualties first appeared before a medical board which decided whether they should be discharged, retained for further ‘treatment, or reassigned to light duties. Soldiers diagnosed as feeble-minded, epileptic, insane, or ‘mentally deficient’ were either returned to the care of family or, if space was available, committed to public asylums within their home province at the MHC’s expense.⁹⁷ As far as medical authorities were concerned these men were ‘incurable’—they would not be able to return to military service, and in most cases would be a ‘burden’ or menace to society if left to their own devices. Such cases were also a minority, and the MHC understood that Canadians would be outraged if returned men with ‘legitimate’ mental illness were funnelled into overcrowded and dysfunctional public facilities.⁹⁸ “We want to remove from these men the stigma of the asylum,” remarked the MHC’s secretary Ernest Scammell in a July 1916 interview with *The Edmonton Bulletin*, “there are men who by proper treatment may be restored.”⁹⁹

⁹⁶ The difficult task of properly diagnosing mental casualties was outlined in the MHC’s first and only annual report. See *MHC Report*, 36-37.

⁹⁷ *MHC Report*, 36-37.

⁹⁸ *DSCR Report* (1921), 10. In New Zealand, early reliance on the public asylum system was met with backlash from the public, breeding widespread support for the creation of specialized institutions for cases of ‘legitimate’ war neuroses. John Weaver and David Wright, “Shell Shock and the Politics of Asylum Committal in New Zealand, 1916-22,” *Health and History* 7, no. 1 (2005): 19-21.

⁹⁹ “Facilities to be in Excess of Requirements,” *The Edmonton Bulletin*, July 10th, 1916, 3.

Like their CAMC counterparts, most MHC physicians were eager to prescribe rest cure—a combination of special diet, warm baths, sleep, and isolation—as the primary means of addressing mild cases of shell shock or neurasthenia. These therapies were common to non-specialists and could easily be administered within the existing hospital network. Chronic cases, especially those exhibiting extreme somatic symptoms such as functional paralysis, mutism, insomnia, or persistent tremors required specialized therapies and expert observation that the average convalescent home or military hospital could not provide. The MHC's solution for these patients was the Ontario Military Hospital in Cobourg, Ontario. Established in July 1916, Cobourg was initially designed to serve as a clearing station for mental cases, but as the war progressed it was increasingly relied upon for the specific care of neurological patients.¹⁰⁰ Similar to Granville Canadian Special Hospital, its approach to rehabilitation relied on a combination of established and experimental treatment methods including massage, physiotherapy, hydrotherapy, electrotherapy, and occupational therapy consistent with the broad and murky objective of "functional re-education."¹⁰¹

The debate over shell shock became more complex as the war progressed. Recognizing that many casualties who had been classified as 'nervous' had either never been exposed to a close call with a shell explosion, or in other cases, had an extensive family history of mental illness, some specialists posited that predisposition played a more significant role than the traumatic event which allegedly precipitated the onset of

¹⁰⁰ In 1917 a new 150-bed clearing hospital for mental casualties was opened in Newmarket, Ontario to take on this role. See *DSCR Report (1920)*, 15.

¹⁰¹ *ISC Report*, 22; *DSCR Report (1920)*, 38.

symptoms.¹⁰² Lt.-Colonel Colin Kerr Russel, a leading neurologist of the day who had worked directly with patients at Granville, argued that the majority of shell shock cases were in fact purely functional rather than organic in nature.¹⁰³ Whatever their trigger, these ‘psychogenetic’ conditions were almost always curable through a combination of tactful encouragement, persuasion, or physical stimuli (but not necessarily of the punitive variety), thus eliminating the need for pensioning. In other words, the symptoms patients exhibited most often emanated from the mind—they were giving in to their baser instincts.¹⁰⁴ While Russel’s ideas and those of other specialists did not drastically alter treatment practices during the war itself, as we shall see in the forthcoming chapters, the presence of these figures within Canada’s military medical community or as consulting physicians to the DSCR and pension officials had a dramatic effect on how authorities granted or denied benefits to traumatized ex-soldiers.¹⁰⁵

Like tuberculosis, mental casualties placed a significant strain on Canadian treatment network at home. By January 1st 1918 the MHC had admitted 4230 cases of

¹⁰² C.B. Farrar, “Neuro-psychiatry and Re-construction,” *Medical Quarterly (Department of Soldiers’ Civil Re-establishment)* 1, no. 1 (January 1919): 16-23. For a concise contemporary summary of wartime shell shock literature see J.L. Biggar, “War Neuroses,” *Medical Quarterly (Department of Soldiers’ Civil Re-establishment)* 1, no. 1 (January 1919): 30-35.

¹⁰³ For a summary of Russel’s attitudes towards neuroses and related disorders based in his own wartime work see Colin K. Russel, “Psychogenetic Conditions in Soldiers, their Etiology, Treatment and Final Disposal,” *CMAJ* 8, no. 8 (August 1918): 673-84. For Russel, persuasion was much different than *suggestion* – the patient was to be shown how the somatic manifestations of his neuroses originated from his mind, in a manner that was indisputable but sympathetic. Hypnosis and other domineering psychoanalytical techniques, he asserted, merely exacerbated hysterical conditions and increased the probability of relapse.

¹⁰⁴ Russel, “Psychogenetic Conditions in Soldiers,” 678-82. See also *Soldiers’ Pension Regulations: Proceedings of the Special Committee Appointed to Consider and Report upon the Pension Board, the Pension Regulations and the Sufficiency or Otherwise of the Relief Afforded thereunder, the Pension Lists in Force in Canada* (Ottawa: King’s Printer, 1918), 154-57.

¹⁰⁵ Mark Humphries, “War’s Long Shadow: Masculinity, Medicine, and the Gendered Politics of Trauma, 1914-1939,” *Canadian Historical Review* 91, no. 3 (September 2010): 503-31.

nervous disease or other mental illness into their institutions, about 50 per cent of which were classified as a form of neuroses—most commonly shell shock or neurasthenia.¹⁰⁶ Nearly 800 cases (19 per cent) were categorized as suffering from psychoses that were not relatable to service, or had not been significantly aggravated by it.¹⁰⁷ As the war intensified, so too did the need for space to accommodate these patients. In 1917 the MHC made an additional arrangement to construct a 600-bed hospital in London, Ontario equipped with all the “essentials of the modern psychiatric clinic.” When opened in 1918, Westminster Hospital was the largest of its kind in the country.¹⁰⁸ The bed space would be needed. Mental injuries, Canadians soon discovered, were unpredictable in their genesis and prognosis. Patients who were purportedly cured could relapse at any time. Otherwise healthy soldiers who had been discharged from the military as Category ‘A’ broke down within months of returning home. Suffering from crippling anxiety, depression, or exhaustion, many found the return to the predictability and strain of everyday work too much to bear. Extreme cases resorted to crime, violence or suicide. For these veterans, their families, and their communities, the opening stages of a life-long battle to cope with war’s trauma was just beginning.

IV. RETOOLING FOR RE-ESTABLISHMENT: THE END OF THE MHC AND EMERGENCE OF THE DSCR, 1917-19

The Great War took an immense toll on the Canadian soldiers who fought in it, but the presence of the disabled on the Canadian home front was comparatively limited

¹⁰⁶ *ISC Report*, 37.

¹⁰⁷ *ISC Report*, 37.

¹⁰⁸ McKelvey Bell, “History and Development of the Medical Branch,” 141.

for much of the war, especially when contrasted with the European belligerents. Geography was a major factor. Immense effort and precious medical resources were required to transport soldiers home from overseas. Hospital ships and transports had to be staffed with orderlies, nursing sisters and physicians drawn from the CAMC's active treatment facilities. It was also dangerous: hospital ships and passenger liners were easy targets for German u-boats. These delays bought the MHC much needed time to concentrate on expanding its facilities and refining its approach to rehabilitating the disabled. What had begun as a modest network of convalescent homes was by 1917 a ubiquitous influence on the lives of disabled soldiers and their families. With nearly 60 hospitals of varying sizes under its direct control and dozens other affiliated public institutions in major cities of every province, the MHC's medical work was a salient and unprecedented reflection of the modern state's organizational and administrative power.¹⁰⁹ The trajectory of this growth, however, was not by deliberate design. The MHC expanded out of desperate necessity, often in reaction to developments overseas or philanthropic gestures by wealthy citizens. When appropriate space became available with limited financial liabilities, it was acquired. Though they recognized that permanent hospitals would be necessary, a general—and somewhat contradictory—reluctance to take on large-scale capital expenditures meant that after more than two years the MHC remained an expansive but uneven manifestation of state medicine. Expertise was scattered between cutting-edge institutions and small convalescent homes that continued

¹⁰⁹ Untitled report, RG 38, MHC Minutes, LAC.

to operate long past their usefulness. Underneath the MHC's impressive façade cracks were beginning to form.

Despite widespread public support for its work and its self-proclaimed rapport with returned soldiers, 1917 saw the commission mired in controversy over its deteriorating relationship with the CAMC. The powers granted to the MHC Command in 1916 had allowed it to supersede the authority of each military district's senior medical officers, establish and carry out its own medical boards for soldiers, and permitted junior officers to direct the medical work of CAMC physicians allocated to its facilities.¹¹⁰ By 1917 all administrative duties for Canada's three discharge depots at Halifax, Saint John, and Québec had also passed under the direct control of the commission. In effect, the MHC had taken on a staff and degree of responsibility that more or less resembled an entire government department with its own independent mandate. Resentful of a civilian organization undermining its authority, behind closed doors the CAMC maintained that it was the only service with the expertise to deliver adequate care to returned men.¹¹¹ In spite of its efforts at reform and gallant intentions of its civilian personnel, the army officials charged that the MHC's facilities were inefficient, lacked professionalism, and disregarded proper military discipline. Civilian physicians and medical orderlies simply did not have the necessary experience to rehabilitate the soldier-patient.¹¹²

The CAMC's criticisms were originally put forward in an October 1916 report compiled by Lt.-Colonel Marlow, then the Assistant Director of Medical Services

¹¹⁰ Untitled report, RG 38, MHC Minutes, LAC.

¹¹¹ "Statement of the President of the Military Hospitals Commission," RG 38, MHC Minutes, LAC.

¹¹² *Special Committee (1917)*, 190-95.

(ADMS) for the Toronto Military District. A respected surgeon and gynaecologist, as well as a founding member of the CAMC in 1900, Marlow resented the MHC for its alleged encroachment on what he considered to be a military responsibility, especially following the its poor handling of the *Metagama* incident in November 1915.¹¹³ Thereafter, Marlow was frank in expressing his views about the MHC's performance. "There should never have been any question as to this responsibility," he protested before a 1917 special committee, "the Army Medical Corps has been in existence for seventeen years, and looks after the work in Canada, and in England... why should it be deprived of the work when the men come back."¹¹⁴ Marlow's critique struck a chord with disgruntled army physicians who had seen the folly of the country's system of dual-management firsthand. Communication between the two medical authorities was poor at best. In some hospitals patients were routinely left for weeks without proper medical examinations. Limited oversight and a high turnover in staff led to administrative chaos, and in some extreme cases, patients being kept on strength for months longer than was necessary.¹¹⁵ Keenly aware of certain inefficiencies that existed within its hospitals, the MHC pointed the finger squarely at the CAMC, citing its indifference to modern notions of rehabilitation and even going so far as to claim that several facilities had been assigned incompetent medical officers with insufficient training and no accreditation.¹¹⁶

¹¹³ "Broken Men Back from War are Turned Into Cars Unfit for Horses," *The Edmonton Bulletin*, November 24th, 1915, 6.

¹¹⁴ *Special Committee (1917)*, 193.

¹¹⁵ Untitled report, RG 38, MHC Minutes, LAC.

¹¹⁶ "Statement of the President of the Military Hospitals Commission," RG 38, MHC Minutes, LAC.

The MHC's charges of sabotage and negligence were largely overblown. In fact, CAMC expertise was instrumental in expanding the commission's work with TB, orthopaedic, and psychiatric casualties. By mid 1917, however, it was clear that some manner of reform was needed to ensure the continued viability of Canada's rehabilitation program. The MHC, Desmond Morton writes, had been "born out of the desperate improvisation of a country and government utterly inexperienced in war."¹¹⁷ In 1915 there was no palatable alternative, nor any past model to draw from. Canada's small community of military physicians and many of its best and brightest civilian practitioners had answered the call to serve overseas. Turning down offers by patriotic civilians to serve their country in a non-military capacity made little sense in a war that had immersed all sectors of the economy and society. As the need for clinical proficiency and hands-on experience with soldier-patients grew, CAMC physicians returned to the home front with increasing frequency, eager to continue their work for the betterment of the war's disabled and to advance their own professional profile.¹¹⁸ With the military medical services taking an increasingly role in rehabilitation, there was good reason to at least consider revising the scope of the commission's mandate.

A 1917 parliamentary special committee on returned soldiers' problems investigated such a question, but found that opinion was largely divided on the care of the disabled. Some members tabled their support for a French-style 'national bureau' that would serve as an intermediary between the CAMC and the MHC. Most preferred a wholesale reorganization of existing infrastructure under the auspices of a new

¹¹⁷ Morton and Wright, 84.

¹¹⁸ *Special Committee (1917)*, xxii.

government department. Whether patients in active treatment would be retained under military discipline or transferred to this new civilian authority remained unsettled.¹¹⁹ After months of meetings and visits to various hospitals around the country, the committee “reluctantly” ended its work with no concrete recommendations on how to resolve the conflict.¹²⁰

In the fall of 1917 Lougheed issued an ultimatum. The MHC would henceforth be responsible for all medical matters concerning returned men, with or without support from the CAMC. The militia department countered, suggesting the MHC be stripped of its treatment facilities and focus its work solely on vocational training and ‘incurables.’ In December, the Director General of Medical Services went one step further, ordering all CAMC doctors to withdraw from the MHC’s main discharge depot in Québec, effectively crippling their ability to disburse men throughout the treatment chain.¹²¹

Callous posturing did little to endear the CAMC to returning soldiers, but it was also painfully clear that the commission’s program of rehabilitation could not continue functioning unless harmony was established between civilian and military authorities. The stalemate was finally ended on 21 February 1918, when an order-in-council established the Department of Soldiers’ Civil Re-establishment. Under the new arrangement the majority of the MHC’s active treatment hospitals and convalescent homes—some 12,000 beds shared between 51 institutions—were transferred to the control of the CAMC. The commission would take on the more limited role of caring for

¹¹⁹ *Special Committee, (1917)*, xxxv.

¹²⁰ *Special Committee (1917)*, xxxiv-xxxv.

¹²¹ Morton and Wright, 87-89.

long-treatment cases and previously discharged men with recurring disabilities. It also was given a new name, the Invalided Soldiers' Commission (ISC), a title military authorities suggested would clear up persistent confusion over jurisdictional responsibility.¹²²

A conflict with roots extending back to the earliest days of the war had finally been settled. Organizationally, the new department was an improvement over the often-confused state of affairs experienced with the hospitals commission. The core staff of the now defunct MHC remained intact, with some occupying new positions. Lougheed was appointed Minister, while Ernest Scammell took on the role of Assistant Deputy Minister. Vocational officers continued at their duties, and civilian practitioners maintained their work under a new Medical Branch headed by the reputable Ottawa physician Lt.-Col. Frederick McKelvey Bell.

The introduction of the DSCR also brought the state more closely into the private lives of returned men. Although many soldiers' families had experienced sporadic intrusions from medical officials, vocational officers, or local members of the Canadian Patriotic Fund during the war, it was not until 1918 that this process of intervention was systematized. As a component of their treatment, out-patients were routinely visited in their homes by a small army of Social Service workers, whose responsibility it was to ensure that household conditions were "conducive to their improvement."¹²³ These workers were tasked with assessing the progress of a patient's treatment as well as their

¹²² "The Invalided Soldiers Commission and the New Department of Soldiers Civil Reestablishment," *CMAJ* 8, no. 5 (May 1918): 431-35.

¹²³ *DSCR Report* (1920), 19.

habits, temperance, financial circumstances, and the general wellbeing of the family. As guardians of the state's resources, they also ensured that men undergoing treatment were not attempting to circumvent regulations by working while receiving benefits, or worse, lying about the number of dependents.¹²⁴

The DSCR also added a measure of permanency to Canada's rehabilitation effort that had not been present under the MHC. Following the restructuring which took place in the winter of 1918 Canada was able to negotiate official agreements between both the United States and Britain for the reciprocal care of patients from each nation's armed services. Any CEF pensioner or approved veteran who required medical treatment could obtain it in either country at the expense of the department, while Imperial or American veterans would be granted similar privileges while they resided in Canada.¹²⁵ These agreements were a prudent way of avoiding administrative difficulties in the post-war period as pension roll soon illustrated how truly international the Canadian Expeditionary Force was. Indeed, as of March 31st, 1921, 12,872 Canadian pensioners—over 25 per cent of all total—were living outside of Canada, including 4297 in the United States and 6894 in the British Isles.¹²⁶

The new department was making its presence felt internationally in other ways as well. In May 1918 the DSCR with cooperation from the CAMC sent several representatives to showcase Canada's rehabilitation efforts at the Inter-Allied Conference

¹²⁴ *DSCR Report* (1920), 19.

¹²⁵ *DSCR Report* (1920), 19-20.

¹²⁶ *Report of the Work of the Board of Pension Commissioners for Canada* (Ottawa: King's Printer, 1921), 29. The breakdown for the British Isles is as follows: England – 5857; Scotland – 432; Ireland – 437; Wales – 168.

on the After-Care of Disabled Men in London, England. Hosted by senior RAMC officials and the British Ministry of Pensions from 20-25 May, the conference was the largest of its kind held during the Great War, featuring special sessions and presentations on a range of issues including pensions and allowances, vocational retraining, care of the deaf and blind, as well as surgical and orthopaedic innovations.¹²⁷ Only the French and Americans matched the Canadian delegation in size. Canada's contributions included presentations on DSCR's approach to vocational retraining and the 'functional re-education' of orthopaedic patients. Attendees were also given exclusive guided tours of Greater London's most renowned treatment facilities, including St. Dunstan's Hostel for the Blind, as well as the military orthopaedic hospitals at Roehampton and Shepherd's Bush.¹²⁸ What delegates witnessed at the conference reaffirmed their conviction that Canada's approach to rehabilitation, while smaller in scale compared to nations such as France or England, was sound in principle, relying on the latest scientific and organization knowledge of the day.

At war's end there were numerous reasons to be optimistic about the prospects of successfully restoring the disabled to civilian life. Canada's re-establishment infrastructure extended from coast to coast and was continuing to grow as facilities previously been handed off to the militia department were returned to the DSCR following demobilization. By the end of 1919 the department's Medical Branch controlled 44 hospitals and sanatoriums, and co-operated six others. It had established treatment arrangements with 54 public and private institutions, providing thousands of

¹²⁷ *Inter-Allied Conference*, 5-10.

¹²⁸ *Inter-Allied Conference*, 5-6.

patients with the ability to access care at their local general hospital or civilian sanatoriums. Every bed and physician's table was a precious national resource. By 1920, 69,203 ex-servicemen, more than 12 per cent of CEF members who survived the war, were receiving a disability pension and accessing free medical treatment.¹²⁹ 6500 patients were still in active treatment with the DSCR—many of them TB cases—and an average of 9000 outpatient treatments were being administered on a weekly basis.¹³⁰ Between 1 April 1918 and 31 March 1919 alone the department treated 34,554 patients in hospital.¹³¹ Inconsistent record-keeping makes determining the total number of patients cared for during the war impossible, but post-war statistics compiled by the DSCR suggest that between the beginning of the war and 31 March 1921, civilian authorities cared for as many as 109,145 patients, with 573,199 treatments administered—a ratio of 5 for every 1 patient.¹³²

V. CONCLUSION

Medicine and care giving was elemental to the Canadian experience on the home front during the Great War just as it was overseas. At the core of this medical effort was a spirit of voluntarism that galvanized the public to action to 'do their bit' and support the cause for civilization and empire. The disabled men who first began returning home in 1915 arrived in a nation eager to lend a helping hand but with almost no experience to draw from. The MHC's early history exemplified this naïveté and, moreover, the

¹²⁹ *BPC Report* (1921), 16.

¹³⁰ *DSCR Report* (1920), 7.

¹³¹ *DSCR Report* (1920), 23.

¹³² *DSCR Report* (1921), 107.

ambivalent role of the state in matters of public health. As Canada's involvement in the military campaign overseas deepened in 1916, necessity drove the MHC to evolve from a conglomeration of voluntarily donated rest homes to an increasingly professionalized medical apparatus of the federal government. The landscape of rehabilitation was thus transformed from the informality, amiability, and inefficiency of the convalescent home to the specialized therapies and advanced technologies of the modern hospital ward.¹³³

As the commission grew in response to the increasing numbers of returned wounded, its methods and conceptualization of rehabilitation also shifted course. "There has been a rude awakening from the complacent fallacy that the proportion of the unfit to the general population is negligible," wrote Lt.-Col. J.L. Biggar of the CAMC in 1919.¹³⁴ Disability, Canadians quickly realized, did not always take the form of shattered limbs and mutilated flesh. Accompanying every shipload of returned battle casualties were countless soldiers suffering from diseases and physical defects that had been overlooked during enlistment or were aggravated by military service. Fearing widespread public backlash, the MHC and DSCR were reticent to deny care to those who needed it—compensation would be another matter entirely. For many returned soldiers, their time in hospitals, convalescent homes, and sanatoria would mark the beginning of a life-long relationship with the state, one which had been forged as part of a broader renegotiation of citizenship precipitated by the wartime crisis of the disabled.

¹³³ Annmarie Adams, "Borrowed Buildings: Canada's Temporary Hospitals During World War I," *Canadian Bulletin of Medical History* 16 (1999): 31.

¹³⁴ J.L. Biggar, "State Medicine and Rehabilitation," 1013.

To label the MHC and DSCR's campaign to rehabilitate the wounded as a wholly reactionary effort would ignore a number of larger social and intellectual forces at work. The sacrifices borne by Canadian soldiers and their families during the war fostered expectations that the post-war period would be a time in which to establish a new social order to atone for the 'mistakes' of the past. Reconstruction, wrote J.L. Todd, would afford Canada the opportunity to strive towards the "social ideals which before the war seemed impracticable and impossible of attainment."¹³⁵ Though a diverse array of opinion existed on what long-term role the state would play in achieving this end, there is strong evidence indicating that the reform impulse was alive and well within wartime medicine. Indeed, at its core, rehabilitation exemplified the symbiotic relationship between science and progress. By returning the disabled to economic self-sufficiency and reconstructing men's bodies, Canada's physicians and re-establishment authorities were confident that they could ensure the future prosperity of the country while simultaneously alleviating their own collective anxieties over racial degeneration and wartime upheaval of dominant gender norms.¹³⁶ In essence, medicine served as a conduit through which to re-establish social harmony and, more importantly suggested Lt.-Col. McKelvey Bell, a safeguard

¹³⁵ J.L. Todd, "The Meaning of Rehabilitation," *The Annals of the American Academy of Political and Social Science* 80 (November 1918): 2.

¹³⁶ As J.L. Todd wrote: "If, in speaking of rehabilitation, our minds are not fully conscious of that which is being done at every minute on the worldwide battle field we lack appreciation of our situation. Those who are fighting are deciding for us the form which the rehabilitation of our country shall take. In fighting, and in planning rehabilitation, we are deciding not only for ourselves but for our children and for our children's children Upon the decision arrived at, the future development of our race depends." J.L. Todd, "The Meaning of Rehabilitation," 2. Todd's piece was written as part of a special edition on the rehabilitation of the wounded.

against “the distressing and unfair social calamity which has followed former wars in all countries, i.e., the pauperization of disabled soldiers.”¹³⁷

The efficacy of rehabilitation was ultimately contingent on a number of other mitigating factors. First and foremost it must be remembered that wartime medicine treated disability overwhelmingly as an economic handicap. Treatment was intended to restore a man to a state of health where he could once again undertake productive labour and resume his role as a breadwinner. Re-establishment officials were adamant that in all but the most exceptional cases, Canada’s war disabled would become self-sufficient, limiting the state’s long-term obligations to its soldier clientele in the process. Rehabilitation, in short, exemplified the collision of established Victorian era attitudes towards social welfare and the burgeoning necessity of state intervention in the lives of citizens during a period of unprecedented crisis and upheaval. Whether rehabilitation could succeed in making the disabled independent, however, was contingent on much more than improved treatment practices. As the succeeding chapters will illustrate, veterans’ expectations of financial compensation needed to be addressed in a manner which offered a bare minimum of material security for those unable to work, but greatly rewarded those who did. To ensure that the vast majority of ex-soldiers could retain their breadwinner role, the state would also have to invest in new and inventive approaches to re-establishing soldiers as workers, regardless of their physical or mental incapacities.

¹³⁷ McKelvey Bell, “History and Development of the Medical Branch,” 150-51.

Chapter 3: ‘The bill is a heavy one’: Canada and the Pension Question, 1914-21

For the thousands of volunteers who enlisted in the Canadian Expeditionary Force (CEF) during the late summer and fall of 1914 the prospect of disablement may have been a remote or passing thought. War offered a unique and idealized opportunity to assert one’s manliness and devotion to Empire.¹ For some, military service was also a rational economic decision. In 1913 Canada had experienced its worst economic recession since the 1890s, leaving tens of thousands of working-class men—many of them recent British immigrants—unemployed and seeking relief. Even for the most devout patriot, the promise of three square meals and \$1.00 a day was reason enough to enlist in the service of King and Empire.²

Canadian authorities too showed little interest in the issue of pensions and compensation during the first stages of the campaign. Instead, the federal government conferred responsibility for the material support of soldiers’ families on the Canadian Patriotic Fund (CPF). Originally established during the Boer War, the CPF was resurrected in September 1914 under the leadership of prominent Montréal manufacturer and social activist Herbert Ames. The fund granted temporary relief to the families of

¹ Mark Moss, *Manliness and Militarism: Educating Young Boys in Ontario for War* (Toronto: Oxford University Press, 2001), 15-16. On Canada and empire in the pre-war period see Carl Berger, *The Sense of Power: Studies in the Ideas of Canadian Imperialism, 1867-1914* (Toronto: University of Toronto Press, 1970). For a more recent discussion see Jonathan F. Vance, *Maple Leaf Empire: Canada, Britain, and Two World Wars* (Toronto: Oxford University Press, 2011), especially chapters 2 and 3.

² Desmond Morton, *When Your Number’s Up: The Canadian Soldier in the First World War* (Toronto: Random House of Canada, 1993), 12. Soldiers were also granted a \$0.10 per day field allowance.

soldiers who had gone overseas, were killed in action, or were severely wounded. Compensation was meagre, and more importantly, contingent upon applicants adhering to the moral and patriotic standards of the CPF's predominantly middle-class investigators.³ Although a charitable approach appealed to federal politicians cautious of over-committing precious financial resources to soldiers' welfare, the extensive casualties incurred during the spring and summer of 1915 shook the assumption that philanthropy could ameliorate the inadequacies of existing pension regulations.

The problem Canada faced was not unique. Indeed, the mobilization of mass citizen-armies forced all belligerent powers to erect plans to offer compensation to soldiers and their dependents in the event of death or disablement. Unlike many of its European counterparts, Canada's limited experience with military pensioning and the absence of a large pre-war professional army presented the unique opportunity to establish a wholly Canadian scheme, one free from political patronage and founded on allegedly impartial scientific principles of medical assessment.⁴ Established models offered little in the way of inspiration. The extravagance of the American Civil War pension system illustrated the extreme economic pitfalls of a general service pension. A more conservative European approach might circumvent exploitation, but ran the risk of negatively impacting public morale, alienating volunteers, and turning veterans' organizations against the state. How, then, would Canada approach the pension question? What disabilities merited compensation and for how long? On what principle should

³ Desmond Morton, *Fight or Pay: Soldiers' Families in the Great War* (Vancouver: UBC Press, 2004), 19-20.

⁴ Desmond Morton, "Resisting the Pension Evil: Bureaucracy, Democracy, and Canada's Board of Pension Commissioners, 1916-1933," *Canadian Historical Review* 68, no. 2 (1987): 199-205.

awards be granted? Could the pension bill be reduced over time through programs like physical rehabilitation and vocational retraining? Most importantly, what was considered ‘adequate’ compensation?

This chapter explores how Canadians approached these questions from the war’s outbreak into the immediate post-war period. At the centre of this discussion are the tens of thousands of disabled ex-servicemen who sought restitution for the injuries and diseases they contracted while on active service, and the main administrative body governing pensions, the Board of Pension Commissioners (BPC). Established in 1916, the pension board served as the sole arbiter of compensation for death or disablement during the Great War, working with government officials, military physicians, and returned soldiers to refine Canada’s nascent pension policies. The nature of the pension board’s work ultimately did little to endear it to the average veteran. Returned soldiers and their families found the pension system to be impersonal, inconsistent, and overly bureaucratic. Compensation rates matched and even surpassed those of most other allied countries, but the high cost of living, coupled with the board’s rigid adherence to pension regulations that measured disability on a strictly economic basis meant that many disabled veterans felt cheated by the awards they received. Persistent backlogs in attending to applications only compounded the board’s woes further.⁵

For their part, government authorities responded expeditiously to veterans’ criticism of the board, implementing four major revisions to pension regulations during the conflict. It was not until September 1919 that these wartime reforms were enshrined

⁵ Morton, “Resisting the Pension Evil,” 206-10.

into law through a dedicated Pension Act. By this time Canada's pensioners numbered some 66,000—over 12 per cent of all surviving soldiers—a majority of whom were suffering from disabilities that did not conform to the popular image of the combat wounded.⁶ As was the case with other major combatants, disease, pre-existing physical ailments, and 'nervous disorders' made up a substantial portion of the war's disabled, a reality which continually frustrated pension officials and perplexed a general public uncertain of just 'who' the war's disabled really were.⁷ In an effort to maintain popular morale and bolster recruitment, Canadian authorities adopted a liberal approach to pensioning during the Great War, awarding compensation to any soldier who could demonstrate that they incurred a disability as a result of, or during their military service. This policy was undertaken on the presumption that most war disabilities would be temporary. The architects of Canadian pension policy were convinced that rehabilitative medicine and vocational retraining could restore all but the most severely disabled to sufficient health to achieve self-sufficiency and economic independence.⁸ Ultimately, if veterans were empowered to recapture their status as independent breadwinners, the state's long-term obligations would be limited.

In the weeks and months following the armistice there was good reason to be optimistic. Wartime medicine and a pervasive ethos of post-war renewal sustained expectations that sensible planning and scientific thought could alleviate the economic

⁶ See Table 2.4 and Table 2.5 in Statistical Appendix.

⁷ Marina Larsson, *Shattered Anzacs: Living with the Scars of War* (Sydney: University of New South Wales Press, 2009).

⁸ J.L. Todd, "The Meaning of Rehabilitation," *The Annals of the American Academy of Political and Social Science* 80, (1918): 6-9.

and social burdens disability imposed on the nation.⁹ The realities of civil re-establishment led to the gradual erosion of this ideal. In spite of multiple reforms and comparatively high pension scales, veterans remained unsatisfied with the levels of compensation they received and continued to find fault with the administrative technicalities found in Canada's pension law. As numerous historians have illustrated, these patterns of discontent were replicated throughout the former combatants.¹⁰ In the Canadian context, medical criteria proved most frustrating. Pension regulations inherently favoured visible physical injuries over the more commonplace 'invisible wounds' such as chronic disease or mental trauma. Within two years of the war's conclusion thousands of veterans suffering from minor illnesses had their awards reduced, commuted, or outright discontinued irrespective of their financial circumstances. Wartime generosity had seemingly given way to post-war penny-pinching.

The early history of Canada's pension system, then, is one of a clash between the ideals of post-war social reconstruction, the struggle to comprehend the unimagined medical calamity of modern war, and the fiscal and organizational limitations of the state. The architects of Canadian pension policy saw themselves as purveyors of liberal-minded reform, but often failed to convince the public and ex-servicemen of Canada's comparative charitableness. In part, this escalating tension was a product of the BPC's

⁹ Todd, "The Meaning of Rehabilitation," 6-9.

¹⁰ Antoine Prost, *In the Wake of War: 'Les Anciens Combattants' and French Society*, trans. Helen McPhail (Providence: Berg, 1992. c. 1977); Robert Whalen, *Bitter Wounds: German Victims of the Great War, 1914-1939* (Ithaca: Cornell University Press, 1984); Deborah Cohen, *The War Come Home: Disabled Veterans in Britain and Germany, 1914-1939* (Berkeley: University of California Press, 2001); Stephen R. Ortiz, *Beyond the Bonus March and GI Bill: How Veteran Politics Shaped the New Deal Era* (New York: New York University Press, 2010).

role as a dogmatic administrator of highly complex and largely experimental pension legislation. Pension officials could easily be scapegoated for their parsimony—and usually were—but it is important to remember that the onus of innovation remained on elected officials and the expert opinion at their disposal. The system reflected Canadians' own conflicting desires to promote self-sufficiency while simultaneously offering the nation heroes a generous reward for their service. Veterans' own lay understandings of their health also played a part. Scientific measures of incapacity resonated little with the average soldier. Indeed, how was it conceivable that a veteran suffering from an amputation would receive equal or less compensation to an elderly enlistee who broke down with rheumatism while in training?¹¹ After four years of brutal conflict and bold promises that the disabled would be cared for to the best of the state's ability, there was much to be dissatisfied with.

Not to be lost are the stories of soldiers whose disability pensions were the crucial feature of their citizenship and evolving relationship with the modern state. Veterans' activism was crucial to reforming the system. This chapter draws on examples from their pension records in order to illuminate how disability affected their lives during wartime. In a similar fashion to Chapter 1, the latter part of this chapter relies extensively on data obtained from the CEF sample group to clarify and facilitate a broader understanding of the pension system and the veterans for whom it served. This data should be considered illustrative rather than authoritative.¹² Nevertheless, the pension files and the statistics

¹¹ Desmond Morton and Glenn Wright, *Winning the Second Battle: Canadian Veterans and the Return to Civilian Life, 1915-1930* (Toronto: University of Toronto Press, 1987), 156.

¹² On the characteristics and limitations of the sample group, see Appendix I: Methodological Essay.

derived from them offer a hitherto unavailable perspective on the ways in which the war impacted its participants. Official sources, while numerous and broad in scope, fail to capture the complex personal struggles that ordinary soldiers faced upon returning to civilian life. The most important findings from the pension records confirm a common but often anecdotal observation in both the Canadian and international literature on civil re-establishment. Disability was a pervasive feature of military service, the compensation for which fell far short of most veterans' needs and expectations.

II. PENSION REFORM AND THE BOARD OF PENSION COMMISSIONERS, 1915-16

It was not until June of 1915 that the Department of Militia and Defence's Pensions and Claims Board was established in England for the purpose of examining disability claims. Under existing legislation pension awards were based on a four-class scale, with each class rated according to the disability's relation to service and its material impact on a soldier in the general labour market. Critics of the system contended that rates were hardly adequate.¹³ Modest revisions to the scheme on the eve of the Battle of Second Ypres in 1915 granted an unmarried private a maximum pension of \$264.00 per year, plus an additional allowance of \$88.00 annually if he was unable to care for himself—a total of just under \$30.00 per month.¹⁴ A 'first-class' pension for 100 per cent disablement was only awarded to soldiers "totally incapable of earning a livelihood as the result of wounds or injuries received or illness contracted in action, or in the presence of

¹³ "Pensions for Unmarried Soldiers are Inadequate," *Toronto Daily Star*, August 14th, 1915, 5.

¹⁴ Sessional Paper No. 150 – "Return to an Address to His Royal Highness the Governor General, of the 3rd February, 1916," in *Sessional Papers of the Dominion of Canada* (Ottawa: King's Printer, 1916), 2-3. Hereafter cited as *Sessional Paper No. 150* (1916).

the enemy.”¹⁵ Any disability that was acquired or aggravated away from a combat theatre, regardless of its severity, was relegated to a second, third, or fourth class pensions, which amounted to \$192.00, \$132.00, and \$75.00 respectively. A married pensioner could receive an additional \$11.00 per month for his wife.¹⁶ An unmarried lieutenant colonel, by comparison, received \$1200.00.¹⁷ Recognizing that rates were inadequate for the rank and file, the Military Hospitals Commission (MHC) established a special ‘Disablement Fund’ in late 1915 to help alleviate the financial hardship experienced by the first waves of returned disabled men and their families.¹⁸ Nevertheless, compensation rates remained well below what a typical working class man required to make ends meet.

By the end of Canada’s first year in combat the limitations of its militia-era pension regulations were becoming more and more apparent. In December 1915 Frank Darling, a noted Toronto architect, along with other members of the Toronto and York County Patriotic Fund Association submitted a short report to Canadian parliamentarians objecting to the “inadequate and unsatisfactory” state of the present system.¹⁹ Amongst many other recommendations, the committee was adamant that the “illogical and

¹⁵ *Sessional Paper No. 150* (1916), 2.

¹⁶ *Sessional Paper No. 150* (1916), 2-3.

¹⁷ *Soldiers' Pensions: Proceedings of the Special Committee Appointed to Consider and Report Upon the Rates of Pensions to be Paid to Disabled Soldiers, and the Establishment of a Permanent Pensions Board* (Ottawa: King’s Printer, 1916), 13. Hereafter cited as *Special Committee (1916)*. British rates were even more polarized. A totally disabled Private received \$316.00 annually, while a lieutenant colonel was granted a pension of \$3000.00 in addition to a special gratuity equal to one year’s pension (a further \$3000.00 if fully disabled).

¹⁸ *Sessional Paper No. 35a* – “The Provision of Employment for Members of the Canadian Expeditionary Force on their Return to Canada,” in *Sessional Papers of the Dominion of Canada* (Ottawa: King’s Printer, 1916), 8.

¹⁹ *Sessional Paper No. 185* – “Return to an Order of the House of the 13th March, 1916,” in *Sessional Papers of the Dominion of Canada* (Ottawa King’s Printer, 1916). Hereafter cited as *Sessional Paper No. 185* (1916).

Sessional Paper No. 185 (1916), 51. Also see Morton and Wright, 46-48.

unreasonable” distinction made between disabilities incurred during training and in combat be abandoned. Rank and file men, especially the unmarried, also required substantial award increases to afford basic necessities.²⁰

In response to Darling’s report the Borden government appointed a special committee in March 1916 to investigate the problems facing returned men and the families of fallen soldiers, focusing specifically on the administration and adequacy of pensions.²¹ Hard lessons from their southern neighbours weighed on the minds of politicians as they pondered how to revise the Canadian scheme. In the late nineteenth century the American Civil War pension system quickly expanded into an immense public expenditure and an equally volatile source of political controversy. As a result of the Arrears Act (1879) and subsequent legislation, the annual cost of Union Army pensions rose from roughly \$28 million in 1878 to an average of over \$140 million annually between 1892-1899.²² By the end of the 1880s a program that began as a modest public expense in comparison to the other costs of post-war reconstruction accounted for 50 per cent of all American federal spending. Partisanship and corruption within the system incited intense public animosity towards Union veterans and their political arm, the Grand Army of the Republic.²³ Nearly 1 million Americans were already receiving some manner of war-related benefits when, in 1907, new legislation granted general

²⁰ *Sessional Paper No. 185* (1916), 58.

²¹ *Special Committee (1916)*, 3-6.

²² William H. Glasson, *Federal Military Pensions in the United States* (New York: Oxford University Press, 1918), 203.

²³ Peter Blanck and Chen Song, “Civil War Pension Attorney’s and Disability Politics,” *University of Michigan Journal of Law Reform* 35, no. 1&2 (Fall 2001 & Winter 2002): 7. For a study of the role of race and ethnicity in the granting of pensions to Civil War veterans see Larry Logue and Peter Blanck, *Race, Ethnicity, and Disability: Veterans and Benefits in Post-Civil War America* (New York: Cambridge University Press, 2010).

service pensions to all Civil War survivors who gave a minimum 90 days' service once they reached the age of 62.²⁴ By 1916, the United States had spent nearly \$5 billion on military pensions, more than the entire cost of the war itself.²⁵

Many witnesses called before the committee were eager to replicate the generosity of their American neighbours, but they found the principles underpinning it baffling, and given the sheer cost, the idea of a general service pension economically impossible. Indeed, when the committee began its work in March 1916 Canada had already raised over 275,000 volunteer soldiers, with Prime Minister Borden ambitiously promising a further 500,000.²⁶ A nation with comparatively little federal revenue could not reasonably support a program equivalent to the American system, but for those disabled while on active service, meaningful reform was needed to rectify the shortcomings of Pension and Claims Board's outdated regulations.

In mid-May the committee's third and final report was submitted and its recommendations adopted through order-in-council. The administration of pensions was passed on to a new Board of Pension Commissioners headed by three members of good public standing, each serving for a period of 10 years. The board would operate on a strictly non-partisan basis to prevent the system from being manipulated for political gain

²⁴ Glasson, *Federal Military Pensions*, 250, 259. The 1907 legislation did add significant numbers of veterans or dependents to the pension rolls, but it did substantially increase the rates for many pensioners receiving benefits for only minor disabilities. The number of pensioners actually decreased between 1902 and 1913 from 999,446 to 820,200 but the annual cost rose from \$137,504,000 to \$172,409,000. *Federal Military Pensions*, 259.

²⁵ Glasson, 273.

²⁶ Tim Cook, *Warlords: Borden, Mackenzie King, and Canada's World Wars* (Toronto: Allen Lane, 2012), 72-73.

(as had happened in the American Civil War pension system).²⁷ To chair the board Borden appointed J.K.L. Ross, a lauded Montréal millionaire who had recently donated three of his private yachts to the budding Royal Canadian Navy and supplied the MHC with one of his residences to use as a convalescent hospital. Accompanying Ross were Lt.-Colonel R.H. Labatt and Major John L. Todd, the former a long-time militia colonel who had served briefly in France and the latter a CAMC physician and rising star in the field of pathology.²⁸ Col. C.W. Belton, a physician and former head of the Pensions and Claims Board, took on the responsibility of chief medical advisor in Ottawa.

Under the new arrangement all pension applications were to be forwarded by army medical boards to the commissioners for consideration and ruling. Unless a discretionary appeal was granted, the board's decision was final. Applicants granted an appeal were personally responsible for appearing before the commission at Ottawa or hiring counsel to represent them. Except in certain cases of permanent disability qualified medical officers or approved civilian practitioners were required to reassess all active pensions on an annual basis. After an up-to-date medical evaluation was submitted the commissioners would decide whether to increase, decrease, or discontinue the award.²⁹

A new framework for the administration of pensions was but one prong of the committee's suggested reforms. Criteria for classification of disabilities and rates of compensation for disablement were also revised. The four-degree militia-era rating system was abandoned for a more flexible six-class scale measured in increments of 20

²⁷ *Special Committee* (1916), 3.

²⁸ Morton, "Resisting the Pension Evil," 204.

²⁹ *Special Committee* (1916), 3.

per cent. The new scale made no distinction between a soldier who became disabled in the ‘presence of the enemy,’ in camp, or whose illness predated service. Instead, any pre-enlistment disabilities were rated by the degree to which military service had aggravated the condition if it predated enlistment. Compensation was also increased dramatically: an unmarried private could now receive a pension of \$480 per year for a 100 per cent disability, supplemented by government-supplied artificial appliances, free medical treatment in MHC facilities or approved institutions, and special allowances.³⁰ To aid in the assessment of pension claims a special Table of Incapacities containing guidelines for army and pension medical examiners was introduced. Blindness, incurable tuberculosis, or loss of both legs were all pensionable to a maximum of 100 per cent, while loss of an arm or leg were pensioned to 60 per cent. Deafness could range from 1 to 40 per cent depending on its severity and relation to service conditions. Few of the examples found in the table, however, provided insight on how to appraise pre-existing conditions or diseases unique to overseas service, a telling reflection of policymakers’ preoccupation with the economic consequences of physical maiming.³¹

The recommendations of the 1916 special committee established the principles that would guide Canadian pension policy for decades to come. The level of compensation a soldier received was to be evaluated on the objective medical impact of his disability in the general labour market. If the system was to be equitable to all soldiers and scientific in administration, then a man’s pre-war occupation could not be taken into

³⁰ *Special Committee (1916)*, 3-5. For 1915 rates see Appendix IV.

³¹ *Special Committee (1916)*, 3-5.

consideration when medical examiners assessed the extent of his disability.³² Most importantly, the committee was adamant that a man's earnings in his post-war occupation should not impact his pension award. They gave their rationale as follows:

That, to encourage industry and adaptability, no deduction be made from the amount awarded to such pensioner owing to his having undertaken work or perfected himself in some form of industry. The welfare of the State demands that so far as possible those who are at all able should endeavour to augment their pension allowance. If the pension granted were subject to reduction owing to the recipient having remunerative work, your Committee are of the opinion that a premium would be put on shiftlessness and indifference.”³³

Committee members were wary of a system that punished soldiers for economic success or obstructed the road to self-sufficiency. The Canadian model would incentivize productive labour and circumvent malingering by structuring the scale of benefits so that only the most severely disabled could live in “decent comfort” at the expense of the state.³⁴ For the vast majority of Canadian soldiers, pensions were only partial compensation for the temporary or permanent loss of earning power. Men of sound character and initiative were expected to overcome these physical barriers, either by adjusting to their old occupations upon the return to civilian life or by applying for training in a new vocation.³⁵ Through empowering the disabled to re-establish themselves on their own terms, pension authorities hoped to safeguard Canada's economic future by

³² *Special Committee (1916)*, 3. Also see “A Permanent Pensions Board,” *CMAJ* 6, no. 10 (October 1916): 924-25.

³³ *Special Committee (1916)*, 4.

³⁴ Todd, “The Duty of a War Pension,” *The North American Review* 210, no. 767 (October 1919): 501.

³⁵ E.M. von Eberts, “Functional Re-education and Vocational Training of Soldiers Disabled in War,” *CMAJ* 7, no. 3 (March 1917): 193-94.

limiting the long-term burden of disability on soldiers' kin, their communities, and the state.³⁶

III. RESPONDING TO THE CRISIS OF THE DISABLED, 1916-18

The Borden government set the BPC to work in September 1916 confident that the Canadian scheme's combination of scientific impartiality and administrative efficiency would do returned men justice. Up to that point the country's pension bill was still miniscule compared to the significant casualties experienced by her European allies. Between 4 August 1914 and 11 September 1916 the Pensions and Claims Board had granted only 3901 pensions and 480 gratuities, a rate of 1 award for every 73 enlistees.³⁷ Existing pensions would need to be re-examined systematically and adjusted to the new scale. Local offices were also required to handle the increasing number of applications for widows and dependents of soldiers killed in the line of duty. More casualties were a certainty. In September the Canadian Corps was called to action in a last ditch effort to break through the extensive German trench network on the Somme at the Battle of Flers-Courcelette. Sir Douglas Haig's faltering offensive came at a heavy price to the Canadians. In two months of fighting the Canadian Corps suffered over 24,000 killed,

³⁶ "Returned Soldiers and the Medical Profession," *CMAJ* 7, no. 4 (April 1917): 343-55

³⁷ *Returned Soldiers: Proceedings of the Special Committee Appointed to Consider, Inquire into and Report upon the Reception, Treatment, Care, Training and Re-education of the Wounded, Disabled and Convalescent who have Served in the Canadian Expeditionary Forces and the Provision of Employment for those who have been Honourably Discharged and the Training and Re-education of those so Discharged who are Unable to Engage in their Former Occupation* (Ottawa: King's Printer, 1917), 142-43. Hereafter cited as *Special Committee (1917)*.

wounded or captured, more than 28 per cent of its fighting strength.³⁸ Frontline infantry bore the brunt of the slaughter, accounting for 90 per cent of all casualties.³⁹

By the end of 1916, disabled men were returning to Canada at the rate of several hundred per month, and although the groundwork for Canada's pension system had been laid, the steady influx of severely ill and wounded exposed a number of conspicuous defects. Soldiers found the pension board to be impersonal and its regulations difficult to comprehend.⁴⁰ With no independent appeal system in place, there was little recourse if a veteran filed a grievance against a ruling. Legal counsel was expensive, and few veterans could afford to appear in person before the commissioners at Ottawa. Pro-forma letters issued to applicants after a ruling was made gave few clues on the medical evidence considered by the commissioners and did little to inspire confidence in the system. According to the letter of the law, a man's disability was either connected with service conditions, unrelated, or non-existent. No additional explanation was deemed necessary.

Compensation rates were the most prominent source of discontent. During the Great War inflation led to substantial increases in the cost of living, especially in major Canadian cities. As of April 1917, a family of five living in Ottawa, for example, required \$105.50 per month to cover rent, heat, food, and other essentials.⁴¹ A pension and supplementary allowances for a totally disabled private barely covered 40 per cent of

³⁸ Tim Cook, *At the Sharp End: Canadians Fighting the Great War 1914-1916* (Toronto: Viking, 2007), 525.

³⁹ Cook, *At the Sharp End*, 525.

⁴⁰ *Official Report of the Debates of the House of Commons for the Dominion of Canada, First Session – Thirteenth Parliament, Vol. 1* (Ottawa: King's Printer, 1918): 122. Hereafter cited as *Hansard*. Of over 800 complaints filed against the commission in 1917. The majority, according to one MP, resulted from soldiers' "insufficient understanding of the Pension Regulations."

⁴¹ *Special Committee (1917)*, 1205. The GWVA's derived their statistics from the April 1917 issue of the *Labour Gazette*.

these costs. The majority of soldiers who returned with minor wounds or physical defects were granted a pension of a few dollars per month, or a one-time gratuity equal to about a month's pay, forcing them to seek outside assistance from patriotic organizations, family, or private charity.⁴² In spite of substantial increases to the pension rates the BPC had inherited a pension scheme that was still largely unable to meet the basic needs of most disabled men. As one prominent Canadian medical officer lamented, for all of its noble intentions, pensions were quickly becoming a "most fruitful cause of complaint" amongst Canada's war heroes.⁴³

Politicians responded in the spring of 1917 by establishing a second parliamentary special committee. Improving the pension system ranked high on the agenda but was quickly overshadowed by unrelenting debate over how to resolve the ongoing conflict between the army medical corps and Military Hospitals Commission. In the final weeks of the committee's investigation, the newly established Great War Veterans' Association (GWVA) tabled a hastily prepared report outlining 22 separate recommendations for improving the pension system. Among the proposed changes were increases to allowances for widows and dependents, raising the maximum pension rate for a totally disabled man to \$840 dollars, and the creation of a formal appeal process.⁴⁴ The effort was too little too late. The committee's final report left parliamentarians to decide how much compensation was necessary, and how the system could be restructured to better

⁴² *Special Committee (1917)*, 526. When a soldier was discharged to a pension their military pay and allowances ceased as well as any funds they may have been receiving from the Canadian Patriotic Fund. See Morton, *Fight or Pay*, 137-39.

⁴³ *Special Committee (1917)*, 1045.

⁴⁴ *Special Committee (1917)*, 1201-1202.

account for the vast assemblage of medical conditions pension officials confronted on a daily basis.⁴⁵

In October, parliamentarians were finally ready to address the burgeoning pension crisis, and agreed to adopt a number of the GWVA's recommendations. The six-class scale was abandoned in favour of a new and more flexible 20-class rating system that measured the impact of a disability in increments of 5 per cent. Pension awards also witnessed a modest increase. A totally disabled private could now receive \$600.00 per year, plus an additional \$300 if he required the aid of an attendant. More substantial allowances for wives and dependent children were also introduced, along with provisions for other dependent kin (such as brothers and sisters).⁴⁶ In all but the most minor cases where a disability fell between 1 and 4 per cent, the much-maligned gratuity was also abolished.⁴⁷ Nearly three-quarters of the GWVA's recommendations had been approved, but as one prominent member cautioned, veterans remained concerned about the durability of the reforms: "While we as an organization regard this amended scheme as satisfactory, lapse of time and constant change in the conduct of the war, and the consequent increase in the cost of living may, sometime in the future, make it necessary to further increase the scale."⁴⁸ Reluctant politicians took the opposite viewpoint, arguing that temporary hardships were no reason to mortgage the country's financial future with

⁴⁵ *Special Committee (1917)*, xxix-xxx.

⁴⁶ See Appendix IV.

⁴⁷ "Increase \$2,000,000 in Roll of Pensions," *Toronto Daily Star*, October 24th, 1917, 4.

⁴⁸ "Increase \$2,000,000 in Roll of Pensions," *Toronto Daily Star*, October 24th, 1917, 4.

lavish spending on benefits. Prices would surely return to normal once hostilities ended.⁴⁹ Even if some veterans were reticent to praise the new Union Government's efforts, with the Military Service Act (1917) now in force, there was little reason to fret about pension rates affecting recruitment.

Parliamentarians and pension authorities could congratulate themselves for their munificence: next to the United States—who compensated disabled soldiers through a combination of compulsory insurance and disability pensions—Canadian rates were now the highest in the world.⁵⁰ Beneath the BPC's softening façade, however, an emerging scandal involving one of its own members threatened to undo the temporary harmony reached between veterans and the state. A decorated reservist in peacetime, R.H. Labatt joined the CEF in August 1914 as a lieutenant colonel, taking command of the 4th Battalion of the Central Ontario Regiment. After briefly serving in France Labatt fell ill with a duodenal ulcer and was eventually returned to Canada where he served in a training capacity until his appointment to the pension board. He was officially discharged from the CEF in October 1917 suffering from what doctors described as a severe case of 'valvular disease of the heart' (VDH), a condition that earned him a full disability pension of over \$2000 per year in addition to his \$5000.00 pension board salary⁵¹

⁴⁹ *Soldiers' Pension Regulations: Proceedings of the Special Committee appointed to consider and report upon the Pension Board, the pension regulations and the sufficiency or otherwise of the relief afforded thereunder, the pension lists in force in Canada for disabled and other soldiers and the dependents of those killed while on active service, and any other matters relating thereto or connected therewith* (Ottawa: J. de L. Taché, 1918), 21. Hereafter cited as *Special Committee (1918)*.

⁵⁰ *Special Committee (1918)*, 81. The maximum pension for a totally disabled private in the U.S. was only \$300, but a government insurance scheme provided an additional \$360.00, bringing the total to \$660.00.

⁵¹ *Special Committee (1918)*, xiii., 126.

As the sole commissioner in Ottawa throughout late 1917 and early 1918 (both Todd and Ross were carrying out work in England), Labatt's extraordinary compensation outraged the GWVA and MPs who had received increasing complaints from ex-soldiers frustrated with the slowness of pension decisions and paltry levels of compensation. H.H. Stevens, a Conservative MP for Vancouver Centre, went so far as to charge that Labatt had been given a patronage appointment because of his relationship with the Minister of Militia and Minister of Railways.⁵² The charges were picked up widely in the Canadian press, but the allegations proved to be a complete farce.⁵³ Ultimately the legitimacy of Labatt's health was not the primary issue. What confounded most was why the colonel had been appointed to a position he could not devote his full energy to in the first place, and moreover, whether his disability was attributable to military service, or pre-dated enlistment.

Labatt's waning health garnered little sympathy from veterans. More compelling examples of personal hardship were ubiquitous on the Canadian home front. Enlisting with the PPCLI on 20 August 1914, Sergeant Albert B., a 35-year-old carpenter from Calgary, was one of the first Canadians to see combat overseas. On 8 May 1915 he was hit in the right forearm by a rifle bullet. The wound caused extensive nerve damage, leaving Albert with stiffness in his elbow and paralysis in his fingers.⁵⁴ Medical records also show that he was exposed to gas on the 24th of April, but for unexplained reasons did

⁵² H.H. Stevens, who sat on the 1918 special committee, originally penned his letter to the committee's chairman N.W. Rowell. It was leaked shortly thereafter to the *Ottawa Citizen* and later published throughout the Canadian press. See "N.W. Rowell Explains the Stevens Letter," *Toronto Daily Star*, May 9th, 1918, 1. For a copy of the letter, see *The Edmonton Bulletin*, May 27th, 1918, 7.

⁵³ *Special Committee (1918)*, xiii.

⁵⁴ Personnel File, Albert B., RG 150, Accession 1992-93/166, Box 528 – 31, LAC.

not report sick. Shortly after Albert's discharge in August 1915, a medical report described his condition as follows: "He appears dazed and unable to give a good acct. of where he has been, is very sallow and unhealthy looking."⁵⁵ Only able to continue with light work, he was initially granted a third degree pension of \$168.00 dollars per year. It was later reduced to a 20 per cent pension under the amended 1916 regulations.⁵⁶ Albert spent the remainder of the war as a court orderly in Calgary. The occupation was by no means strenuous, but he soon developed chronic fatigue and a severe cough. Despite strong evidence that his poor health resulted from exposure to chlorine gas, the commissioners did not formally recognize this ailment until October of 1919 when doctors diagnosed him with disordered action of the heart, a condition remarkably similar to the one that afflicted Colonel Labatt. By this time Albert's pension had been reduced to 10 per cent, and was later commuted in 1920 for a one-time gratuity.⁵⁷

The Labatt scandal neared its climax as yet another parliamentary special committee was deliberating revisions to pension regulations—a fact that was quickly lost on members as they immersed themselves in a thorough investigation of the colonel's medical history and service record. In spite of the glaring disparity between Labatt's pension compensation and those typically awarded to ordinary soldiers, committee members could find no fault in the assessment of his case. BPC physicians had followed the letter of the law: the colonel's disability was a severe handicap in the 'general labour market'—but evidently not for a desk job—and it was incurred on active service. In an

⁵⁵ Pension File, Albert B., VAC.

⁵⁶ Pension File, Albert B., VAC.

⁵⁷ Pension File, Albert B., VAC.

effort to determine whether the disability predated his enlistment the committee went so far as to interview his friend and family surgeon, who regaled members with an account of a rugged camping trip to Temagami Lake that the two had embarked upon days before the war broke out.⁵⁸ In their final report the committee stood by the beleaguered colonel, lauding him for his “able advice and assistance” and the “most efficient” manner he displayed in carrying out his duties.⁵⁹ Shortly thereafter, Labatt resigned his post.

Even if the 1918 special committee could find no wrongdoing, Labatt’s case accentuated the need for more equity and transparency in the pension system. The BPC had survived its first major political crisis but not without a black mark on its already diminishing reputation amongst veterans and the public alike. The prioritization of administrative efficiency over humanity and compassion remained endemic behind closed doors. Indeed, it was commonplace for a single officer in Belton’s pension medical branch to handle dozens—even hundreds—of cases without the head commissioners even glancing at a single one. As a general rule, senior officials scrutinized only difficult cases or those related to a “question of policy.”⁶⁰ Army medical boards only added to the administrative confusion by diverging wildly in their appraisal of the same disability, sometimes by as much as 75 per cent between individual cases.⁶¹ In part this was due to the subjectivity of the pension board’s disability table, but the pension officials were

⁵⁸ *Special Committee (1918)*, 328-29.

⁵⁹ *Special Committee (1918)*, xiii.

⁶⁰ *Special Committee (1918)*, 222-23.

⁶¹ *Special Committee (1918)*, 12-13.

quick to blame army physicians for their ‘inexperience’ and propensity towards sentimentality.⁶² They were simply not being ‘scientific’ enough.

The final report of the 1918 special committee offered disabled veterans few tangible improvements to existing pension regulations, instead focusing primarily on how to increase efficiency and accountability within the BPC. Despite the increasing cost of living and a steady rise in the number of severely wounded men returning from overseas, pension rates were left unaltered. The bill was already a heavy one: by 28 February 1918, 19,900 disability pensions had been granted to returned Canadian soldiers. An additional 30,000-40,000 applications were expected over the course of 1918-1919, a number that proved to be a gross underestimation.⁶³ In anticipation of the public calamity that might ensue if these cases were not handled with tact and efficiency, the committee recommended that parliamentarians return to the question of ‘returned soldiers problems’ yet again in the months ahead.

IV. THE PENSION ACT AND THE RETURN TO CIVVY STREET, 1919-20

By mid 1919, all three original commissioners had stepped aside. J.L. Todd, the key architect of Canada’s pension policy and international face of the commission, resigned in February 1919 to pursue his own academic and personal interests.⁶⁴ J.K.L.

⁶² A version of the BPC’s disability table in use during 1918 is available in *Special Committee (1918)*, 37, 98-102. The table covers 90 varieties of impairments with additional sub-variants and the corresponding range of incapacity for each. Heart disease, for instance, could range from 0 to 100 per cent, while chronic bronchitis was capped at 40 per cent. An injury to the ulnar nerve in the arm was capped at 15 per cent but severe damage to the brachial plexus (nerves running from the spine to the arm) could result in an 80 per cent pension.

⁶³ *Special Committee (1918)*, 245-46. These pensions included over 1600 for ‘nervous diseases,’ 3000 for respiratory conditions, 1400 heart conditions, and more than 5500 ‘unclassified’ illnesses or injuries.

⁶⁴ Morton, “Resisting the Pension Evil,” 210.

Ross followed in May 1919 after becoming fed up with persistent government intervention in the board's affairs.⁶⁵ For the next 18 months the pension board experienced frequent turnover in its leadership and a revolving door of physicians in Belton's medical branch as a result of many returning to their pre-war practices. The administrative chaos came at an inopportune time. The full costs of the European war were manifested in catastrophic fashion throughout 1917 and 1918. In 1917 alone the Canadian Expeditionary Force suffered 49,326 non-fatal casualties. The Canadian Corps, whose soldiers quickly gained a reputation as the 'shock troops' of the British Empire, lost a staggering 10,500 men at the Battle of Vimy Ridge between 9 and 15 April, and a further 16,000 from mid October to mid November at the Battle of Passchendaele.⁶⁶ Operationally, the Corps spent much of 1918 in a supporting role, recuperating from the extensive losses it suffered during the failed offensives of 1917. Its pivotal role in the Hundred Days' offensive brought another heavy wave of casualties—some 42,600 between 8 August and the armistice on 11 November.⁶⁷ Over the span of just two years nearly 100,000 Canadian soldiers were wounded on the battlefield, many of whom would carry the scars of war for the rest of their lives.⁶⁸

The armistice brought with it no respite for parliamentarians or the pension commissioners. In addition to planning for the daunting task of demobilizing nearly

⁶⁵ "Chairman of the Pension Board Threatens to Quit Unless Supported by the Government," *The Edmonton Bulletin*, July 22nd, 1918, 3.

⁶⁶ Tim Cook, *Shock Troops: Canadians Fighting the Great War 1917-1918* (Toronto: Viking, 2008), 143, 367.

⁶⁷ Cook, *Shock Troops*, 552.

⁶⁸ *Report of the Ministry, Overseas Military Forces of Canada, 1918* (London: Overseas Military Forces of Canada, 1919), 58.

400,000 active-duty soldiers, medical examinations, final pay, and travel arrangements would have to be made for all. Formal legislation was also needed to compress and enshrine the numerous wartime orders-in-council that comprised Canada's patchwork of pension regulations. In customary fashion, the responsibility of determining how Canada's program measured up was assigned to a parliamentary special committee.⁶⁹ Did existing regulations grant soldiers sufficient benefit of the doubt when determining 'attributability'? Would placing a deadline on pension applications prevent abuse of the system in the future? Did veterans and advocates working on their behalf agree with the principle of awarding pensions based on scientifically measured physical incapacity? Should awards based on rank be abolished, especially after the Labatt fiasco?

By the time the war ended, Canada could draw on other models for inspiration. The British Ministry of Pension, for example, allowed soldiers whose disabilities prevented them from re-attaining their pre-war income to receive an "Alternative Pension" for "pecuniary sacrifice" that supplemented their basic pension with additional allowances scaled according to pre-war earnings.⁷⁰ For a short time the ministry also offered one-time gratuities of up to £150.00 (but usually averaging £30.00) to physically unfit soldiers who were mistakenly admitted into the ranks.⁷¹

⁶⁹ *Pensions and Pension Regulations: Proceedings of the Special Committee Appointed to Consider the Questions of Pensions and Pension Regulations, and all Matters Pertaining thereto, and to Prepare a Bill Dealing with Pensions for the Consideration of the House* (Ottawa: King's Printer, 1919), 1. Hereafter cited as *Special Committee (1919)*.

⁷⁰ Lieut.-Col. Sir A. Griffith-Boscawen, "Pensions and Allowances," in *Proceedings of the Inter-Allied Conference on the After-Care of Disabled Men* (London: H.M.S.O., 1918), 20.

⁷¹ Griffith-Boscawen, "Pensions and Allowances," 21.

Fearing an administrative calamity and potential backlash from returning veterans, Canadian planners stuck to the operating principle that pensions were to be awarded on the basis of objective physical or mental impairment only. The British model would unduly privilege men of means over those with severe disabilities whose relative sacrifice had been greater. One contradictory thread, however, remained in the fabric of Canadian pension policy: compensation rates continued to be based on a soldier's rank. In spite of persistent pressure from the GWVA and other veterans' organizations to base pension rates solely on the extent of a man's disability, there was little will to remove military hierarchy from the system, though future reforms would at least narrow the compensation gap between officers and other ranks.⁷²

More than three years of debate and reform culminated in September 1919 with the passing of the Pension Act (1919), a landmark piece of legislation that solidified and institutionalized the burgeoning relationship between the state and Canada's veterans. In response to mounting pressure from the GWVA and other veterans' organizations the Act provided disabled soldiers with a one-year 20 per cent bonus, raising the maximum pension for a totally disabled private to \$720.00 per year.⁷³ Veterans had hoped for an increase of 40 per cent, but the 1919 committee justified a smaller increase in the ongoing belief that high wartime prices would soon diminish. In an acknowledgement that many soldiers might yet perish as a result of lingering war wounds or chronic diseases such as tuberculosis, the new legislation also extended pensions to the widows of soldiers who

⁷² *Special Committee (1918)*, 22-31. Also see *G.W.V.A. Soldiers Civil Re-establishment Scheme as Submitted to the Dominion Government October 1919* (1919).

⁷³ See rates for 1919 in Appendix IV.

died after leaving the army, so long as their death was attributable to their pensionable disability. There was one minor caveat. In order for widows to receive their husband's pension, the marriage had to have taken place prior to the emergence of the disability, a feature of Canadian policy undoubtedly tempered by the American experience of Civil War veterans and 'deathbed' marriages.⁷⁴

When the Pension Act came into effect in September of 1919 the principles of Canadian pension policy remained largely intact. However, the scope and complexity of the system had changed dramatically since its beginnings in 1916. At over 30 pages in length and comprising dozens of sections amalgamated from previous orders-in-council, the Pension Act was a daunting piece of legislation that did more to confuse ex-servicemen than clarify the benefits that their disabilities entitled them to. The Act was itself a conflation of numerous and often-competing ideas found within wartime discourse on disability. Patriotism, sentimentality, and social progressivism galvanized MPs, re-establishment authorities and the public to create a program that showcased Canada's philanthropy towards her disabled soldiers and their kin while simultaneously promoting self-sufficiency and the breadwinner ideal. In practice, however, pension legislation largely betrayed the "blithe spirit" of post-war reconstruction by becoming increasingly "intricate, technical, and bewildering."⁷⁵ Fiscal prudence and administrative rigidity did little to endear the Act to veterans who tied pension benefits to their heightened sense of citizenship. Even so, the commissioners continued to dispense pensions at an astounding

⁷⁴ Morton and Wright, 155-59.

⁷⁵ Morton and Wright, 156.

pace—over 78,000 between April 1918 and March 1921. Veterans, however, measured the adequacy of these efforts in quality rather than quantity.⁷⁶

The GWVA and other veterans' groups wasted little time in pressuring the government for further action to address shortfalls in the pension legislation. For the fifth year in a row, a parliamentary special committee was formed in the spring of 1920 to investigate pensions and returned soldiers' problems. The committee's recommendations led to several important amendments to the Pension Act. In addition to a base pension of \$600.00, a fully disabled man was now eligible to receive a 50 per cent bonus of \$300 for the years 1921, 1922, and 1923, bringing the total disability pension for an unmarried private to maximum of \$900.00 per year.⁷⁷ Thanks to other increases in rates for dependents a totally disabled veteran with a wife and three children would receive \$1644.00, well above average wages for a working man in most areas of the country.⁷⁸ At the behest of the GWVA and other veterans' organizations a new system of optional gratuities was also introduced for men whose disabilities fell between 5 and 14 per cent (class 19 and 20). Under the amendment a veteran could opt to receive a lump sum gratuity of \$300.00 (class 20) or \$600.00 (class 19) in lieu of future pension payments, the full amount to be determined based on the "probable duration" of their disability.⁷⁹ Eager to reduce the country's bloated pension bill and administrative costs of annual

⁷⁶ *Report of the Work of the Board of Pension Commissioners for Canada* (Ottawa: King's Printer, 1921), 27. Hereafter cited as *BPC Report*.

⁷⁷ For 1920 rates see Appendix IV.

⁷⁸ Appendix IV; *BPC Report* (1921), 8-9.

⁷⁹ *BPC Report* (1921), 10-11. Married pensioners were required to gain permission from their wives to accept any gratuity, a clear acknowledgement of women's own material rights to benefits as dependents of disabled veterans.

medical examinations, the politicians were more than willing to acquiesce. If a man's disability deteriorated significantly he could apply to have his pension status reassessed, but the commissioners anticipated that the impact of the war on most soldiers suffering from 'minor' disablement had reached its apex. Continued access to the medical services of the DSCR would prevent most of these cases from regressing significantly.⁸⁰

The strains of reintegration coupled with widespread frustration over abysmal monthly pension rates of \$2.50-\$5.00 for a private compelled a significant portion of eligible veterans to commute their pension. Edward P. was one such veteran. An electrician by trade, Edward enlisted in March 1916 at the age of 38 but never made it out of Canada after suffering an inguinal hernia during training at Camp Borden, Ontario.⁸¹ He was discharged in early 1917 with a \$50.00 gratuity, but was later placed back on the pension roll with a 10 per cent disability pension following the October 1917 amendments. With a steady job in hand, Edward opted to forego his monthly pension in favour of a lump-sum payment of \$600.00 in September 1920.⁸² His case was typical of ex-servicemen who were enticed by the allure of a significant payday, frustrated with continuing bureaucracy, and emboldened by the hope that their health and vitality would not regress. Indeed, between September 1920 and March 1922, 22,998 ex-servicemen—nearly a third of all disability pensioners—commuted their pensions in favour of these gratuities.⁸³ By 31 March 1922 only 45,133 were still receiving a disability pension.⁸⁴

⁸⁰ *BPC Report* (1921), 10-11.

⁸¹ Personnel File, Edward P., RG 150, Accession 1992-93/166, Box 7973 – 29, LAC.

⁸² Pension File, Edward P., VAC.

⁸³ *BPC Report* (1921), 29; *BPC Report* (1922), 10, 17. Figure arrived at by adding the number of pension 's awarded between 1918-21 and total awards for 1922, the latter of which totalled 1894.

V. PENSIONING IN PRACTICE, 1914-21

In the eyes of pension officials the 1920 amendments reaffirmed Canada's international reputation as the most generous country in the world to its disabled ex-servicemen. With the exception of the United States, which capped awards at \$1200.00 per year regardless of the number of dependents, Canada's pension rates were "practically double" those of any other former combattant.⁸⁵ Who, though, could access benefits of this magnitude? Moreover, what could the average pensioner expect from the state as compensation for his disabilities? What disabilities were worthy and unworthy? As Chapter 1 illustrated, disability was pervasive in the Canadian Expeditionary Force, encompassing an array of conditions ranging from pre-existing deformities such as flat feet to battlefield-specific illnesses such as trench fever or gas poisoning. Because few studies of disability and the First World War have utilized service records and pension files in a systematic fashion we know very little from a quantitative perspective about the connections between military service, the incidence of disability, and pensioning. In the Canadian case, the dearth of knowledge is compounded by the fact that official pension data was not standardized and published in annual reports until 1921.

The data presented below and the accompanying discussion form a modest attempt to identify who Canada's Great War disabled were and how they parlayed their wartime experiences into claims for a pension during and immediately after the conflict. The data also allow us to measure how pension authorities responded, and moreover, why

⁸⁴ *BPC Report* (1922), 14.

⁸⁵ *BPC Report* (1921), 10-11. See Appendix IV for pension scale comparison.

the experiences of soldiers with certain disabilities may have differed from others. Perhaps most importantly, the data offer insight on the health of Canada’s soldiers and boundaries of wartime medicine, the limits of state generosity, and provide a foundation to chart the changing meanings of disability in war and peace.

Of 384 CEF members in the sample group, 127 were discharged with a disability identified by an army medical board before leaving the service. Of these 127 cases, 29 had two disabilities, while a further five had three. To better understand the data, each disability was placed under a broader category of disabilities—eight in total—that roughly correspond to official nomenclature used during this period.⁸⁶ The breakdown according to number of cases and number of disabilities by category is presented in Table 3.1 below.

TABLE 3.1 – DISTRIBUTION OF DISABILITIES AT DISCHARGE BY CATEGORY

DISABILITY CATEGORY	TOTAL CASES	TOTAL DISABILITIES	% OF DISABILITIES
Gunshot Wounds	28	32	19.9%
General Diseases/Injuries	37	47	29.2%
Respiratory	13	13	8.1%
Circulatory	9	9	5.6%
Psychological/Nervous	16	16	9.9%
Skin/Special Senses	32	36	22.4%
Digestive	3	3	1.9%
Genito-urinary	5	5	3.4%
Total	143	161	100%

Table 3.1 reveals several important features of disability in the Canadian Expeditionary Force. The evidence from the sample group overwhelmingly confirms that non-combat disabilities were the more common source of impairment amongst soldiers. Many of these

⁸⁶ Categories for the classification of disabilities were present on various iterations of army medical board reports, and eventually were incorporated into the annual reports of the Board of Pension Commissioners. See *BPC Report* (1925), 12-13.

conditions fall under categories representing disorders that were frequently discovered amongst the rank and file of the CEF only after enlistment. Skin diseases and impairment of special senses (vision and hearing) were especially prevalent amongst troops, including 11 cases of defective hearing and 17 non-combat related cases of defective vision.⁸⁷ General injuries and diseases ranged widely. Included were 15 soldiers with flat feet and other foot deformities, 10 with conditions that could be best described as ‘general pain’—namely rheumatism, myalgia and arthralgia—and six who suffered hernias. Nervous disorders and circulatory conditions, for which wartime medicine had few concrete answers, constituted over 15 per cent of all disabilities at discharge.⁸⁸

To what extent were soldiers’ disabilities attributable to their military service? In their journey back to civil life, the first step for all men leaving the CEF was a final medical board, normally held at one of Canada’s three main discharge depots in Québec City, Halifax, or Saint John. Patients who required further treatment would receive their examination after leaving hospital. Medical boards normally consisted of three army physicians who assessed a man’s medical history and present physical condition based on the same Table of Incapacities utilized by the BPC.⁸⁹ If a soldier was discharged as ‘medically unfit,’ and sufficient evidence for a pension claim was present, a detailed medical report was forwarded to the head office of the BPC in Ottawa for a final ruling. The commissioners were adamant that medical boards not openly discuss the extent of the

⁸⁷ The total number of soldiers suffering from defective vision was 20, three of which suffered injuries in combat.

⁸⁸ Circulatory conditions include both DAH and VDH, both of which treated as distinct from nervous disorders by official nomenclature by the war’s end. See *BPC Report* (1925), 12-13.

⁸⁹ W.T. Connell, “The Returned Soldier,” *CMAJ* 8, no. 9 (September 1918): 800-802.

soldier's disability with him during the examination, nor were multiple disabilities to be assessed individually. The only important information for ruling purposes was "the extent of the total disability existing in the person concerned."⁹⁰ Providing this information to soldiers while in the presence of the board, pension officials feared, might compel sympathetic medical officers to exaggerate the extent of a man's impairment.⁹¹ Cold, rational scientific objectivity was essential to determine the attributability and extent of a man's disability.⁹²

Unfortunately, the numerous alterations in pension regulations and medical instructions, as well as the variations in descriptive quality of the reports make it too difficult to assess how frequently army medical boards diverged from BPC assessments. Administrative changes further complicate matters. Following the summer of 1918, for example, the BPC instructed medical boards to refrain from estimating the percentage of a man's disability, and instead provide the commissioners with "the fullest possible description of the history and the present condition of the man."⁹³ Nevertheless, it is still useful to analyze how medical boards interpreted disability and weigh these findings against trends in pensioning.

Tables 3.2 and 3.3 below each illustrate that a substantial portion of disabilities were classified as attributable or aggravated by service, and an even larger portion of soldiers were discharged with at least one disability connected with military service.

⁹⁰ See Appendix V.

⁹¹ See Appendix V.

⁹² Connell, 800-802. Connell's article struck a nerve with the BPC, who saw the article as a veiled attack on the professionalism of the BPC's medical officers. For a rebuttal, see J.M. Biggar, Letter to the Editor, *CMAJ* 8, no. 11 (November 1918): 1038-39.

⁹³ Connell, 801.

TABLE 3.2 – DISTRIBUTION OF DISABILITIES AT DISCHARGE ACCORDING TO ATTRIBUTABILITY

ATTRIBUTABILITY	DISABILITY 1	DISABILITY 2	DISABILITY 3	TOTAL DISABILITIES	
	CASES	CASES	CASES	COUNT	%
Not Attributable	37	8	1	46	28.6%
Attributable	70	18	2	90	55.9%
Aggravated	14	3	2	19	11.8%
Not Given	6	0	0	6	3.7%
Total	127	29	5	161	100%

TABLE 3.3 – DISTRIBUTION OF CASES ACCORDING TO ATTRIBUTABILITY⁹⁴

ATTRIBUTABILITY	CASES	% OF DISABLED	% OF SAMPLE
Not Attributable or Aggravated	35	27.6%	9.1%
Attributable or Aggravated	86	67.8%	22.4%
Not Given	6	4.7%	1.6%
Total	127	100%	33.1%

Each of the above tables shows that just over two-thirds of disabilities were linked to military service in some way. Disabilities resulting from gunshot or shrapnel wounds, to no surprise, were the most common, accounting for 35.5 per cent of all attributable disabilities. More striking are the number of other disabilities that boards ruled favourably upon: 12 of 16 nervous disorders (75 per cent), for example, were classified as attributable, including three cases of neurasthenia. With the exception of one case of suspected tuberculosis, all respiratory illnesses were deemed attributable or aggravated as well. A number of physical conditions that predated enlistment also received the benefit of the doubt, including over 50 per cent of all foot defects ($n=8/15$).

In addition to determining the attributability and degree of a soldier's incapacity, army medical boards also considered whether the disability was permanent or would heal

⁹⁴ In this table several cases included multiple disabilities. If a case included at least one attributable or aggravated condition they were tabulated in that row. If they lacked any ruling information, or all disabilities were deemed not attributable they were assigned to one of the other remaining rows.

over time. Table 3.4 presents a breakdown of disabilities and cases according to prognosis, while Table 3.5 lays out the relationship between a disability’s prognosis and attributability.

TABLE 3.4 – DISABILITY PROGNOSIS ACCORDING TO FREQUENCY AND NUMBER OF CASES

PROGNOSIS	TOTAL DISABILITIES	CASES	% OF DISABLED	% OF SAMPLE
1 Month	2	1	0.8%	0.3%
2 Months	1	1	0.8%	0.3%
3 Months	6	5	3.9%	1.3%
6 Months	32	22	17.3%	5.7%
12 Months	5	5	3.9%	1.3%
Permanent	99	79	62.2%	20.1%
Not Assessed	16	14	11.0%	3.7%
Total	161	127	100	33.1%

TABLE 3.5 – DISABILITY PROGNOSIS ACCORDING TO ATTRIBUTABILITY

PROGNOSIS	NOT ATTRIBUTABLE	ATTRIBUTABLE	AGGRAVATED	NOT GIVEN	TOTAL
1 Month	2	0	0	0	2
2 Months	0	0	1	0	1
3 Months	0	4	2	0	6
6 Months	1	27	2	2	32
12 Months	1	3	0	1	5
Permanent	39	47	12	1	99
Not Assessed	3	9	2	2	16
Total	46	90	19	6	161

Of the 46 non-attributable disabilities, 39 (84.7 per cent) were permanent and in all probability existed before enlistment. More than half of the attributable or aggravated conditions were also classified permanent, while 34.9 per cent received a prognosis of six months or less. The majority of permanent disabilities were not combat injuries but illnesses. In fact, only 16 disabilities resulting from gunshot/shrapnel wounds were classified permanent, including five amputations, two enucleations of the eye, and two cases of facial disfigurement. Ultimately, medical examiners expected that soldiers would

overcome severe wounds after receiving extended treatment and physical rehabilitation.

Another important factor to consider in determining the probability of a soldier obtaining a pension is the theatre in which he served. Post-war pension statistics indicate that the majority of awards granted (upwards of 85 per cent) went to men who served in Belgium or France. Little, however, is known about where the disabled, both pensioned and non-pensioned, served during the war. By cross-tabulating medical board ruling data according to theatre of service, we can begin piecing together this part of the story. Table 3.6 provides a breakdown of disability attributability according to a soldier’s final theatre of service, while Table 3.7 provides a breakdown of all cases. Table 3.8 shows the incidence of disability by theatre served and attributability. The value counts do not reflect the number of disabilities that arose while a soldier served in a particular theatre, but instead represent the furthest theatre of service that a soldier reached during their time in the CEF.

TABLE 3.6 – DISTRIBUTION OF DISABILITY ATTRIBUTABILITY BY THEATRE OF SERVICE (ALL DISABILITIES)

ATTRIBUTABILITY	THEATRE OF SERVICE					TOTAL
	CANADA	ENGLAND	BELGIUM/FRANCE	SALONICA	SIBERIA	
Not Attributable	20	8	18	0	0	46
Attributable	4	6	79	1	0	90
Aggravated	3	6	10	0	0	19
Unknown	2	1	3	0	0	6
Total	29	21	110	1	0	161

TABLE 3.7 – DISTRIBUTION OF DISABILITY ATTRIBUTABILITY BY THEATRE OF SERVICE (TOTAL CASES)

ATTRIBUTABILITY	THEATRE OF SERVICE					TOTAL
	CANADA	ENGLAND	BELGIUM/FRANCE	SALONICA	SIBERIA	
Not Attributable	17	8	15	0	0	46
Attributable	4	5	64	1	0	90
Aggravated	3	4	10	0	0	19
Unknown	2	1	3	0	0	6
Total	26	18	92	1	0	127

TABLE 3.8 – INCIDENCE OF DISABILITY ACROSS THEATRES OF SERVICE BY ATTRIBUTABILITY (ALL CASES)

ATTRIBUTABILITY	THEATRE OF SERVICE				
	CANADA	ENGLAND	BELGIUM/FRANCE	SALONICA	SIBERIA
Not Attributable	20.2%	19.0%	6.0%	0.0%	0.0%
Attributable	4.8%	11.9%	25.6%	50.0%	0.0%
Aggravated	3.6%	9.5%	4.0%	0.0%	0.0%
Unknown	2.4%	2.4%	1.2%	0.0%	0.0%
Total	31.0%	42.9%	36.8%	50.0%	0.0%
Total Cases in Sample	84	42	250	2	6

The information presented in the above tables is limited by the fact that a soldier's medical records do not always indicate *where* a disability originated, especially in the case of certain diseases. Throughout the war, army medical boards faced the daunting challenge of uncovering the aetiology of all manner of ailments, many of them with curious symptoms rarely encountered by general practitioners in peacetime. In adherence with existing pension regulations, the medical boards tended to give men undergoing examination the benefit of the doubt unless there was clear evidence that the disability pre-dated enlistment and was not exacerbated by service conditions. To no surprise, out of the three main theatres the highest portion of disabilities linked to service conditions occurred in France, followed then by England, and then Canada. Compared to Canada, the number of disabled soldiers who served exclusively in England was proportionately

higher. The ongoing need to maintain military manpower largely explains this feature of the data. Out of necessity, military authorities kept thousands of soldiers with pre-enlistment conditions to perform non-combat duties during the war.⁹⁵ Nearly 50 per cent of these men could claim that their service had a negative effect on their health when they were discharged, though their chances of obtaining a pension remained uncertain. With few exceptions, soldiers who served in Canada fared much less favourably: only one in every four soldiers had their disabilities attributed in some way to military life on the home front.

The statistics derived from the medical board reports contained in veterans' military service records provide an important benchmark to measure pension rulings against. In total, 86 of 127 soldiers in the sample group left the CEF with a disability that was ruled attributable or aggravated by military service. Between the beginning of 1915 and 31 December 1920, 75 veterans in the sample received a pension ruling from the BPC for their conditions—61 of these applicants were discharged from the military with a disability and 14 without. A total of 57 disability pensions or gratuities were awarded while 17 applications were rejected, a success rate of 75 per cent. Of the 61 veterans discharged with a disability who applied for a pension, 45 (73.7 per cent) received a pension. Among 55 successful applications for which pension rating information was available, the median award was 15 per cent, equal to a Class 18 pension worth \$7.50 per

⁹⁵ On the politics and administration of the Canadian army overseas, see Desmond Morton, *A Peculiar Kind of Politics: Canada's Overseas Ministry in the First World War* (Toronto: University of Toronto Press, 1982). On the health of recruits and rationalizing military 'fitness' see Nic Clarke, "Unwanted Warriors: The Rejected Volunteers of the Canadian Expeditionary Force" (PhD diss., University of Ottawa, 2009), especially chapters 3-5.

month based on Schedule A in the Pension Act.⁹⁶ The distribution of awards was skewed heavily towards the lower end of the pension scale: 64.8 per cent of pensions handed out ranged between 1 and 20 per cent. Only six veterans received pensions of 75 per cent or over on initial application, and only three received a disability pension of 100 per cent. Table 3.9 below shows the breakdown of pension awards and disability ratings (the actual degree of incapacity) issued by the BPC to members of the sample group during this period.

TABLE 3.9 – MEAN AND MEDIAN PENSIONS AWARDED BETWEEN 4 AUGUST 1914 AND 31 DECEMBER 1920

	DISABILITY RATING	PENSION RATING
Pension Mean	28.7%	27.8%
Pension Median	15.0%	15.0%
Standard Deviation	26.929	27.074
Total Cases	55	55

There is a dearth of reliable official statistics to compare against the sample group largely because the pension situation was extremely fluid during the late stages of the war and into the early post-war years. Indeed, the BPC did not publish its annual reports on a regular basis until 1921, and the occasional statistical returns presented to parliamentarians during the war offer little in the way of standardized data. The 1921 report is also unreliable because by that point a large portion of veterans had commuted their awards in favour of a final lump-sum gratuity through the provisions of the September 1920 amendments to the Pension Act. Statistics from the Department of

⁹⁶ This figure does not include the one-year, 20 per cent bonus that was added to soldiers' pensions. See Appendix IV.

Pensions and National Health compiled after thousands of commuted pensions were reinstated in the early 1930s show that most pensioners suffered from disabilities of 15 per cent or less.⁹⁷ Given that many of these soldiers would have experienced deterioration in their overall health as a result of economic hardships, post-war lifestyle, or the effects of aging, it is reasonable to conclude that a similar number, and perhaps even more, received comparable awards between 1918 and 1921. Thousands would have to seek out a life of hard labour to make ends meet, a requirement that only made their conditions worse, especially those whose large gratuity payments were used up immediately after receiving them.

Pension officials were optimistic that if they could objectively classify disability on a scientific basis then the legitimacy of their rulings would be self-evident to the majority of returned soldiers. A watchmaker who suffered from paralysis in his fingers was severely handicapped in respect to his former trade, but in the open labour market this disability would not be of great hindrance to finding gainful employment, especially if ongoing treatment would heal the wound or the veteran took advantage of free vocational training. Disability was a temporary roadblock. Veterans struggled to comprehend this underlying rationale of Canadian pension policy, believing that their afflictions deserved much greater compensation than the state was willing to offer. In the face of uncertainties over employment, economic hardship, and chronic pain or sickness, it was hard to be optimistic about one's theoretical capacity to persevere in the general

⁹⁷ See *Report of the Work of the Department of Pensions and National Health* (Ottawa: 1933), 49. All told, 56.6 per cent (44,097 of 77,967) of pension awards in force during 1933 were pensioned at a rate of 20 per cent or less.

labour market. This was especially true for men who suffered from ‘invisible wounds’—pre-existing or contracted diseases with chronic symptoms that could be exacerbated while on the job.

Table 3.10 provides an overview of disabilities that were deemed pensionable and those that were rejected according to categories derived from official nomenclature.

TABLE 3.10 – PENSIONED AND DISABILITIES UPON INITIAL APPLICATION BY CATEGORY, 1914-20

DISABILITY CATEGORY	PENSIONED DISABILITIES	TOTAL REJECTED DISABILITIES	% OF PENSIONED DISABILITIES
Gunshot Wounds	21	1	28.0%
General Diseases/Injuries	22	7	29.3%
Respiratory	9	0	12.0%
Circulatory	6	2	8.0%
Psychological/Nervous	8	0	10.7%
Skin/Special Senses	6	9	8.0%
Digestive	1	0	1.3%
Genito-urinary	2	1	2.7%
Total Disabilities	75	20	100%
Total Cases	57	18	75

Unsurprisingly, the most common source of disability amongst pensioners in the sample emanated from the effects of gunshot or shrapnel wounds. The remaining pensioners suffered from a constellation of illnesses and injuries, many in combination with combat wounds or other disorders. Seven veterans (12.3 per cent) received pensions for nervous disorders, including three men suffering from neurasthenia and one from ‘psychogenetic neuroses.’ Chronic diseases such as pulmonary tuberculosis, nephritis, chronic bronchitis, and heart disease (namely VDH and DAH) accounted for 26.3 per cent of successful applications. The remainder ran the gamut from deformities to defective vision, including five cases of flat feet aggravated by service conditions.

In spite of widespread antipathy towards the pension board, evidence from the sample suggests that the BPC usually ruled in favour of a disabled soldier and was generally reluctant to withhold a pension unless there was substantial evidence that the man's health was unaffected by service conditions. Six of the rejected disabilities, for instance, were for pre-enlistment vision defects. Other rejected disability claims included syphilis, chronic rhinitis, lumbago, psoriasis, bunions, and two cases of rheumatism, all of which appeared to have predated enlistment or emerged after a soldier was discharged.

Half of rejected pension claims came from men who served in Canada or England only. Though the commissioners were eager to extend benefits to soldiers who 'did their bit' by serving in combat, they were more sceptical of those who did not experience the stress and strain of life at the front. Table 3.11 breaks down pension rulings according to the theatre in which the applicant served.

TABLE 3.11 – PENSION ATTRIBUTABILITY BY THEATRE OF SERVICE (CASES)

THEATRE OF SERVICE	ATTRIBUTABILITY				TOTAL
	NOT ATTRIBUTABLE	ATTRIBUTABLE	AGGRAVATED	NO DISABILITY	
Belgium/France	4	44	4	5	57
Canada	2	2	3	1	8
England	5	3	1	1	10
Total Cases	11	49	8	7	75

A majority of pension awards were granted to soldiers who served in battlefield conditions, but it was not uncommon for compelling cases that served in other theatres to come before the board. Lance-Corporal George C., for example, joined the CEF in November of 1915, eventually serving in England with the Canadian Forestry Corps. Throughout his service George was hospitalized several times for minor injuries

including a fracture to his tibia and fibula as well as an acute attack of rheumatic fever in 1916. During his final medical examination in March 1919 George complained that he had been experiencing heart palpitations and exhaustion for some time, symptoms that his medical board determined were associated with VDH. The board, however, was sceptical of the disease's origins.⁹⁸ Tests showed that George could march up to five miles without much difficulty, and a doctor's evaluation showed that symptoms only seemed to appear "when he [was] excited."⁹⁹ Based on this evidence, George's medical board ruled that the disability was of pre-enlistment origin and had not been aggravated by service conditions. When the BPC assessed his claim they reached a similar conclusion: George had no apparent disability. His fractured leg was functioning without issue, and although he had purportedly suffered from the lingering effects of rheumatic fever during much of his time overseas, there was no compelling medical evidence to suggest that his wartime health issues would cause him any grief in civilian life.¹⁰⁰

Shell shock and related nervous disorders arguably presented the most significant challenge for the BPC when determining attributability. The cases of two veterans from the sample group help illustrate how pension authorities rationalized their verdicts and determined compensation during this crucial period. The first example is Private Jack C., a 35-year-old labourer who enlisted for overseas service in late June 1915. On 10 September 1916 Jack was buried by an exploding shell while in a trench and evacuated from the front. He spent the next year convalescing in England before finally returning

⁹⁸ Personnel File, George C., RG 150, Accession 1992-93/166, Box 1700 – 41, LAC.

⁹⁹ Personnel File, George C., RG 150, Accession 1992-93/166, Box 1700 – 41, LAC.

¹⁰⁰ Pension File, George C., VAC.

home to Canada. A final medical board found that he was suffering from two permanent disabilities: myalgia and kyphosis, the former of which had emerged after his encounter with the exploding shell and was ruled deemed to military service.¹⁰¹ Pension officials agreed with the medical board's diagnosis, granting Jack a 10 per cent pension from the date of his discharge.¹⁰² In spite of the low rating, Jack's disabilities were more numerous than his army medical board records indicated. A follow-up examination by pension officials revealed that he was suffering from dyspnoea, chronic bronchitis, DAH, and hypertension. Rather than fixating their attention on the event that precipitated the appearance of these disorders, physicians instead focused on a physical explanation for his nervous symptoms, attributing them to a series of organic defects that were exacerbated by the physical toll of life at the front.¹⁰³ While he may have been predisposed to break down, under normal circumstances Jack would not have been easily susceptible to the development of a nervous disorder—his condition was a war injury.

The second and more complex case is Alfred W., a 19-year-old farm labourer who enlisted at Toronto in November 1914. After a lengthy period in training, Alfred entered the front lines in September of 1916 during the Battle of Courcelette. Over the course of eight months the young private was buried by exploding artillery shells on three occasions before being evacuated in April 1917 with a gunshot wound to his left arm. While in reserve in England he was placed on light duty in a convalescent camp cookhouse. When word came that his return to the front lines was imminent Alfred broke

¹⁰¹ Personnel File, Jack C., RG 150, Accession 1992-93/166, Box 1580 – 21, LAC.

¹⁰² Pension File, Jack C., VAC.

¹⁰³ Pension File, Jack C., VAC.

down into an epileptic fit. Between May and November 1918 he suffered 11 more such attacks. When physicians asked Alfred to talk about his experience in France he would laugh and remark that “No M.O. ha[d] yet been able to offer any suggestions as to the cause of his fits,” nor had he any idea what triggered them.¹⁰⁴ During the worst of these attacks six men were needed just to hold him down, but not before he had managed to kick a nursing sister. According to his medical case sheets the soldier was dancing no less than an hour later.¹⁰⁵ Doctors noted that he seemed very depressed, was “strongly antagonistic,” and “easily excited.”¹⁰⁶ “From his attitude and his history,” noted one physician, “I should think his fits are purely hysterical, with motive to get out of the army.”¹⁰⁷

Alfred returned to Canada in September 1918 and after several months’ additional treatment was discharged on 4 February 1919 suffering from ‘nervous debility,’ a condition his army medical board viewed as both permanent and attributable to service.¹⁰⁸ Pension medical officials felt differently. A specialist’s report from Newmarket DSCR hospital contended that the veteran’s recurring fits were probably of a “functional nature” and lacked an organic explanation.¹⁰⁹ His case history contained several close encounters with exploding shells and exposure to intense front line combat, but the extreme somatic manifestation of his neuroses, coupled with his overall demeanour, did not conform to the wartime medical definition of a neurasthenic. His symptoms, on the contrary, were

¹⁰⁴ Personnel File, Alfred W., RG 150, Accession 1992-93/166, Box 10523 – 47, LAC.

¹⁰⁵ Personnel File, Alfred W., RG 150, Accession 1992-93/166, Box 10523 – 47, LAC.

¹⁰⁶ Personnel File, Alfred W., RG 150, Accession 1992-93/166, Box 10523 – 47, LAC.

¹⁰⁷ Personnel File, Alfred W., RG 150, Accession 1992-93/166, Box 10523 – 47, LAC.

¹⁰⁸ Personnel File, Alfred W., RG 150, Accession 1992-93/166, Box 10523 – 47, LAC.

¹⁰⁹ Pension File, Alfred W., VAC.

considered to be of the ‘psychogenetic’ variety, for which pensioning was inadvisable and a full cure entirely possible if treated with a combination of rest cure, occupational therapy, and gentle persuasion.¹¹⁰ Like so many similar cases, Alfred had failed to adhere to standards of Victorian masculine comportment and soldierly discipline—to retain his lost manliness he had to first regain control over his baser instincts.¹¹¹ To aid in this process of reclamation the DSCR granted him a 3-month vocational course following his treatment at Newmarket, with the possibility of further treatment if his condition did not improve.¹¹²

The wartime experiences and social backgrounds of Jack C. and Alfred W. were much the same, but the way their cases were handled by pension authorities underscores some salient features of the politics of attributability in the immediate aftermath of the war. The chief difference was the character of each patient’s symptoms and their general disposition while undergoing treatment. Jack’s malady pointed to a likely organic cause, while the more sensationalized symptoms illustrated by Alfred resembled those of a patient who had succumbed to their baser instincts. Authorities refused to concede that Alfred W.’s nervous condition constituted a pensionable disability, but they showed some leniency, eventually granting him a 10 per cent disability pension for chronic bronchitis. Based on recommendations forwarded by the CAMC’s chief neurologist Colin Kerr

¹¹⁰ Colin Russel, “A Study of Certain Psychogenetic Conditions Among Soldiers,” *CMAJ* 7, no. 8 (August 1917): 704-5. For a discussion of Russel’s recommendations on pensioning see *Special Committee* (1919), 75-101.

¹¹¹ For a discussion of the gendering of trauma in the First World War and the Canadian experience see Mark Humphries, “War’s Long Shadow: Masculinity, Medicine, and the Gendered Politics of Trauma, 1914–1939,” *Canadian Historical Review* 91, no. 3 (September 2010): 503-31.

¹¹² Pension File, Alfred W., VAC.

Russel, these cases were not to be given pensions until after extensive treatment at a neurological centre, where they would be closely monitored to determine whether their condition was purely functional, or an organic disorder. Given that Alfred had only one very brief episode of respiratory difficulties in 1915 when he was suffering from appendicitis, it is possible that pension officials simply wanted to avoid unfavourable public attention while keeping a potential problem case within arm's reach of DSCR medical authorities.

A token monthly pension offered little hope to rank and file soldiers like Alfred W. who continued to suffer periodic unemployment and a slow deterioration of their health. As with thousands of other Canadian veterans, Alfred chose instead to commute his pension in the fall of 1920. He was one of 11 pensioners in the sample group to do so. Table 2.1 and Figure 2.2 in Appendix II (Statistical Appendix) present a general overview of pensions awarded between 1918-1921 and remaining awards in force as of 31 March 1922 according to official nomenclature. The substantial decline of pension awards within certain categories such as gunshot wounds (fractures), nervous disorders, general diseases, and general injuries offers some indication of what types of disabilities gratuities were accepted for, as well as which categories of disability had a more favourable prognosis. 'Miscellaneous Diseases and Injuries,' for example, encompassed a range of disparate physical conditions including disfigurements (non-facial), adherent scars, skin disorders, and other 'unclassified' wounds.¹¹³ 'General Diseases' included acute conditions such as cerebrospinal fever or dysentery, as well as more chronic

¹¹³ *BPC Report* (1925), 12-13.

conditions such as diabetes.¹¹⁴ Fractures from gunshot/shrapnel wounds, not surprisingly, had a more favourable prognosis than complex wounds to joints.

Even though a substantial number of pensioners opted to receive a gratuity in lieu of future pension payments, many still held on to their meagre awards in the anticipation that future medical examinations would lead to additional compensation. The majority of pensioners were volunteers from the urban working class and small rural communities. Most had enlisted in hopes of doing ‘their bit’ for King and Empire, escaping the drudgery and economic instability of a workingman’s life, or out of a longing for adventure.¹¹⁵ The Canada that they returned to had changed dramatically after only a few short years. By 1919 the cost of living had skyrocketed, jobs were growing scarce, and employers were expressing increasing reluctance to hire ex-soldiers who had not yet ‘adjusted’ to the daily routine of civilian life. A disability pension was an important affirmation of a veteran’s contribution to the war effort, but the material reality was that for most they offered little more than a supplement to a family’s income. Indeed, the median pension rate for the 45 privates in the sample who received an award between 1914 and 1920 was a paltry \$5.00 per month (exclusive of the 20 per cent ‘bonus’) under Schedule A of the Pension Act.¹¹⁶ In 1920, a typical family of five required a budget of

¹¹⁴ *BPC Report* (1925), 12-13.

¹¹⁵ The occupational background of this sub-sample and other pension applicants will be discussed in Chapter 5.

¹¹⁶ The breakdown of pensions according to rank was as follows: Privates – 45; Corporals – 8; Lance Corporals – 5; Sergeants – 4; Major – 1. The median pension awarded for privates was 10 per cent (Class 19), for Corporals 40 per cent (Class 13), for Lance Corporals 20 per cent (Class 17), and Sergeants 32.5 per cent (Class 15). The lone officer, a Major, received a 100 per cent disability pension for pulmonary tuberculosis contracted while on active service. With the exception of a few minor discrepancies in cases where a disability had been aggravated by service, the disability rating provided by pension medical examiners and the actual award granted were usually equal.

\$25.91 per week for food, fuel, light, and rent.¹¹⁷ An amputee receiving a 60 per cent disability pension with a family of five only received \$16.80.¹¹⁸ With prices soaring, even the most well compensated veterans of the working-class and modest means experienced great difficulties in making ends meet.

VI. CONCLUSION

In assessing the pension experience during the Great War, acknowledgement must be extended to the unique circumstances from which the system emerged. Disability pensions were, much like the wartime medical system, a response to a deepening social crisis engendered by the unanticipated exigencies of modern industrial warfare. The Canadian response was an unparalleled, if reluctant, government foray into social policy for which there was no suitable model to follow. The reforms and public debate that took place between 1914 and 1920 were indicative of the broader wartime struggle between the progressive ideals of social reconstruction and deeply entrenched Victorian era virtues of manliness and economic self-sufficiency that soldiers were expected to strive towards. Augmenting this epistemological conflict were the very real financial and administrative hurdles the federal government faced in guiding the disabled into civilian life. The ‘success’ or ‘failure’ of Canada’s pension scheme was contingent on both the anticipated efficacy of rehabilitation and a willingness from employers and provincial authorities to

¹¹⁷ “Prices of a family budget of staple foods, fuel and lighting, and rent, for 60 cities in Canada, 1920,” 1926, and 1928 to 1936,” *Statistics Canada*, http://www65.statcan.gc.ca/acyb02/1937/acyb02_19370800009a-eng.htm (accessed December 8th, 2013).

¹¹⁸ Includes 50 per cent bonus under 1920 amendments. The rate breakdown per annum is as follows: 60 per cent disability pension – \$360.00; pension bonus – \$180.00 per year; allowance for wife: \$57.60 per year; allowances for first, second, and third child – \$108.00, \$96.00, and \$72.00 respectively.

do all that they could to ensure men who had served and sacrificed would have opportunities available to them to prosper when they returned home. The former was overestimated, while the latter underestimated. For all of their pioneering work during the war, physicians could not prophesize the post-war trajectory of veterans' health. Wartime patriotism likewise faded in the face of post-war economic turmoil and widespread unrest amongst the working-class.¹¹⁹ As a new, dominant memory of the war emerged, the plight of the disabled was gradually subordinated to Canadians' collective desires to grieve and mourn the glorious dead, and recapture the more palatable, nostalgic features of pre-war life.¹²⁰ The humanitarianism that had characterized wartime efforts to care for disabled veterans rapidly eroded and the managerial impulse of the pension board grew more firmly entrenched.

Nevertheless, politicians felt they had done their utmost to ensure the success of civil re-establishment. By privileging scientific principles of compensation and partially acquiescing to veterans' demands for reform they created a system that was rigid in its approach, but 'just' in its execution. The American example offered a constant reminder of the price to be paid when politics and pensions mixed. The underlying objective of Canada's pension law was to avoid a financial catastrophe by compelling soldiers to return to productive industry. For a young nation ripe for economic expansion, 'work,' above all else, was the ethos of re-establishment, and pensions were designed to motivate soldiers to strive towards this ideal. As we shall see in the next chapter, provisions for the

¹¹⁹ Craig Heron, ed., *The Workers' Revolt in Canada, 1917-25* (Toronto: University of Toronto Press, 1998).

¹²⁰ Jonathan F. Vance, *Death So Noble: Memory, Meaning, and the First World War* (Vancouver: UBC Press), 3-11.

industrial retraining of Canada's disabled bolstered hopes that the long-term medical and material impact of disability would diminish. Work and its curative powers could rejuvenate soldiers broken in body and mind while facilitating the economic transition from war to peace all at the same time. Pensions would still have to be paid, but the prevalence and severity of disability in the post-war period was by no means certain. If medical science could rebuild men's bodies through surgery, rehabilitation and orthopaedic appliances, or restore shattered nerves through rest, diet, and exercise, there was the possibility that industrial science could accomplish similar miracles.

Chapter 4: ‘The future of these glorious victims is a woeful question’: Retraining and Re-education on the Road to Civil Re-establishment, 1915-23

In the early hours of 9 April 1917, Private Vincent J. of the 42nd battalion (Black Watch) climbed over the parapet of his trench, joining tens of thousands of Canadians in the advance on Vimy Ridge. During the uphill march an artillery shell exploded behind Vincent, knocking him unconscious and killing several men nearby. The wounded private lay surrounded by bodies for some time before a fellow soldier discovered his mangled body and helped him to a dressing station behind the Canadian lines. His injuries were severe but treatable: he had shrapnel wounds to his left shoulder and a fractured left femur from exploding shell fragments. On 12 April, he was admitted to No. 13 General Hospital in Boulogne before being transported across the Channel for treatment in England. After a few weeks, however, Vincent’s condition had taken a turn for the worse and he was listed as “dangerously ill.”¹ On 11 May, he underwent an operation to remove additional shrapnel from around the fracture but following the procedure his wound began to haemorrhage. In order to save his life surgeons had no choice but amputate his leg five inches from the top of the thigh.²

Vincent returned to Canada in September 1917 after months of painful rehabilitation in England. As with many Canadian amputees, he was taken on strength at

¹ Personnel File, Vincent J., RG 150 Overseas Military Forces of Canada [hereafter ‘RG 150’], Accession 1992-93/166, Box 4983 – 21, Library and Archives Canada [hereafter ‘LAC’].

² Personnel File, Vincent J., RG 150, Accession 1992-93/166, Box 4983 – 21, LAC.

the Davisville Orthopaedic Hospital in Toronto, where he underwent extensive physiotherapy and was later fitted with an artificial limb. After his treatment, Vincent returned home to Saint John, New Brunswick where he worked for a short time as a storekeeper. His leg continued to plague him with severe pain every day, forcing him to abandon his occupation and pursue a civil service course offered through the Department of Soldiers' Civil Re-establishment's (DSCR) retraining program.³ Thanks to his training he quickly found work as a mud surveyor, earning a stable salary on top of a disability pension of nearly \$50.00 per month.

In 1925 Vincent had to leave his position once again. His stump had never healed properly, and as a result, he was rarely able to take full advantage of his prosthetic leg, preferring instead to use crutches for mobility. In spite of his young age and the promise of a new beginning offered by vocational retraining the ex-private was unable to overcome the debilitating physical and psychological effects of his military service. He remained unemployed for the rest of his life, living out of a small house in Saint John paid mostly by his pension. Years later he was diagnosed with neurasthenia after repeated breakdowns and, according to one report contained in his pension records, contemplations of suicide.⁴

In many respects, Vincent J. was the archetype of Canada's war disabled. His injuries were not only a gruesome reminder of modern war's savagery, at 19 years of age his military experience was also a reflection of the terrible toll war had exacted on a generation of Canadian youth. For men like Vincent the transition from the hospital to

³ Pension File, Vincent J., Veterans Affairs Canada [hereafter 'VAC'].

⁴ Pension File, Vincent J., VAC.

civilian life was thus both an existential as well as a metaphorical struggle. Civil re-establishment presented the war's disabled with an opportunity for redemption over wounds, as well as a chance to return home and contribute to Canada's economic future. Whether or not these men would succeed in securing a livelihood contributed in no small part to popular anxieties over how Canada might withstand the transition from war to peace. Would the country's wounded heroes thrive, or would they be condemned to a life of pauperism and idleness like those of past wars? If medical innovations could restore the disabled to physical fitness, were similar scientific innovations applicable to the economic rehabilitation of war's human wreckage?

As previous chapters have illustrated, the problem confronting policymakers in Ottawa as the first wounded arrived on the home front was not unique to Canada. In addition to offering medical treatment and providing financial compensation for disability, every combatant nation from Australia to the United States faced the daunting prospect of securing suitable employment for hundreds of thousands—perhaps even millions—of returned soldiers. Many of them were irreparably damaged in body and mind. Writing in 1918, Douglas McMurtrie, a leading American expert on industrial rehabilitation, presented a sobering reminder of how these soldiers had been treated in the aftermath of previous conflicts:

The disabled hero of past campaigns, fortified alone by a Victoria Cross or some other badge of honor, was awarded a niggardly pension on which he could not live, and left to a life of idleness and dependence, if not of mendicancy. About the best the crippled soldier could hope for in the way of employment was a job as doorman, night watchman, or street vendor.⁵

⁵ Douglas C. McMurtrie, *Reconstructing the Crippled Soldier* (New York: Red Cross Institute for Crippled and Disabled Men, 1918), 1.

To contemporaries the disabled veteran conjured up the “unhappy spectacle” of neglect and despair.⁶ But no matter how unsettling the thought of professional soldiers living in squalor was to nineteenth century societies, the terms of their military service and diminutive social status ostensibly allowed European nations to relegate their care to kin or private charity.⁷ Disability was a regrettable but unavoidable personal tragedy beyond the state’s responsibility.

The Great War was a departure from this unfortunate tradition. As Desmond Morton reminds us, the war “transformed the historic status of the wounded veteran as a tragic and forgettable detritus of conflict.”⁸ For the generation of 1914-18 parsimony and indifference to the war’s disabled was both morally unappealing and economically indefensible. Canada, like other combatants, had mobilized a substantial portion of its predominantly volunteer army from a diverse cross-section of the adult male population. Pensions and free medical treatment were a sufficient means of compensating ex-soldiers who were able to return to their former occupations, but army physicians discovered soon after the war began that this was an impossibility for many. In order to avoid a post-war economic unrest, rehabilitation had to not only restore the physical health of the wounded, but also facilitate their return to occupational independence.

⁶ J.L. Biggar, “State Medicine and Rehabilitation,” *Canadian Medical Association Journal* [hereafter *CMAJ*] 9, no. 11 (November 1919): 1015.

⁷ A concise survey of contemporary attitudes towards disability in Britain is given in Chapter 1 of Julie Anderson’s study of war and rehabilitation in Britain. See Julie Anderson, *War, Disability and Rehabilitation in Britain: ‘Soul of a Nation’* (Manchester: Manchester University Press, 2011), 14-41.

⁸ Desmond Morton, “‘Noblest and Best’: Retraining Canada’s War Disabled, 1915-23,” *Journal of Canadian Studies* 16, no. 3 (1981): 75.

Canada's solution was an unprecedented and internationally lauded system of re-education and vocational retraining. This chapter explores how the Military Hospitals Commission (MHC) and its successor the Department of Soldiers' Civil Re-establishment envisioned and implemented these wartime initiatives to return the disabled to employment and prosperity in their post-military lives. At the core of discussion are the experiences of individual soldiers derived from pension records. Government publications, official reports, and contemporary medical literature offer additional insight into the objectives of retraining and the ideological currents that informed it. As this chapter will illustrate, the story of retraining follows a strikingly similar trajectory to that of the medical experience on the Canadian home front. As the war pressed on and the scope of rehabilitation expanded, the definition of 'retraining' took on new, more complex meanings. What began as a piecemeal initiative by individual convalescent homes to occupy their patients with crafts, workshops, and busywork had evolved into a truly national and world-renown system of industrial retraining by the war's end. In the process, the soldier-patient was transformed from an object of humanitarianism to a 'social problem' that needed to be managed and guided towards independence by the state.

More than any other aspect of Canada's re-establishment scheme, vocational retraining and its antecedent stages fortified Canadians' hopes that prudent planning, modern medicine, and the spirit of wartime progressivism would coalesce seamlessly to alleviate the burden of disability on ex-servicemen, their families, communities and the nation as a whole. Politicians and pension officials shared similar enthusiasm for

retraining, believing that it would eliminate the need for costly future increases to veterans' benefits and promote political harmony between veterans and the state. By incentivizing work and impelling disabled men to recapture their status as breadwinners, the architects of Canada's retraining scheme were also working to assuage private and public insecurities surrounding the war's impact on deeply entrenched masculine norms.⁹ Empowered by the state's generosity, medical science, and educational expertise, disabled veterans who in generations past would have been condemned to the workhouse or street corner could now rejoin their able-bodied compatriots in the fields or on the shop floor.¹⁰

In spite of its popular appeal and widespread publicity as a key pillar of Canada's re-establishment plans, retraining and re-education had a number of limitations. Only disabled men who could prove that they were no longer physically fit for their pre-war occupations were eligible to receive a sanctioned retraining course (an exception was added in 1919 for soldiers who enlisted underage). Once a course was completed, it was a veteran's responsibility to make sure that he parlayed his training into a suitable occupation. Although the MHC and DSCR approved nearly 52,000 applications for retraining between 1916 and 1923, and 40,000 of these courses were completed, a substantial minority of disabled men were unable to find stable work in their field of training. In an effort to make ends meet, many accepted jobs that were unsuited to their

⁹ Mark Moss, *Manliness and Militarism: Educating Young Boys in Ontario for War* (Toronto: Oxford University Press, 2001), 15-16 and 110-15.

¹⁰ For an account of disabled soldiers in previous wars offering a contemporaneous perspective, see Edward T. Devine, *Disabled Soldiers and Sailors Pensions and Training* (New York: Oxford University Press, 1919), 19-49.

physical or mental condition. Employers who at one time eagerly awaited the chance to hire Canada's disabled war heroes discovered that some were not compatible with the fast pace of the increasingly mechanized industrial world. Other men, like Vincent J., simply broke down under the strain of life after combat.

II. VOCATIONAL RETRAINING: FROM THEORY TO PRACTICE, 1915-16

Like the MHC hospital system, the early history of Canada's retraining program was characterized by a mixture of improvisation and experimentation. The initial organization on the home front fell largely on shoulders of the MHC's conscientious secretary Ernest H. Scammell. With the MHC's leadership occupied by the need for more hospital space, Scammell set to work over the summer of 1915, gathering official reports and professional accounts of early European efforts to reclaim the war's disabled. When completed in October 1915, Scammell's investigation offered the first blueprint for Canada's own scheme. In his introductory letter, the MHC secretary made it clear that the state's responsibility to the disabled would not be "extinguished by the award of a pension from public funds."¹¹ Unlike previous wars, rehabilitation had to go beyond medical treatment and financial compensation: a modern democratic state like Canada needed to do everything in its power to return disabled soldiers to self-sufficiency. To achieve this, authorities would not only have to work to find employment for the permanently wounded, they might also have to train them in a new trade of calling.

¹¹ Sessional Paper No. 35a – "The Provision of Employment for Members of the Canadian Expeditionary Force on their Return to Canada," in *Sessional Papers of the Dominion of Canada* (Ottawa: King's Printer, 1916), 5. Hereafter cited as *Sessional Paper No. 35a*.

Scammell drew particular inspiration from the work of the Belgians and French, both of whom had borne the brunt of the allied casualties on the Western Front in 1914. In response to their own crisis of the wounded, several French municipalities created schools and annexes to retrain permanently disabled men from local military hospitals.¹² The Belgians, operating primarily out of the Anglo-Belgian Hospital at Rouen, established retraining courses that sought to restore wounded soldiers to other essential war-related occupations—a necessity given Belgium’s status as an occupied country.¹³ To Scammell and the MHC, the French model offered a more scientifically appealing and practical means of reintegrating the disabled into industry. One of the largest and most advanced programs was presided over by Dr. Maurice Bourillon at the St. Maurice Hospital in Paris. Bourillon’s methods for determining occupational suitability were rigorous in design, taking into account a soldier’s work history, intelligence, mentality, and most importantly, their physical condition. According to Bourillon’s approach, an accountant who lost a leg to amputation did not require retraining because of the sedentary nature of the position. On the contrary, a pianist suffering from paralysis of even one finger would not be able to continue earning his livelihood.¹⁴ In essence, the degree to which the handicap affected a soldier’s day-to-day work was the guiding principle for determining retraining and compensation. Pain and suffering could only be taken into account if it would negatively influence a soldier’s economic station in life.

¹² For a full overview of the French approach to retraining and rehabilitation, see J.L. Todd, *The French System for Return to Civilian Life of Crippled and Discharged Soldiers* (New York: The Red Cross Institute for Crippled and Disabled Men, 1918).

¹³ *Sessional Paper No. 35a*, 49-50. Military Hospitals Commission, *Special Bulletin, April 1916* (Ottawa: King’s Printer, 1916), 15. Hereafter cited as *MHC Special Bulletin*.

¹⁴ *Sessional Paper No. 35a*, 31.

The possibility of receiving a course at the state's expense, however, was only one piece of the retraining puzzle. At the earliest stage possible, disabled soldiers needed to enter a process of "functional re-adaptation," using work and exercise to restore strength to weakened muscles and nerves, or to acclimate the patient to their new prosthetic. It was only after the disabled man demonstrated a sound work ethic that he could be expected to succeed in some form of technical re-education. In Bourillon's view, without early intervention and moral guidance, patients would inevitably "refuse work and acquire a tendency to sloveness [sic], drunkenness and rebellion."¹⁵ In the absence of proper motivation, discipline, and expert guidance from physicians, the disabled could easily fall prey to "want and debauchery," might unadvisedly return to their former occupation, or worse, resort to living off of the "all-provident-state."¹⁶

The MHC praised the French principles but was unsure of how applicable Bourillon's disciplinarian approach was to the Canadian context. When Scammell had submitted his inaugural report, the MHC was caring for a little over 500 patients among 11 scattered convalescent homes based primarily in Ontario, Québec and the Maritimes.¹⁷ The largely volunteer staff of the homes had neither the authority nor the expertise to enforce the same high standards of military discipline expected of the soldiers at St. Maurice or other military hospitals in Europe, nor had the MHC attracted sufficient

¹⁵ *Sessional Paper No. 35a*, 31.

¹⁶ *Sessional Paper No. 35a*, 31.

¹⁷ Untitled report, RG 38, Department of Veterans Affairs, Military Hospitals Commission fonds [hereafter 'RG 38'], Series B-1, Minutes, Memoranda, and Reports, vol. 287, [hereafter 'MHC Minutes'], LAC.

¹⁷ Morton and Wright, 7.

medical personnel to engage patients in carefully monitored physiotherapy or other ‘curative work.’

Nonetheless, there was growing evidence to suggest that Canadian hospitals could adopt a similar approach. During the summer and early fall of 1915, 29-year-old Ina Matthews, sister-in-law of Montréal millionaire and soon-to-be pension commissioner J.K.L Ross, had introduced various handicrafts to the patients of the Ross Convalescent Home in Sydney, Nova Scotia.¹⁸ Matthews’ work was brought to the attention of Frederick Sexton, Principal of the Nova Scotia Technical College, and a report was soon forwarded to Scammell and the MHC outlining the beneficial effect these activities had on the health and morale of the patients undergoing treatment in the home.¹⁹

Judith Friedland has recently credited Matthews’ work as the first concrete example of modern occupational therapy employed in Canada, and a key influence on the direction of the MHC’s broader rehabilitation program.²⁰ While the French and Belgian methods already in practice probably did more to sway Scammell and other members of the MHC in favour of developing their own scheme, Matthews’ report undoubtedly reinforced the feasibility and practicality of gradually introducing some manner of occupation into the treatment regimes of patients. At a minimum, immersing sick and injured soldiers in craftwork, weaving, gardening, and other activities would serve as a diversion to the boredom and malaise of convalesce—it might even harden men who had

¹⁸ Judith Friedland, *Restoring the Spirit: The Beginnings of Occupational Therapy in Canada, 1890-1930* (Montréal and Kingston: McGill-Queen’s University Press, 2011), 102-104. For a history of occupational therapy see

¹⁹ Friedland, 102-104.

²⁰ Friedland, 102-104. Also see Virginia A.M. Quiroga, *Occupational Therapy: The First Thirty Years, 1900-1930* (Bethesda, MD: American Occupational Therapy Association, 1995).

become ‘soft’ at the hands of overly sympathetic caretakers.²¹ For the most severely injured, however, graduated work had the potential to serve as the crucial stepping-stone between hospital life and complete economic rehabilitation.

In the early fall of 1915, the most pressing question for Scammell remained how to convert the improvised busy-work in convalescent homes into a system resembling the formalized vocational training on display in Europe. A lack of resources and constitutional barriers stood in the way. Although the order-in-council that established the MHC permitted it to call on the resources of any federal department or agency, under the British North America Act (1867) employment and education were provincial responsibilities.²² Any program to retrain soldiers and place them in positions would require consent and cooperation from the provinces, a matter which, if not approached carefully, could derail the MHC’s current program.

The MHC did not have to wait long for a response. On 18 October 1915, Prime Minister Robert Borden assembled representatives from every province in Ottawa for an inter-provincial conference on problems facing returned soldiers. Eager to see his vision turned into reality, Ernest Scammell used the conference to highlight the findings of his European fact-finding mission and table a number of recommendations based on his painstaking research. Scammell’s scheme called for each province to create a special commission in charge of employment and retraining. Under the auspices of the MHC, these commissions would work to establish relationships with major employers and

²¹ Morton, “‘Noblest and Best,’” 77.

²² *Report of the Work of the Military Hospitals Commission* (Ottawa: King’s Printer, 1917), 17-18. Hereafter cited as *MHC Report*.

industrial organizations to match both able-bodied and disabled soldiers with occupations that suited their physical abilities and existing skills.²³ At the same time, they would also work to establish apprenticeships and retraining courses for men who could not return to their former trade of calling. The most severely disabled would be granted preferential treatment for vacant civil service positions, including newly created administrative roles within the MHC.²⁴

The provincial representatives in attendance eagerly accepted Scammell's overarching framework. The MHC would shoulder all costs for retraining and medical treatment, while the provincial commissions would cover the costs of day-to-day operations and finding employment for soldiers.²⁵ Over the next several months, each province established its own dedicated commission headed by local politicians, federal MPs, physicians, and businessmen.²⁶ With limited time at their disposal, however, the MHC was unable to come away from the October meetings with a clear plan in place for implementing its vision of a national retraining scheme. Instead, the provinces were left to their own devices, and were only instructed to furnish the federal commission with a list of possible institutions and organizations that could be relied upon to aid in future

²³ "Memorandum of Suggestions at Inter-Provincial Conference, Ottawa, October 1915, Regarding the Problem of Taking Care of and Providing Employment for Members of the Canadian Expeditionary Force who Return to Canada During the Period of the War," [hereafter "Memorandum of Suggestions...October 1915," MHC Minutes, LAC. Scammell's original ideas surrounding Provincial Commissions were already contained in his introductory letter to Sessional Paper No. 35a. See *Sessional Paper No. 35a*, 6-8.

²⁴ "Memorandum of Suggestions...October 1915," MHC Minutes, LAC.

²⁵ "Memorandum of Suggestions...October 1915," MHC Minutes, LAC.

²⁶ Minutes for 15 December 1915, MHC Minutes, LAC.

work.²⁷ Retraining was attracting wide interest, but a lack of leadership and expertise was hindering further coordination.

Scammell was up to the task but constantly overburdened with the day-to-day work of running the commission. To spearhead the MHC's vocational program, James Lougheed summoned Calgary's Director of Technical Education, Thomas B. Kidner, to Ottawa in January 1916.²⁸ Born in Bristol, England in 1866, Kidner began his career as an apprentice in the building trades and later received formal training in architectural design. During the 1890s, he worked as a teacher in Bristol, eventually immigrating to Canada in 1900 to take up a position as a technical educator in Truro, Nova Scotia.²⁹ In the years leading up to the Great War, Kidner had emerged as a leading expert on technical education in Canada, appearing as an expert witness before the 1911 Royal Commission on Industrial Training and Technical Education, and publishing frequently in educational periodicals.³⁰ When the first wounded returned to Calgary in 1915 he volunteered his time to help counsel returned men and find them suitable occupations or apprenticeships.³¹

Kidner was an essential acquisition for the budding MHC. As a progressive educationalist, he was committed to the notion of self-improvement and social renewal through work. More importantly, Kidner was aware of the curative powers of 'occupations' in a medical context, and quickly set to work establishing classes and workshops in Canadian convalescent homes during the spring of 1916. These initiatives

²⁷ "Memorandum of Suggestions...October 1915," MHC Minutes, LAC.

²⁸ Walter E. Segsworth, *Retraining Canada's Disabled Soldiers* (Ottawa: King's Printer, 1920), 11.

²⁹ Judith Friedland and Naomi Davids-Brumer, "From Education to Occupation: The Story of Thomas Bessell Kidner," *Canadian Journal of Occupational Therapy* 74, no. 1 (February 2007): 28-29.

³⁰ Friedland and Davids-Brumer, 28-30.

³¹ Friedland and Davids-Brumer, 30.

mirrored similar efforts by the CAMC to introduce ‘ward occupations’ and ‘curative workshops’ in major Canadian hospitals and convalescent homes throughout England during the same period, but ultimately drew their inspiration from early experiments in occupational therapy carried out by volunteers like Ina Matthews.³²

Kidner’s most important contribution in 1916 was his seminal role in establishing the official principles and framework that would guide Canada’s vocational training scheme. Under Kidner’s plan, the MHC’s medical personnel would take care of work within convalescent homes and larger hospitals, and a new Vocational Branch would work with the provincial commissions to re-establish the wounded into civilian life. Rather than being open to all disabled men, vocational courses would only be available to soldiers whose disabilities were attributable to service conditions and prevented them from returning to their pre-war occupation. Retraining, in effect, was not a right of service, but a privilege bestowed upon those who could no longer carry on in their former line of work through no fault of their own. Kidner also envisioned a greater degree of standardization and procedural consistency. To prevent relapse or re-injury, a soldier could not begin a course until his vocational officer was satisfied that he was physically and mentally capable of steady work. Once a course began, the soldier was obliged to attend regularly, remain disciplined, and graduate on schedule. Unsatisfactory

³² On the origins of vocational training see Harvey Kantor, “Work, Education, and Vocational Reform: The Ideological Origins of Vocational Education, 1890-1920,” *American Journal of Education* 94, no. 4 (August 1986): 401-26.

performance or poor discipline could result in cancellation at any time, with no possibility of renewal.³³

There were other practical considerations that Kidner and the MHC needed to address. Due to the slow pace at which the Pensions and Claims Board processed applications for disability pensions during the first two years of the war, many soldiers found themselves faced with hardship if they were unable to return to work after leaving hospital. The level of compensation was also problematic. A farmer suffering from rheumatism or the effects of a gunshot wound might only receive a 20 per cent disability pension and could not afford to take an unpaid retraining course, especially if he had dependents. In an effort to assuage veterans' anxieties over their financial circumstances and further incentivize retraining, in June 1916 the MHC approved a scale of training allowances for all vocational students. Under the new scale, a single man living inside a hospital or training facility received free maintenance and was eligible to collect his pension at the same time. Single men living outside could receive a 60-cent per day subsistence allowance in addition to pension benefits and an \$8.00 monthly supplement. A married man with three children living away from home was eligible for up to \$50.00 per month in allowances (less his pension) paid directly to his wife. If the soldier chose to remain at home, he was eligible for a 60-cent per diem and additional allowances based on his marital status and age of his dependents.³⁴ The compensation was modest, but

³³ "Section B, Vocational Re-training," in *Vocational Training Regulations*, RG 38, Series B-3 Circulars and Bulletins, vol. 371 [hereafter 'Vocational Training Regulations'], LAC.

³⁴ *MHC Report*, 52-53.

authorities hoped that the promise of gainful employment would entice the disabled to take up retraining.

By the end of 1916 the groundwork of Canada's vocational training scheme was in place, in no small part due to the leadership and vision of T.B. Kidner, Ernest Scammell, and a handful of physicians, volunteers, and educational experts who collectively viewed work as a source of salvation for Canada's disabled. In spite of a year of planning, however, the MHC had little to show for its efforts. Vocational work remained "largely experimental," was confined primarily to convalescent homes, and had yet to attract much interest from soldiers, many whom falsely believed that their pensions would be reduced if they opted to enrol in a course.³⁵ Some vocational officers and hospital staffs also demonstrated a great deal of ambivalence over the distinction between retraining and increasingly labelled 'occupational therapy.' For example, beginning in April 1916 convalescent homes in Québec and the Maritimes introduced a regimented schedule of 'vocational retraining' for patients who had reached a particular stage in their recovery.³⁶ After two weeks of physical exercise,³⁶ patients were obliged to attend classes offered by the staff of each home unless excused by a physician on medical grounds.³⁷ The content of each class varied widely from home to home, but generally included arts, crafts, carpentry, gardening, and general education subjects such as shorthand, arithmetic

³⁵ *MHC Report*, 54.

³⁶ Minutes for 29 April 1916, MHC Minutes, LAC.

³⁷ *Returned Soldiers; Proceedings of the Special Committee Appointed to Consider, Inquire into and Report upon the Reception, Treatment, Care, Training and Re-education of the Wounded, Disabled and Convalescent who have Served in the Canadian Expeditionary Forces, and the Provision of Employment for those who have been Honourably Discharged who are Unable to Engage in their Former Occupation* (Ottawa: 1917), 555-57. Hereafter cited as *Special Committee (1917)*.

and technical drawing.³⁸ Such activities were often successful in keeping patients from remaining idle or getting into mischief, but few were rigorous or lengthy enough to prepare a disabled man for the return to a civilian occupation.³⁹ Like bedside handicrafts or recreational sport, this purported form of ‘vocational training’ was essentially a benign diversion from the ennui and malaise of rehabilitation, with soldiers benefiting much more from a psychological standpoint than a vocational one. As with the MHC more broadly, 1916 represented a more or less transitional year between the piecemeal humanitarian and philanthropic initiatives of the early wartime period and the more structured, scientific programs its visionaries sought to implement.

III. REFORM AND EXPANSION, 1917-19

During the first year and a half of its existence, the growth of the MHC was due primarily to the ambition and dedication of its civilian staff. Vocational training was a lauded ideal, but standardization, expertise, and popular support proved elusive. In 1917, however, a series of important changes to the MHC’s approach were introduced which, for the first time, allowed vocational training to expand to a degree that had only been dreamed of on paper. These reforms were also timely: as previous chapters have discussed, 1917 was an exigent year for Canada’s re-establishment program where authorities struggled to adapt to the sporadic influx of disabled soldiers and the complex array of conditions they brought with them upon their return.

³⁸ *Special Committee (1917)*, 618-20.

³⁹ *Special Committee (1917)*, 102-103, 555-57.

To ease the administrative burden on Ernest Scammell, in December 1916, Lougheed appointed Samuel Allan Armstrong as Director of the MHC. A long-time Ontario civil servant, Armstrong proved an invaluable asset to the commission. During his tenure as Director and later as Deputy Minister of Soldiers' Civil Re-establishment, he worked tirelessly to establish formal agreements with almost every Canadian university to make courses and training space available to disabled soldiers.⁴⁰ His most important contribution, however, was hiring a little-known Toronto mining engineer named Walter Segsworth in the summer of 1917 as the MHC's new director of vocational training.⁴¹ Like his fellow educationalists Kidner and Sexton, Segsworth was a staunch proponent of technical education as a pathway to social progress and individual prosperity. But where Segsworth excelled most was in his organizational prowess and sound leadership. Within just a few months of his appointment, Segsworth successfully spearheaded a series of substantial administrative and policy reforms that resulted in the harmonization of the provincial committees with the MHC's head office. Importantly, his reforms also established a clear distinction between hospital-based occupational therapy and the broader campaign of vocational training that was directed through the MHC's Vocational Branch.⁴²

The most crucial step for the MHC was the creation of local boards in each province to manage all vocational training applications and administer soldiers' courses.

⁴⁰ *Report of the Work of the Invalided Soldiers' Commission, May 1918* (Ottawa: King's Printer, 1918), 17, 88-90. Hereafter cited as *ISC Report*.

⁴¹ *Report of the Work of the Department of Soldiers' Civil Re-establishment* (Ottawa: King's Printer, 1920), 16. Hereafter cited as *DSCR Report*.

⁴² Segsworth, 15

These Disabled Soldiers' Training Boards (DSTBs) operated as an extension of each provincial commission but reported directly to the MHC's head office in Ottawa. The boards were strategically placed in major Canadian cities and towns, normally being staffed by at least one MHC vocational officer, a consulting physician, and a representative appointed by the provincial commission. Under the new arrangement, the members of the DSTB were responsible for interviewing applicants in their locality, providing a detailed medical examination, and monitoring their progress for the duration of their retraining.⁴³ The boards were an important step forward in bringing standardization to the MHC's retraining efforts, while also making each provincial commission more accountable to the MHC's head office. More importantly, Segsworth's system granted vocational staff more control over which courses were approved and for whom. Whereas previously soldiers had been directed to employment opportunities based on the advice of the commission or through informal arrangements, each district's DSTB was charged with providing a comprehensive assessment of the candidate and forwarding his application to Ottawa for final approval.⁴⁴

Each DSTB application for retraining began with a thorough medical examination to determine the extent of the man's disability and the unique features of his condition that might inhibit a successful return to his former trade of calling. Following the examination, a district vocational officer interviewed the soldier in order to document his educational and occupational background, intelligence, habits, interests, and overall demeanour. The questions asked often had as much to do with determining the moral

⁴³ *MHC Report*, 51.

⁴⁴ *ISC Report*, 15.

character of the soldier—believed to be key to their success—as it did his actual interests in certain lines of work. For example, vocational officers were required to document whether a man drank or smoked, what his appearance and mannerisms were at the time of interview, comment on his family and educational background, and give an overall assessment of his work habits.

Henry H, a lance corporal from Sherbrooke, Nova Scotia presents a typical example of how the MHC vetted candidates for retraining. Henry was admitted to the Pine Hill Convalescent Home in Halifax during 1917 where he spent several months recovering from the effects of trench nephritis. Near the end of his treatment, he was granted an interview with the district's DSTB. According to his medical examination, Henry was suffering from weakness and aching in his back upon exertion, and required a special diet, making it impossible for him to return to a life of manual labour. During his interview, he appeared "healthy, neat, [and] attentive" with an "easy" manner, and a typical social disposition.⁴⁵ He was a moderate smoker, but otherwise temperate. The corporal's conduct while in the army was "very good" and he had demonstrated similarly good behaviour while in the convalescent home, exhibiting a steady work ethic and taking interest in the hospital's general education courses.⁴⁶ The vocational officer also noted that Henry was an avid football fan, took pleasure in building model ships, and enjoyed reading fiction. His work experience was limited, but he was intelligent and fairly well educated, having stayed in school until he was 17. Before enlisting, Henry worked as an assistant to his father, a Sherbrooke mining engineer, and wished to follow his footsteps

⁴⁵ Pension file, Henry H., VAC.

⁴⁶ Pension file, Henry H., VAC.

by pursuing a career in steam engineering. The DSTB determined that the occupation was suited to Henry's interests and educational experience, and more importantly, would allow him to work on a flexible schedule and eat appropriately. He was granted an 8-month engineering course, which he successfully completed in late 1918 and parlayed into a steady career.⁴⁷

A more accountable and standardized approach also allowed Segsworth to implement a formal apprenticeship program for soldiers looking to train on the job, something the MHC had previously been reluctant to introduce over fears that crooked employers would exploit disabled men. To prevent any wrongdoing, and to monitor the progress of soldiers during their training, under Segsworth's system vocational officers would occasionally visit men at work or request written reports from their employers on their performance and conduct. William C., for instance, received an apprenticeship in electric welding at the Hanover Iron Works in Hanover, Ontario. As part of his retraining obligations, William was required to fill out time sheets that were forwarded to the district office and placed on file. Shortly after beginning his course, the district vocational officer also requested a detailed report on his conduct and performance, followed later by a personal visit to the Iron Works. According to the officer's report, William's performance to that point was "very satisfactory."⁴⁸ He continued his course for several more months but left prematurely in favour of a position as a garage mechanic in Owen Sound, Ontario.⁴⁹

⁴⁷ Pension file, Henry H., VAC.

⁴⁸ Pension file, William C., VAC.

⁴⁹ Pension file, William C., VAC.

As the war pressed on, retraining was increasingly touted as the crucial linkage within a wider, holistic process of rehabilitation. If a man returned home too early and was physically or occupationally unprepared to stand on his own two feet, the effects could be devastating. As one article in the MHC's flagship periodical, *Reconstruction* contended:

Too often home conditions are not ideal... Through ignorance, perhaps, he [the soldier] does not get the care he should have; he over-exerts himself on behalf of his family, and finally he suffers a recurrence of his disability—he has to give up his work and may even require further medical treatment. Or again, his family may not have the sympathy and understanding necessary; their attitude towards the whole soldier problem is wrong.⁵⁰

Statements like these arguably exaggerated the domestic problems the average soldier faced upon returning home, but authorities were nonetheless concerned about familial conditions upsetting the rehabilitation process, especially in the case of vocational training. As a result, in April 1917 the MHC increased retraining allowances by 50 per cent to further incentivize retraining and prevent disabled men from abandoning their courses and rushing into an occupation too early for the benefit of their family.⁵¹ Further increases were made in June 1918 and March 1919 to offset the rising cost of living.⁵² As an extra measure to ensure the MHC was getting full value for its investment, social service workers also began visiting the homes of patients who faced difficult familial

⁵⁰ "Social Service and Follow-up Work is Important Phase in Re-establishment," *Reconstruction* (November 1918): 6-7.

⁵¹ *MHC Report*, 52-53.

⁵² *DSCR Report (1919)*, 32-34

circumstances, especially those suffering from tuberculosis, shell shock, and other diseases with complicated symptoms and uncertain prognoses.⁵³

The organizational and policy changes enacted during Segsworth's first year as vocational director had far-reaching implications for patients in hospitals as well. Before 1918 there was little distinction between what was ambiguously labelled 'curative work' on the one hand, and 'vocational retraining' on the other. Although Kidner, Sexton, and the MHC's small vocational staff had expended a great deal of effort to implement retraining courses at hospitals across the country, much less attention had been paid to systematizing this nascent form of occupational therapy first introduced to soldiers by Ina Matthews in 1915. The Canadian Army Medical Corps' (CAMC) experience overseas, however, had demonstrated that there was an incontrovertible medical benefit to engaging patients in carefully monitored and graduated work, even while they remained in bed.⁵⁴ As more severely wounded returned to Canada and the hospital system continued to expand, CAMC and MHC authorities increasingly realized the need to synergize their approach.

The key turning point came in February 1918, when the MHC's active treatment hospitals were handed over to the militia department and the Department of Soldiers' Civil Re-establishment took over control of remaining convalescent homes, sanatoriums, and long-term treatment facilities. To alleviate confusion the DSCR formally adopted a new set of definitions for its retraining regimen that brought it in line with current practices already in place in some home front facilities as well as most CAMC hospitals

⁵³ "Social Service and Follow-up Work," 6-7; *DSCR Report* (1919), 19.

⁵⁴ "Returned Soldiers and the Medical Profession," *CMAJ* 7, no. 4 (April 1917): 343-55.

overseas. The first stage of a patient's economic rehabilitation now consisted exclusively of 'ward occupations'—bedside handicrafts such as basketry, weaving, modelling, painting, and simple woodworking that were introduced at the earliest stage possible.⁵⁵ To supervise these occupations the DSCR began training special Ward Aides through a newly established program at the University of Toronto.⁵⁶ Donning their own distinctive uniforms, these women volunteers reported directly to the medical officer commanding each hospital and spent much of their day working at patients' bedsides in an effort to provide physical stimuli and moral support.⁵⁷ Patients responded with varying levels of aptitude and interest, but the overriding purpose was to simply "hasten the functional cure" and prevent severely wounded men from entering a "morbid state."⁵⁸ The latter was especially important in the DSCR's long-term care facilities, including Euclid Hall, where soldiers suffering from paralysis partook in handloom weaving, embroidery, drawing, and other bedside occupations.⁵⁹ Such an approach, noted the DSCR's annual report for 1919, was "considered preferable to placing patients ordinarily classed as 'incurable' in homes for incurables to await tediously the end of their lives, rendered inactive by war service."⁶⁰ Occupation ultimately offered hope for the disabled soldier while simultaneously ensuring that he remained stoic and disciplined.⁶¹

⁵⁵ Circular for May 1918, in *Circulars of Information*, RG 38, Series B-3 Circulars and Bulletins, vol. 371 [hereafter 'Circulars and Bulletins'], LAC.

⁵⁶ Segsworth, 24.

⁵⁷ Segsworth, 35-36.

⁵⁸ Department of Soldiers' Civil Re-establishment, *Canada's Work for Disabled Soldiers* (Ottawa: King's Printer, 1920), 56-57.

⁵⁹ *ISC Report*, 81.

⁶⁰ *DSCR Report* (1919), 16.

⁶¹ Segsworth, 35-36.

When a patient became ambulatory he was expected to participate regularly in workshops and educational courses offered by the hospital. By 1918, the range and specificity of what were now classified as “curative workshops” had evolved dramatically.⁶² Larger hospitals and the acquisition of better-trained staff permitted patients to experiment in advanced carpentry, machine-shop work, horticulture, motor mechanics, motion picture operation, and other trades before they even applied for a vocational course.⁶³ To promote an entrepreneurial spirit, the DSCR also allowed patients to sell their creations through bazaars and local retailers.⁶⁴ Under Segsworth’s system, the utility of these workshops also took on new meaning. Rather than explicitly preparing soldiers for a career after they left the hospital, the DSCR and army physicians conceptualized and administered curative workshops as an advanced stage of the physical rehabilitation process. While they allowed patients with an inclination towards a particular type of occupation to hone their skills, the physical activity required for them served primarily as an exercise in ‘functional re-education.’⁶⁵ This was especially important for patients suffering from chronic illnesses (particularly TB or orthopaedic cases) who typically required more time to acclimate themselves to the industrial workplace than other disabled men.

In order to draw a line of distinction between the preparatory retraining many soldiers received in curative workshops, in 1918 the DSCR’s Vocational Branch formally redefined vocational work as ‘industrial retraining.’ Despite its seemingly narrow

⁶² Untitled report, MHC Minutes, LAC.

⁶³ Segsworth, 24-25.

⁶⁴ *Canada’s Work for Disabled Soldiers*, 59.

⁶⁵ Segsworth, 35-36.

definition, for official purpose industrial retraining encompassed all formal education approved by vocational authorities and district DSTBs. Unlike curative workshops, this stage of a soldier's re-establishment was under the exclusive jurisdiction of the DSCR and its district offices. Through an agreement established with the CAMC, vocational officers were able to offer pre-discharge interviews to all invalided soldiers who were potentially eligible for retraining. The DSCR also made the interview process more rigorous by involving as many as three or four industrial advisors, and if possible, an expert from the soldier's prospective trade.⁶⁶

A final major revision to the program came in April 1919 when the DSCR extended retraining benefits to any soldier who enlisted in the CEF as a minor. The rationale was that due to their young age and limited industrial experience, most 'boy soldiers' would return to civilian life at a substantial disadvantage in the labour market. While healthy in body and mind, the loss of their youth was in purely economic terms framed as an equivalent material hardship to that which was imposed by a permanent disability. When compared alongside young men of the same age who had remained at home to work in the heavily mechanized wartime economy, boy soldiers offered little in the way of appeal to prospective employers.⁶⁷ Veterans' associations welcomed the decision, but asserted that this was in fact the reality for most of Canada's servicemen, irrespective of their age. Because military service interrupted the working lives of countless young men who were not yet fully established in their careers, retraining was a service benefit that all returning soldiers could benefit from. A substantial cash bonus

⁶⁶ Segsworth, 32.

⁶⁷ *DSCR Report* (1920), 47.

would further aid soldiers transitioning from military life to a civilian occupation.⁶⁸ In principle, there was modest support to the notion of expanding retraining, but at an estimated cost of \$640.00 per student, per course, the financial implications and additional expertise required seemed too daunting. The GWVA's 'bonus campaign' fared little better, even as evidence accumulated that returned soldiers were struggling to find stable employment.⁶⁹ For government authorities, re-establishing the disabled ultimately took precedent over more utopian visions of what advanced education could achieve for post-war Canada.

IV. PROMOTING THE 'IDEAL' WAR DISABLED, 1917-19

The reforms initiated between 1917 and 1919 had a profound impact on the trajectory of Canada's retraining program. At the beginning of 1918, only 133 soldiers had graduated from the MHC's still comparatively modest retraining program.⁷⁰ By 31 December 1919, thanks in large part to Segsworth's organizational talent, patriotic volunteerism, and the efforts of a growing network of technical educators and vocational experts, 23,626 Canadian soldiers were in the process of completing a retraining course—12,342 in DSCR classes, and 11,284 in industrial institutions. By this point the DSCR offered courses and apprenticeships for 314 occupations, and since 1916 had graduated over 9500 students.⁷¹ With thousands of men severely injured in the final hundred days of

⁶⁸ For the Great War Veterans' Association's reconstruction platform, see *G.W.V.A. Soldiers Civil Re-establishment Scheme as Submitted to the Dominion Government October 1919*.

⁶⁹ On the bonus campaign see Desmond Morton and Glenn Wright, "The Bonus Campaign, 1919-21: Veterans and the Campaign for Re-establishment," *Canadian Historical Review* 64, no. 2 (1983): 147-67.

⁷⁰ *DSCR Report (1919)*, 34.

⁷¹ Segsworth, 3.

the war still recovering from their wounds and others who were unable to carry on in civilian life coming forward each day, industrial retraining was proving an invaluable investment in the future of Canada's war wounded. To T.B. Kidner its efficacy and promise was self-evident: "...instead of leaving as an aftermath of the war... dragging out a useless existence as pensioners on the nation and on other agencies, public or private, they are self-supporting, capable members of the community, fulfilling their duties in peace as they did in war."⁷²

As with pensions, formalized retraining sought to alleviate the material impact of disability on Canada's war disabled. The extent of a man's incapacity was measured not in pain and suffering, but by the degree to which it impeded him from working to his 'normal' physical capacity. Like the architects of Canada's pension system, retraining advocates relied on the authority of medical science, as well as the emerging field of technical education to craft and rationalize their scheme. The object was to avoid mendicancy and idleness by providing each soldier with the means for "self re-establishment."⁷³ By re-educating the disabled for modern industry, Canada was not only bolstering its economic future, it was instructing its ex-soldiers in the virtues and obligations of democratic citizenship, breadwinning, and self-reliance.⁷⁴

The DSCR's publicity machine did not shy away from highlighting its achievements. By 1918, the department's publicity branch was contributing semi-monthly

⁷² T.B. Kidner, "Vocational Work of the Invalided Soldiers' Commission of Canada," *Annals of the American Academy of Political and Social Science* 80 (November 1918): 148.

⁷³ "Section B, Vocational Re-training," Vocational Training Regulations, LAC.

⁷⁴ "Section B, Vocational Re-training," Vocational Training Regulations, LAC.

feature stories to over 150 different Canadian newspapers and periodicals.⁷⁵ These propaganda pieces presented numerous examples of how disabled soldiers were fulfilling their civic and masculine duty to their country by reequipping themselves for a life of labour.⁷⁶ The department also released a five-part informational film entitled “Canada’s Work for Wounded Soldiers.” The film, which laid out in detail the various rehabilitation programs the DSCR offered wounded soldiers, was screened frequently for the benefit of patients at Canadian hospitals overseas and for the general public in theatres on the home front.⁷⁷ At the 1918 meeting of the American Medical Association, the DSCR representatives arranged for a special screening before a crowd of 5000 delegates, which according to the department’s own account was met with great interest and enthusiasm.⁷⁸

To ensure that its message reached patients, patriotic societies, and government officials on a regular basis, in November 1917 the MHC continued to highlight ‘success stories’ in its monthly periodical *Reconstruction*. A typical example presented the case of a soldier who had lost both legs and an eye, but through hard work and determination was able to complete a course in silver polishing. The soldier quickly found steady work at a salary of \$75.00 per a month in addition to a 100 per cent disability pension—well over \$1500.00 per year.⁷⁹ Blinded soldiers were perhaps the most miraculous example pointed to in the pages of *Reconstruction*, and no one’s story received more attention than that of

⁷⁵ Untitled report, MHC Minutes, LAC.

⁷⁶ A more complete discussion of the MHC and DSCR’s wartime propaganda is found in Jeff Keshen, *Propaganda and Censorship During Canada’s Great War* (Edmonton: University of Alberta Press, 1996), 187-216.

⁷⁷ Suzanne Evans, “Canada’s Work for Wounded Soldiers on Film,” *Canadian Military History* 19, no. 4 (Autumn 2010): 41-49. As Evans notes in her piece, despite its popularity and wide usage in Canadian hospitals no copies of the film have surfaced, although a glass lanternslide version still exists.

⁷⁸ “Canadians at A.M.A.,” *Reconstruction* (August 1918): 12.

⁷⁹ “Totally Disabled but Earning,” *Reconstruction* (August 1918): 6.

the venerable Captain Ervin Alfred Baker. A graduate of Queen's University and Croix du Guerre recipient, Baker had worked as an electrical engineer at Niagara Falls before enlisting for overseas service. After only a month in France, Baker lost sight in both of his eyes as the result of a gunshot wound to the head. He was one of the first Canadians to undergo retraining at St. Dunstan's, after which he returned to his former position as an electrical engineer. He would later go on to accept an appointment to the DSCR in 1918 as an advisor on rehabilitation for the blind.⁸⁰ What made Baker's story most compelling is that it was emulated by others, including Private James H. Rawlinson, whose 1919 book *Through St. Dunstan's to Light* offered a glowing assessment of the veritable miracles retraining could offer the war's blinded.⁸¹

The DSCR's insatiable appetite for self-promotion was only emboldened by the increasing recognition Canada's retraining scheme was receiving from the international community. Indeed, Canada's prominent role in the May 1918 conference on the after-care of disabled soldiers hosted in London helped establish its reputation as a world leader in vocational retraining methods. In addition to a photographic display, the Canadian exhibit featured a screening of "Canada's Work for Wounded Soldiers" and examples of high-quality handicrafts produced by disabled patients at Canadian hospitals. Québec's District Vocational Officer, Major R.T. MacKeen, shared the spotlight with other vocational experts from Italy, Britain, and France, delivering a detailed presentation on the beneficial impact the DSCR's retraining scheme was having on the Canadian home

⁸⁰ "Blind Man Appointed to Represent Government in Dealing with Blind," *Reconstruction* (October 1918): 6.

⁸¹ James H. Rawlinson, *Through St. Dunstan's to Light* (Toronto: Thomas Allen, 1919).

front.⁸² At the same time, the United States, which had yet to experience a significant influx of battle casualties, was beginning to take notice of Canada's widely acknowledged expertise.⁸³ To implement its own program for retraining, in August 1918 the U.S. Federal Board for Vocational Training recruited T.B. Kidner and J.C. Miller, a district vocational officer for Alberta, as consulting authorities. By the time Kidner's work was complete, wrote Garrard Harris of the U.S. vocational board in 1919, the U.S. had "scrapped all old traditions, theories, and ideas. The sole animating and dominating purpose was justice to the man who was prepared to give his life for the Nation."⁸⁴ The Canadian example, it appeared, had left an indelible impression.⁸⁵

V. VOCATIONAL RETRAINING: A BALANCE SHEET, 1919-23

Even if official propaganda overwhelmingly highlighted the exceptional rather than the typical, it would be disingenuous to dismiss Canadian authorities' unwavering faith in vocational training as a chimera of wartime patriotism. According to its architects, Canada's retraining scheme was the envy of other allied nations because of its rigorous standards and persistent reliance on scientific methods at each stage of the rehabilitation process. At face value, all cogs of the machine appeared to be working impeccably.

⁸² R.T. MacKeen, "The Training of the Disabled Canadian Soldier," in *Proceedings of the Inter-Allied Conference on the After-Care of Disabled Men* (London: H.M.S.O., 1918), 157-64.

⁸³ The most prolific authority on retraining during this period in the U.S. was Douglas C. McMurtrie, who acted as director of the Red Cross Institute for Crippled and Disabled Men in New York City, and wrote extensively on the topic of disability and retraining, including Douglas C. McMurtrie, *The Evolution of National Systems of Vocational Reeducation for Disabled Soldiers and Sailors* (Washington, DC: GPO, 1918); *The Disabled Soldier* (New York: MacMillan, 1919).

⁸⁴ Garrard Harris, *The Redemption of the Disabled: A Study of Programmes of Rehabilitation for the Disabled of War and of Industry* (Toronto: McClelland & Stewart, 1919), viii.

⁸⁵ The best account of retraining and rehabilitation efforts in the U.S. is Beth Linker, *War's Waste: Rehabilitation in World War I America* (Chicago: University of Chicago Press, 2011), especially chapter 7.

Exceptional personal stories of perseverance and determination showed that any disability was surmountable with the appropriate support and proper attitude. Provincial commissions took care to survey which occupations were best-suited to men from various categories of disabilities, as well as to forecast which occupations would continue to grow and require additional labour in the future.⁸⁶ DSTB medical advisors routinely visited businesses and industrial establishments to determine the physical strain a life working in a particular occupation might have on various categories of disabled men. After-care procedures—something most countries lacked—also ensured that graduates were directed towards suitable employers and monitored until vocational authorities were assured that they had found a stable career.⁸⁷

How, then, did the application of these rigorous standards and scientific methods of re-education work out in practice for the average veteran? Although the Vocational Branch had established a follow-up system in 1918, Segsworth and the DSCR had little more than anecdotal results to report until 1919. Early data on graduates obtained by the after-care section pointed to a number of positive trends that reinforced officials' belief that the disabled were embracing retraining. In total, vocational officers had interviewed a staggering 43,462 prospective students up to 31 December 1918.⁸⁸ The presence of a disability, however, was no guarantee of a course. In fact, only 8004 applicants who were interviewed—18.4 per cent—were granted a course or apprenticeship from the vocational

⁸⁶ *ISC Report*, 20-21; *DSCR Report* (1919), 43-44.

⁸⁷ *DSCR Report* (1919), 48-49.

⁸⁸ Segsworth, 164.

branch.⁸⁹ The remainder were ineligible for training based on the criteria DSTBs used to determine whether a soldier was still employable in his former occupation. Table 4.1 below provides an overview of the status for each of these 8004 veterans at the time of the survey.

TABLE 4.1 – STATUS OF VOCATIONAL TRAINING STUDENTS TO 31 DECEMBER 1918

OUTCOME	TOTAL STUDENTS	% OF STUDENTS
Courses not accepted	455	5.7%
Courses discontinued	707	8.8%
Courses not commenced	1088	13.6%
Men in Training	3469	43.3%
Completed Courses	2285	28.5%
Total	8004	100%

Source: Segsworth, Retraining Canada's Disabled Soldiers, 164.

Of the 8004 students in this first cohort studied by the DSCR, 14.5 per cent never completed their course, while a further 13.6 per cent had yet to commence their retraining. The ultimate outcome for over 40 per cent of students still in-training remained unknown. Walter Segsworth, however, interpreted the results as overwhelmingly positive, even in cases where soldiers had declined to take a course or withdrew prematurely:

The fact should not be lost sight of that a number of men are awarded courses, who at the time their cases come up for consideration, sincerely believe that they cannot return to their former work. They are not malingerers but their belief is due to a station of intuitionism induced by their life in the army and in the hospital. After a few months of training with the Department they find that their idea is false and go back to their old occupation, but if they had not been trained by the Department they would have persisted in their former state of mind and very likely have sunk lower and lower in the social scale.⁹⁰

⁸⁹ Segsworth, 164.

⁹⁰ Segsworth, 165-66.

Irrespective of the outcome, according to Segsworth the DSCR had done its part by arousing a disabled man’s interest in an occupation at any one stage of the rehabilitation process. Rather than coercing disabled men into taking a particular course, the Canadian system granted them agency on the premise that promising students would languish if an authoritarian approach was adopted. As one department official contended, “it has been demonstrated time and time again that men with the requisite ability, grit and determination, can reach any height and successfully fill any position they desire.”⁹¹ Vocational training was merely intended to cultivate these innate, masculine qualities of Canada’s citizen soldiers.

In addition to the above survey, Segsworth and the Vocational Branch also proceeded to initiate a follow-up study on the 2285 men who had successfully graduated before 31 December 1918, the results of which are reproduced in Table 4.2 below.

TABLE 4.2 – SURVEY OF 2285 VOCATIONAL TRAINING GRADUATES

OUTCOME	TOTAL STUDENTS	% OF STUDENTS
Following line of training	1491	65.2%
Unemployed	110	4.8%
Sick or deceased	56	2.5%
Unable to trace	197	8.6%
Following other occupation	431	18.9%
Total	2285	100%

Source: Segsworth, Retraining Canada’s War Disabled, 165.

The data obtained from this first cohort of graduates offers a more sobering picture of the Vocational Branch’s performance. On a positive note, it was entirely possible that a

⁹¹ Circulars and Bulletins, June 1919, LAC.

portion of ‘untraceables’ had yet to find work, however, on balance the findings suggest that comparatively few graduates were unemployed. More troubling were the proportion of students unable to obtain a position in the occupation for which they had trained. Irrespective of their enthusiasm, few veterans could expect to master a new trade in its entirety with only six to eight months of theoretical instruction and on-the-job training. For the majority, vocational retraining was supposed to assist in the adaptation of old skills to new physical circumstances and occupational contexts.⁹² That nearly 20 per cent of graduates (or more) were not able to find work in fields related to their course or apprenticeship raised troubling questions about the existing employment opportunities available to returned men, and more seriously, the potential impact an ill-suited occupation might have on a veteran’s health and claims to future entitlements from the state.

Part of the explanation for the underwhelming outcome for some students lay in the courses themselves. Self-congratulatory propaganda from the DSCR highlighted the litany of occupations for which retraining courses were available, but most students were clustered into a few fields. Table 4.3 lays out the proportion of students undergoing training for the 10 most popular course-types:

⁹² Morton and Wright, 134-35.

TABLE 4.3 – DISTRIBUTION OF STUDENTS ENROLLED BY COURSE-TYPE OF 31 JANUARY 1919

COURSES	% OF ALL STUDENTS
Commercial	15.0%
Auto Mechanics	12.0%
Shoe Repair	7.0%
Agriculture	5.0%
Farm Mechanics	5.0%
Telegraphy	5.0%
General Education	4.0%
Machine Shop	4.0%
Electrical Work	4.0%
Gas Tractor Operation	4.0%
Total Percentage	65.0%

Source: Segsworth, Retraining Canada's War Disabled, 80-83.

In spite of concerted efforts to ensure veterans were trained in a broad range of careers, these 10 fields of study accounted for 65 per cent of all courses granted by the DSCR up to 31 January 1919. Many of these occupations were forecasted to be in high demand, but the return of able-bodied (and some disabled) veterans to positions which they had held prior to enlistment, coupled with the appeal of hiring men who had gained valuable skills and experience working in wartime industries, both posed a substantial obstacle. Few sectors of the economy could absorb all graduates promptly. Moreover, the allure of offering positions to ex-servicemen as a gesture of patriotism waned significantly as the hardships a post-war economic recession quickly forced many employers to prioritize their bottom line.

The DSCR was hopeful that veterans would be able to carve their own path towards prosperity, but they were not oblivious to the harsh realities of the industrial capitalist marketplace. Preferential treatment for civil service appointments was one major safeguard, though it too would prove unsustainable. By 1921, over 8000 disabled

veterans were employed full time by the civil service—nearly one of every five vocational graduates—and 29,000 in temporary positions. At its peak in 1921 the DSCR staffed over 9000 men and women, many of them disabled soldiers, but as requirements for civil re-establishment and military demobilization diminished, so too did the need for an expansive bureaucracy. In the years that followed the department fell into steep decline, closing or relinquishing most of its hospitals and retraining facilities, and ultimately downsizing its staff to a little over 2000 men and women.⁹³

Vocational training reached its apex in 1921 with some 27,000 students enrolled. Its meteoric ascension as a pillar of Canada's reconstruction plans, however, declined rapidly in the years that followed as the federal government attempted to curtail lavish spending on veterans' benefits.⁹⁴ Consequently, after-care and follow-up services were largely abandoned, and with the exception of a handful of cases that fell under extenuating circumstances, vocational training was discontinued for all ex-members of the CEF as of 1923. By that time, the entirety of Canada's vocational brain trust, with the exception of E.H. Scammell, had left the DSCR in search of new opportunities to further their careers. Beyond the few early studies carried out in late 1918 and early 1919 that formed the statistical basis for Segsworth's 1919 survey of Canada's retraining scheme, little additional data was collected on retraining outcomes for students over the long-term. Once a soldier found employment, the department's responsibility to the client ceased unless he required medical treatment or additional pension support.

⁹³ Morton and Wright, 134-37.

⁹⁴ Morton and Wright, 134-37.

Pension records offer an interesting, albeit incomplete picture of how vocational graduates navigated their way through the re-establishment process. Of 384 veterans in the sample group 27 (7.0 per cent) successfully completed vocational retraining courses under the MHC and DSCR. All but one of these courses took place between 1916 and 1921, while an additional course was approved for a special case in 1930. Six courses were granted to soldiers who enlisted underage. Only one of the 21 disabled soldiers who received a course prior to 1921 abandoned their training, while another soldier found work related to his retraining course before it was officially completed.⁹⁵ The mean course length was eight months, the shortest lasting three months and the longest a year. Of the 20 disabled soldiers who completed their training, 16 were for ‘light occupations’ involving indoor work and limited physical strain, ranging from hardware sales to shoe-repair.⁹⁶ More remaining four trained for more strenuous and physically demanding occupations, which included auto mechanics, gas tractor operation, and electric welding.⁹⁷

Table 3.1 in Appendix II (Statistical Appendix) outlines each vocational student’s pre-war occupation, post-discharge disabilities, retraining course, and, if known, their post-war occupation. It reveals that, at least on the surface, vocational retraining enhanced a soldier’s chances of finding gainful employment after the war. All five cases for which no information was found were in stable positions shortly after leaving training, and 11 of

⁹⁵ The soldier who found work, Henry H., is included in the discussion of this data as a graduate of retraining.

⁹⁶ Courses falling under this category included: architectural drawing ($n=1$); barbering ($n=1$); commercial/ civil service course ($n=3$); hardware sales (1); insurance sales ($n=1$); shoe-repair ($n=4$); tailoring ($n=1$); and steam engineering ($n=1$).

⁹⁷ These more physically demanding courses included: bench carpentry ($n=1$); welding ($n=1$); gas tractor operation ($n=1$); bandsaw filing/fitting ($n=1$); motor mechanics ($n=1$); and poultry farming ($n=2$).

15 found an occupation related to their training course. The table also illustrates the scientific and educational principles that vocational officers and medical consultants used to guide their decision-making when granting courses. For example, soldiers from a background in general labour were usually encouraged to take courses that required minimal schooling or prior knowledge of the trade in order to succeed. Conversely, the sample also illustrates that vocational officers preferred to train soldiers from more technical backgrounds in occupations that would allow them to maintain a similar standard of living to that which they had enjoyed before enlistment. Irrespective of the man's work experience, the most important factor guiding a training board's recommendations was the degree to which the occupation would affect a soldier's health. As the data from the sample indicates, few disabilities conformed to popular expectations of what types of disabled men would necessitate retraining. A mere five soldiers with disabilities resulting from gunshot wounds required retraining, and only one of these five cases was an amputee. Medical officers erred on the side of caution, in most cases recommending lighter, indoor work in lieu of an occupation that would expose a man to the elements and wear down his health.

Unfortunately, due to the state of many pension records and each man's unique relationship with veterans' agencies after the war, it is not possible to rigorously track the sample's employment history, what they earned, or how each veteran's disability/disabilities affected his working life.⁹⁸ A close examination of individual cases, however, reveals that the efficacy of retraining varied greatly from soldier to soldier.

⁹⁸ For a full discussion see Appendix I: Methodological Essay.

Private Alexander W., for instance, enlisted in the CEF in July 1915 and served in France with the 4th Battalion before losing his left eye from a bullet wound in October 1916.⁹⁹ A vocational officer determined that his disability would not permit him to continue his pre-war career as a railway mechanic or any other related trade. Instead, he was granted a six-month commercial course. Alexander graduated successfully and on time, obtaining a position as a clerk at a Hamilton manufacturing company where he earned a salary of \$90.00 per month. His records show that he continued with this line of work for the remainder of his career.¹⁰⁰

Some soldiers were unable to translate their training into a career, but found success in other fields. Frank T. was discharged in February 1919 with a 10 per cent pension for pain and weakness in both legs resulting from shrapnel wounds. Although his pension was meagre, his disability prevented him from returning to his pre-war occupation as a mechanic. The DSTB for Toronto instead suggested Frank take a six-month course in commercial telegraphy, which he turned down in favour of his own suggestion of completing an apprenticeship in tailoring. Vocational authorities approved the transfer, and Frank continued in his new line of work for two years at a rate of \$24.00 per week before taking up a position as a city bus driver for the remainder of his career.¹⁰¹

Other veterans similarly opted to chart their own paths to civil re-establishment but were sometimes less fortunate. Charles H., a 35-year-old sapper from the 1st Pioneer Battalion who was discharged from the CEF in with debility from nephritis. Before the war Charles

⁹⁹ Personnel File, Alexander W., RG 150, Accession 1992-93/166, Box 10188 – 33.

¹⁰⁰ Pension File, Alexander W., VAC.

¹⁰¹ Pension File, Frank T., VAC.

was able to earn as much as \$90.00 per month in support of his wife and lone child, but persistent, indigestion, weakness, and dyspnoea meant that he could no longer carry on in his previous line of work. As a result, vocational authorities recommended that the veteran be enrolled in a six-month course in shoe-repair. Charles completed the course on time, but showed little interest in turning it into a career. Instead, the aging soldier chose to take up farming near the small community of Shining Bank, Alberta, believing that his experience working on a farm as a child would make for a smooth career transition. He was wrong: the strain of farming took a heavy toll on the ex-soldier's already diminished health. By 1927 Charles was unemployed, frequently in and out of hospital, and subsisting on nothing more than his meagre pension.¹⁰²

Perhaps more than any other disability, tuberculosis posed the most significant challenge for soldiers who underwent vocational training. Work had to be managed carefully in order to avoid triggering a relapse, and those veterans who were able to train for a new occupation often found it difficult to balance a regular work schedule with the need for rest. The lone veteran with TB in the sample group who completed a retraining course was Private Edwin S., an underage soldier from Medicine Hat, Alberta who developed symptoms in February 1917 while he was working in a German POW camp. Fearing that the infection might spread throughout the inmate population, he was transferred to a sanatorium in neutral Switzerland before eventually being returned to Canada in October 1918.¹⁰³ A DSTB recommended that Edwin be granted a course in hardware sales, a position that he was adept at but could not continue with because of

¹⁰² Pension File, Charles H., VAC.

¹⁰³ Pension File, Edwin S., VAC.

frequent spells of weakness and dyspnoea from working indoors.¹⁰⁴ In 1920, Edwin was offered an appointment as a letter carrier, a position that department physicians hoped would combine an ideal mix of fresh air and exercise to keep his condition arrested. Although Edwin's health remained very delicate and routine medical examinations revealed that he was "just holding his own," he pressed on in civilian life, earning a steady paycheque from the post office and collecting a 50 per cent pension for the duration of his career.¹⁰⁵

VI. CONCLUSION

Soldiers like Edwin S. were emblematic of the DSCR's ideal disabled veteran: a young man who through perseverance and masculine fortitude achieved victory over his disability by taking control of his economic future.¹⁰⁶ Although we can never know how many soldiers followed a similar path in civilian life, the evidence from the sample group suggests that retraining did positively affect the lives of some veterans, while its influence on others was largely inconsequential beyond the short term. Vocational training ultimately did not fail Canadian veterans, but neither was it able to completely alleviate the material, physical, or psychological hardships that war imposed on its survivors. The rapid dismantling of the program and the failure of the DSCR to provide sufficient oversight after soldiers were placed in their occupations proved to be its most significant shortcoming, one that was justified by elected officials on the assumption that the state

¹⁰⁴ Pension File, Edwin S., VAC.

¹⁰⁵ Pension File, Edwin S., VAC.

¹⁰⁶ Pension File, Edwin S., VAC.

had done its part and Canada's citizen-soldiers could carry on without difficulty.¹⁰⁷ As the Canadian economy faltered in the transition from war to peace, however, employers who had once approached the idea of employing the disabled with patriotic zeal were confronted with the troubling reality that many veterans, especially young men who had not had sufficient time to master a trade, were less efficient than their able-bodied counterparts.

Heroic examples of severely maimed or chronically-ill soldiers making a livelihood for themselves were always present, but with the passing years, there were equally tragic stories of Great War veterans—both disabled and non-disabled—who had broken down on the job or were forced out of their occupations due to ill-health. There was little consolation for these men. They had simply failed to make good on the generous albeit temporary benefits the state provided to them. Vocational training presented an idealized opportunity to limit the impact of disability on the lives of ex-servicemen, but in a society that privileged the male breadwinner ideal and in the absence of sustained support from the state, few could truly overcome the material burdens imposed by sickness and injury. It was this disconnect between the lauded ideals of civil re-establishment and the harsh realities that many ex-servicemen lived with daily that came to dominate the relationship between Canadian veterans and the state during the inter-war years, and as we shall see in the chapters that follow, galvanized ex-soldiers to challenge authorities to live up to their alleged promises.

¹⁰⁷ As Scott Gelber has illustrated, the American program also went through a rapid period of decline after the war ended. See Scott Gelber, "A 'Hard-Boiled Order': The Reeducation of Disabled WWI Veterans in New York City," *Journal of Social History* 39, no. 1 (2005): 161-80.

**Chapter 5: ‘We have not had a square deal’: Austerity and the Politics of Veterans’
Health, 1919-1929**

In March 1925, the *Toronto Telegram* published the distressing story of Daniel L., a veteran who had been refused pay and allowances while undergoing treatment in Christie Street Hospital for a medical condition that he believed was directly related to his wartime service. The *Telegram* presented Daniel as a soldier with an exemplary record of service. A Russian-born labourer, he had lied about his background and enlisted at Winnipeg in November of 1915, eventually serving overseas with the 44th Battalion of the Canadian Expeditionary Force (CEF). In a letter to the *Telegram* that accompanied his story, Daniel noted that he had been wounded in combat on several occasions. He was first hospitalized in March 1917 after receiving a minor shrapnel wound to the groin, followed by a second trip to hospital in June after being exposed to poison gas and taking shrapnel to the chest. Just two days before the Armistice, Daniel was hospitalized a third time for a broken arm and exposure to more poison gas.¹ Despite the physical turmoil he faced during his lengthy service, a final medical board ruled that Daniel had made a full recovery from his war wounds. He was discharged from the CEF on 8 April 1919 as ‘physically fit.’²

¹ “Charity for Our Disabled: Ottawa Will do Nothing,” *Toronto Telegram*, March 31st, 1925.

² Personnel File, Daniel L., Ministry of the Overseas Military Forces of Canada, RG 150 [hereafter ‘RG 150’], Accession 1992-93/166, Box 5595 – File 10, Library and Archives Canada [hereafter ‘LAC’].

The *Telegram*'s account of Daniel L.'s service record revealed perseverance, but his post-war life was marked by hardship. Following the war the ex-private travelled from city to city in search of work, a journey that took him from Winnipeg, to Northern Ontario, and eventually Toronto. His health also began to languish. Medical reports in Daniel's pension records show that he was suffering from bronchitis and intestinal complications resulting from an appendectomy, both of which physicians deemed as post-discharge conditions.³ The *Telegram* was unconvinced, claiming instead that there remained "a considerable amount of mystery or a like degree of secrecy" surrounding the origins of the veteran's illness.⁴ Wary of drawing any more negative attention from the press, the Department of Soldiers Civil Re-establishment (DSCR) responded by admitting Daniel to Christie Street Hospital for treatment on compassionate grounds. After several weeks Daniel was discharged to carry on under his own strength. For better or worse, he was back to square one.

The editor of the *Telegram* and Daniel's supporters at the Ontario Soldiers' Aid Commission were indignant at the level of discourtesy the DSCR had displayed towards the case. What began as a human-interest story in March of 1925 quickly escalated into a heavily publicized dispute between government officials and local veterans' advocates over Daniel L.'s right to a war pension. After going to the papers once more in April 1927, Daniel's case spawned a succession of journalist and veteran-authored articles and editorials in the *Telegram* and *Toronto Daily Star* ostracizing local authorities for their

³ Pension File, Daniel L., Veterans Affairs Canada [hereafter 'VAC'].

⁴ "Charity for Our Disabled: Ottawa Will do Nothing," *Toronto Telegram*, March 31st, 1925.

parsimony and indifference to the plight of disabled veterans.⁵ Since leaving Christie Street Daniel's circumstances had worsened considerably. The press reported that he was now deathly ill and had resorted to begging on the streets for food. In a desperate effort to avoid starvation, he voluntarily had himself jailed for six months at a reformatory farm on the charge of vagrancy.⁶ For the Mackenzie King government the case was quickly turning into a national embarrassment. In November 1927, Ottawa finally intervened, granting Daniel re-entry to Christie Street Hospital and a promise to aid him in obtaining stable employment when his health returned.⁷

To a sensationalist press Daniel's compelling account required no independent validation. As a story, it garnered sympathy from thousands of ex-servicemen whose disdain for the pension system and broken promises of re-establishment increasingly coloured their view of the Great War and its legacy. A sympathetic public was equally indignant over Daniel's treatment. Here was a returned man who, presumably no fault of his own, was unemployed, disabled, and destitute. How could his case be unworthy of compensation? Had military physicians misjudged his condition, or were they guilty of operating on a circumscribed and unjust definition of a war disability? That a veteran was obliged to demonstrate a definitive medical link between his disability and service

⁵ Pension File, Daniel L., VAC. Daniel L.'s pension records contain clippings of over 40 articles and opinion columns that appeared in the *Star*, *Telegram*, and other papers between 1925 and 1930.

⁶ Pension File, Daniel L., VAC.

⁷ Personnel File, Daniel L. RG 150, Accession 1992-93/166, Box 5595 – File 10, LAC. Daniel L. did not actually serve at Vimy in March of 1917. On the contrary, his service records show that between 5 March and 18 April he was on base detail behind the lines. His medical records also show no record of a shrapnel wound to the groin region in March 1917 (which Daniel alleged contributed to his intestinal disorder), and the reported fracture to his left arm due to German shellfire was actually incurred on 14 December 1918 from a falling stone. This evidence was made available to both the *Telegram* and *Star* in subsequent correspondence between department officials and the editors.

conditions in order to obtain a pension was not only a brazen example of bureaucratic pedantry, it was also antithetical to the patriotic and compassionate spirit of civil re-establishment. For an increasingly hostile and well-organized veterans' lobby, this politics of 'attributability' came to symbolize the post-war state's betrayal of the ideals for which a generation of men had sacrificed life and limb. As one editorialist in the *Toronto Daily Star* mused, "I sometimes wonder what their fallen comrades think of the tons of granite erected to the dead heroes while some of the living ones walk the streets destitute or go to jail."⁸

The response to Daniel L.'s plight was thus much more than a sporadic outpouring of popular support for a disabled veteran's struggles with the pension system. As Canadians searched to find meaning in the war's aftermath, they were confronted by the unsettling reality that the Great War's lingering shadow had cast a pall over what many had hoped would be a period of regeneration and social progress.⁹ For veterans and civilians alike the 1920s offered a perplexing mix of economic volatility, unprecedented material prosperity, social unrest, and political inertia. Wartime progressivism faltered and then ceased to sustain its forward momentum as the federal government searched for ways to curb public spending and mediate popular demands for increased state involvement in matters of social welfare.¹⁰ Disabled veterans found themselves on the

⁸ "Private L.," *Toronto Daily Star*, October 26th, 1927.

⁹ Richard Allen, *The Social Passion: Religion and Social Reform in Canada, 1914-28* (Toronto: University of Toronto Press, 1971); Robert Craig Brown and Ramsay Cook, *Canada, 1896-1921: A Nation Transformed* (Toronto: McClelland and Stewart, 1974).

¹⁰ Desmond Morton and Glenn Wright, *Winning the Second Battle: Canadian Veterans the Return to Civilian Life, 1915-1930* (Toronto: University of Toronto Press, 1987), xi. Also see Dennis Guest, *The Emergence of Social Security in Canada* (Vancouver: UBC Press, 1980).

front lines of this public battleground between what post-war planners had promised and what the state allegedly could afford. More than any other group, they came to epitomize a disjuncture between the ideals and realities of reconstruction.

Canadians were not alone in their quest to reconcile the war's human legacy with the political and fiscal imperatives of peacetime. Among all the former belligerents, the health and wellbeing of veterans rose to level of social and political significance that had few parallels.¹¹ Hastily developed wartime policies for the care of the disabled and the families of deceased soldiers were placed under immense strain as veterans returned en masse and organized to lobby for additional compensation for their service. While comparatively generous, Canada's re-establishment program and pension system were not without defects. But, unlike more radical counterparts in Germany, France or the United States, Canada's veterans' movement sought to remedy these shortcomings by working within the political mainstream, pressuring politicians and bureaucrats to amend existing legislation and introduce new programs that would catch ex-servicemen who fell through the cracks. As had been the case during the war, veterans' conventions and parliamentary special committees were the primary mechanisms through which policy was crafted and debated. In doing so the veterans' lobby was able to cultivate legal expertise while simultaneously building the political capital necessary to garner public support for reform.

Throughout the 1920s Canada's ex-soldiers struggled to adapt to the personal and administrative exigencies disability imposed on their daily lives. This chapter examines

¹¹ The only international survey of the Great War and its veterans is Stephen R. Ward, ed., *The War Generation: Veterans of the First World War* (Port Washington, NY: Kennikat Press, 1975).

how ordinary veterans confronted disability, persevered through physical and emotional stress, and contended with material insecurity. Importantly, it also explores how these experiences were mobilized into an emerging lexicon of disability rights within post-war veterans' activism. As Canadians struggled to come to terms with the complex legacy of the Great War, stricken by grief, and infused with optimism that the sacrifices of so many had not been in vain, they were confronted with the discomfiting reality that the archetype of the self-sufficient and industrious disabled veteran was more figment than fact.

Canadians also discovered that the war's physical legacy was far more insidious than the maiming and bloodshed that occurred between 1914 and 1918. Throughout the 1920s waves of ex-soldiers who had left the military in supposedly good health began coming forward in search of compensation for mysterious illnesses, chronic physical injuries, and forms of trauma that had degraded their quality of life and economic independence. Within this context the highly contested matter of 'attributability' took on new significance as thousands of disabled veterans fought to have their ailments recognized by the over-burdened pension system. As we shall see in this chapter and the one that follows, the growing movement to reform the system offers a vivid illustration of how the politics and discourse surrounding veterans' health contributed to a crucial shift in the shifting relationship between citizens and the state in Canada. These debates, I argue, also had a profound impact on Canadians' understanding of the war's meaning. By the onset of the Great Depression, the disabled veterans had claimed a prominent space

within Canadians' collective memory of the conflict, serving as a symbol of the war's enduring legacy and the promises that remained unfulfilled

II. DEMOBILIZATION AND ITS DISCONTENTS: THE RETURN TO CIVIL LIFE IN THE FACE OF AUSTERITY

Between November 1918 and November 1919, Canada demobilized over 360,000 troops from its military, including 267,000 serving overseas.¹² During the war military and civilian authorities had gone to great lengths to prepare for the orderly return of wounded and disabled men, but the demobilization of a quarter million predominantly volunteer soldiers was, at least initially, marked by chaos and disarray. The Canadian Corps' Commander Sir Arthur Currie had convinced senior military staff to return entire units based on their level of combat experience, but not before thousands of non-combat veterans and conscripts prematurely disembarked for Canada. The majority of the Corps' veterans, many of whom fought for years on the front lines, lingered in convalescent depots or demobilization camps, embittered and disillusioned that they were ignored in favour of 'lesser' soldiers.¹³ Morale and discipline proved extremely difficult to maintain. Discontent spread quickly and soon turned violent, reaching its climax on 4-5 March 1919 when hundreds of soldiers rioted at Kimmel Park Camp, vandalizing local businesses and, according to some accounts, pilfering as much drink as they could

¹² G.W.L. Nicholson, *Official History of the Canadian Army in the First World War: Canadian Expeditionary Force, 1914-1919* (Ottawa: Queen's Printer, 1962), Appendix C.

¹³ Desmond Morton, *When Your Number's Up. The Canadian Soldier in the First World War* (Toronto: Random House, 1993). Also see Morton, "'Kicking and Complaining': Demobilization Riots in the Canadian Expeditionary Force, 1918-19," *Canadian Historical Review* 61 no. 3 (1980): 334-360. A full report on the demobilization was released in 1920. See Department of Militia and Defence, *The Return of the Troops: A Plain Account of the Demobilization of the Canadian Expeditionary Force* (Ottawa: King's Printer, 1920).

stomach along the way. By the time the melee subsided five soldiers were dead and a further 25 wounded.¹⁴

Military officials were quick to dismiss the unrest as a sporadic outburst of hoodlumism and Bolshevik provocation. Little consideration was given to the role of inadequate demobilization plans.¹⁵ The violence was inexcusable, but the discontent hardly surprising. With the absence of an enemy and dangers of the battlefield, military discipline and routine grew old quickly. Few soldiers from the first Canadian contingent remained, but tens of thousands had been away from home for years putting off their livelihoods and sacrificing their youth in the defence of King and Empire. The average time served among 384 members of the sample group was 852 days, or 2.33 years. Nearly 40 per cent of the sample served for three years or longer, the vast majority of them in Belgium or France. The average veteran served in this combat theatre for 1084 days before their discharge. Of all sample group members, the average age at discharge was 28.4, and the median discharge date was 28 March 1919. Many, including the disabled, waited months longer to return home—some as late as September and October 1919 when Canada's few remaining hospitals were finally closed.¹⁶

The monotony of military life coupled with fresh memories of the trepidation and terror of combat made the prospect of returning home all the more appealing to CEF veterans. At the peak of demobilization transport ships were marshalling Canadian

¹⁴ Morton, "Kicking and Complaining," 350.

¹⁵ Morton, "Kicking and Complaining," 351-53.

¹⁶ Canada's main orthopaedic hospital, Granville Canadian Special Hospital, remained in operation until 17 September 1919, while the Petrograd Red Cross Hospital for Officers was not closed until 3 October 1919. No. 14 General Hospital (Eastbourne) operated until 23 October 1919.

soldiers from England at a pace of 25,000 per month. As they had overseas, Canadian officials struggled to accommodate the vast number of soldiers seeking emancipation from their military duties. The militia department's main discharge depots at Halifax, Québec City and Saint John were overwhelmed with weathered soldiers eager to return to their communities and loved ones. To a weary combat veteran, a final medical board was just another procedural obstacle standing between him and his home. Army physicians were instructed to be as thorough as possible in their medical assessments, but the pace at which men were returning was simply too frantic for Canada's modest medical infrastructure to handle. Medical boards lacked uniformity in expertise and many exams were performed hastily. Marginal cases of disability were commonly passed over in favour of a speedy discharge, while others were misdiagnosed entirely. These shortfalls would have a profound effect on the future of Canada's pension system and the veterans it was designed to serve. Of 76 soldiers in the sample group who were granted a pension between 1915 and 1944, 24 (31.6 per cent) were discharged from the CEF as 'medically fit.'

The demobilization of the CEF also raised a number of important questions about the future shape of Canada's wartime rehabilitation program and the manner in which it would continue to serve the needs of disability pensioners. How many veterans would require in-patient care on an annual basis? Should the DSCR continue to offer medical treatment through its own infrastructure, or would veterans be better served by establishing treatment agreements with local public hospitals? What about men who needed routine medical examinations for pension purposes, especially those living in

remote areas of the country? The DSCR was eager to continue exercising its mandate as the primary caregiver to Canada's wounded soldiers, but the department's leadership also knew that their extensive wartime treatment network was unsustainable. Downsizing had to be considered. With the exception of neuropsychiatric and tuberculosis patients, most veterans would only require intermittent treatment and routine examinations. Modern surgery and rehabilitation, at least in theory, had restored most severely wounded soldiers to a remarkable degree of self-sufficiency and good health. Generous pensions and vocational retraining would ensure that only rare cases would face material hardship or substantial deteriorations to their health.

In anticipation of its shifting role, between 1919 and 1923 the DSCR rapidly dismantled its treatment facilities in favour of a small network of centralized veterans' hospitals located across the country. All but two of the department's sanatoria were either transferred to the control of provincial health departments or closed down. In addition to the two remaining sanatoria, the department continued to operate seven general treatment hospitals as the backbone of its Treatment Branch.¹⁷ Added to this were two neuropsychiatric treatment facilities, one at St. Anne's Hospital and a larger facility at Westminster Hospital in London, Ontario. At full capacity, the department could accommodate 2794 in-patients (including some 300 beds at its two sanatoria), a dramatic

¹⁷ *Report of the Work of the Department of Soldiers' Civil Re-establishment* (Ottawa: King's Printer, 1923), 2. Hereafter cited as *DSCR Report*. The names and locations of these seven hospitals is as follows: Shaughnessy Hospital (Vancouver), Colonel Belcher Hospital (Calgary), Deer Lodge Convalescent Hospital (Winnipeg), Christie Street Hospital (Toronto), St. Anne's Hospital (Montréal), Lancaster Hospital (Saint John) and Camp Hill Hospital (Halifax).

decrease from a peak of nearly 12,000 during wartime.¹⁸ As expected, demand for lengthy in-hospital care diminished rapidly after 1920, with in-patient admissions remaining well within the department's capacity in the years that followed (see Figure 1.1 in Appendix II: Statistical Appendix).

A far greater difficulty facing the DSCR's Treatment Branch was the need for thousands of routine and investigatory medical examinations that its physicians were responsible for carrying out in support of the pension board. In an effort to reduce administrative costs and streamline its services, in 1920 the Board of Pension Commissioners (BPC) amalgamated its district offices with those of the DSCR. A year later, the pension board and DSCR head offices were also merged.¹⁹ Under the new arrangement the DSCR and BPC were able to employ some 450 physicians and specialists spread among department hospitals, public hospitals and smaller clinics across Canada.²⁰ To expand the reach of the department, authorities arranged for travelling medical boards to visit remote localities and carry out routine pension examinations.²¹ Under certain circumstances, applicants or existing pensioners could receive their assessment from private physicians, whose report was then forwarded on to Ottawa for

¹⁸ *DSCR Report (1923)*, 1.

¹⁹ The full details of the amalgamation are laid out in *DSCR Report (1922)*.

²⁰ *Pensions, Soldiers' Insurance and Re-establishment: Proceedings of the Special Committee Appointed ... to Consider Questions Relating to the Pensions, Insurance and Re-establishment of Returned Soldiers, and any Amendments to the Existing Laws in Relation thereto which may be Proposed or Considered Necessary by the Committee, etc.* (Ottawa: King's Printer, 1922), 21-23. Hereafter cited as *Special Committee (1922)*.

²¹ *Report of the Work of the Board Of Pension Commissioners for Canada (1921)*, 14. Hereafter cited as *BPC Report*. Special travelling chest clinics were also organized through the DSCR for tuberculosis cases. See *DSCR Report (1923)*, 9.

evaluation.²² If the pension board was not satisfied with the private doctor's appraisal, or if further investigation was required, an official examination was arranged with a DSCR physician.

Medical re-examinations were a necessary measure to ensure that veterans were being compensated appropriately and were in a satisfactory state of health, but they frequently aroused anxiety and discontent amongst Canada's disability pensioners. Irrespective of severity, the pension officials classified few disabilities as permanent until years after the war had ended. Even conditions such as amputations, disarticulations or tuberculosis, which by their very nature were 'incurable,' required check-ups at least once every 12 months. Gunshot wounds, chronic respiratory or cardiac illnesses, and cases of nervous disease could be reassessed as often as every four to six months in order to ensure a veteran's pension was commensurate with his actual incapacity. For example, between January 1918 and October 1921 Private Alexander D. of Vancouver saw the rate of his original 10 per cent pension for valvular disease of the heart revised on six separate occasions.²³ Another veteran, Sapper Charles H., witnessed his pension for nephritis and septic arthritis changed four times in four years before finally stabilizing at a rate of 40 per cent.²⁴ When necessary, the DSCR compensated veterans for the costs of travel, meals, and lodging, but for those living far from a district office, frequent re-examination might mean several days away from work and family, all for only a few minutes spent on

²² See *DSCR Report* (1924), Appendix I.

²³ Pension File, Alexander D., VAC.

²⁴ Pension File, Charles H., VAC.

the physician's table.²⁵ If a veteran deliberately missed his scheduled appointment, or was tardy in rescheduling, his pension would be suspended until the examination took place.²⁶ As with army medical boards, examinees were not to be informed of the state of their health until after the report had been completed. The anxiety of not knowing whether one's pension would be decreased, or possibly discontinued, undoubtedly weighed heavily on a veteran's mind.

As the preceding discussion illustrates, a veteran whose disability status was in a state of fluctuation had good reason to be anxious about his future. From its inception the BPC had been granted final authority on all matters related to the interpretation of medical evidence and the applicability of pension regulations in each case that came before it. These powers were enshrined in the Pension Act, an unprecedented if imperfect achievement in Canadian social policy. As Chapter 3 illustrated, for over four years prior to the creation of the Act, Canadian pension regulations had been crafted and revised in response to a diverse assemblage of administrative hurdles and philosophical dilemmas provoked by the return of some 70,000 disabled soldiers. Parliamentarians ultimately declined to create a pension scheme that granted compensation as a universal right of service, but the spirit of the Act, at least in principle, was one of generosity and liberality. What remained uncertain was how long this generosity could be sustained by a nation

²⁵ *Pensions and Returned Soldiers' Problems: Reports, Proceedings and Evidence of the Special Committee on Pensions and Returned Soldiers' Problems, Comprising Proposed Amendments to the Pension Act, Returned Soldiers' Insurance Act, Land Settlement Act, Employment and Care of Problem Cases* (Ottawa: King's Printer, 1928), 439-40. Hereafter cited as *Special Committee (1928)*.

²⁶ *The Pension Act, Statutes of Canada* (1919), C.43.

encumbered with debt and guided by political ideals that sought to restrain the federal state's role in matters of social welfare.

It was these virtues that Major John L. Todd, the chief architect of Canada's wartime pension regulations, had envisaged as the most pragmatic and equitable approach to a lifelong social contract between ex-servicemen and the state.²⁷ For Todd, a pension was a form of financial insurance against the *potential risk* of disablement—what contemporaries commonly referred to as the “insurance principle.”²⁸ Officials were to grant disabled men of all stripes the benefit of the doubt when they presented their case. If a disability emerged while a soldier remained in uniform, it was only right to assume that, except in cases of deliberate concealment or misconduct, the ailment was to some degree attributable to service and therefore worthy of compensation.²⁹ Conditions that pre-dated enlistment and were aggravated while on duty could be objectively measured by comparing a man's physical capacity in the open labour market before and after his period of military service. When significant time had passed between the man's discharge from the military and submitting a pension claim, however, the pension board's ability to scientifically measure the degree to which a disabling condition was attributable to service was comprised. It was entirely possible that other mitigating factors could influence the onset and acuity of symptoms. In anticipating this quandary, the original Pension Act placed a three-year time limit on applications, either from the date of the

²⁷ J.L. Todd, “The Duty of a War Pension,” *The North American Review* 210 (July 1919): 502-504. Also see Desmond Morton, “Resisting the Pension Evil: Democracy, Bureaucracy, and Canada's Board of Pension Commissioners, 1916-33,” *Canadian Historical Review* 68, no. 2 (1987): 205-209.

²⁸ Todd, “Duty of a War Pension,” 504.

²⁹ *The Pension Act, Statutes of Canada* (1919), C.43.

declaration of peace or from the moment the individual was discharged from the military, whichever came first.³⁰

From the outset, the window of opportunity to obtain a pension was narrow, and with the exception of the travelling medical boards coordinated through the DSCR shortly after the war, the BPC expended little effort to add new names to the pension roll. Policy placed the onus squarely on veterans themselves to apply before they were no longer eligible, something the GWVA hoped to compensate for in 1921 by inaugurating a ‘clean sweep’ campaign aimed at resolving all outstanding applications and adjustments.³¹ At the same time, the BPC, led by its conservative and doctrinaire chairman, Colonel John Thompson, was seeking further revisions to the Pension Act to enhance its clarity and the board’s ability to separate legitimate from illegitimate pension claims. Thompson had been wary of Todd’s liberal approach since taking over as Chairman of the BPC in 1918. In Thompson’s assessment, to continue providing the benefit of the doubt long after the war’s conclusion would merely encourage veterans who were discharged as medically fit to unreasonably seek compensation for post-discharge disabilities that were entirely unrelated to their military service. Indeed, the original language of the Act invited potential for abuse. Though it provided the pension board with a great deal of discretion, it also left the door open for any soldier suffering from incipient disease to claim that it originated during military service.³²

³⁰ *The Pension Act, Statutes of Canada* (1919), C.43.

³¹ Royal Commission on Pensions and Re-establishment, *Report on First Part of Investigation (Matters Referred to in G.W.V.A. Telegram), February 1923* (Ottawa: King’s Printer, 1923), 122-23. Hereafter cited as *Ralston Commission I*.

³² *The Pension Act, Statutes of Canada* (1919), C.43.

Thompson and the board wasted little time, presenting representatives of the 1920 and 1921 parliamentary special committees on returned soldiers with several key amendments to the Pension Act that were adopted with little debate.³³ While veterans were scrambling to collect their final gratuity payments or piece together their outstanding applications, few noticed that the commissioners had made a significant revision to the wording of Section 11 of the Act. The paragraph in question as it appeared in the 1919 Act offered the following explanation for determining attributability:

The Commission shall award pensions to or in respect of members of the force who have suffered disability, in accordance with the rates set out in Schedule A of this Act, and in respect of members of the forces who have died, in accordance with the rates set out in Schedule B of this Act, when the disability or death in respect of which the application for pension is made, was attributable to or incurred on service.³⁴

The amendment passed in 1920, however, altered the language of the final sentence in Section 11 to the following: "...when the disability or death in respect of which the application for pension is made, *was attributable to military service*."³⁵ To further clarify the meaning of the section, in 1921 the commissioners modified the wording once more to state "attributable to military service *as such*."³⁶

For Colonel Thompson and the board the modification seemed like an innocuous and wholly sensible response to the changing role of Canada's pension law during

³³ Morton, "Resisting the Pension Evil," 213.

³⁴ *The Pension Act, Statutes of Canada* (1919), C.43.

³⁵ *BPC Report* (1921), 5.

³⁶ *BPC Report* (1922), 5.

peacetime.³⁷ With the war over, the CEF disbanded, and an anticipated decline in the number of new pension applications, the need for a clear distinction between disabilities *incurred* on service versus those *attributable* to service appeared self-evident. The spirit underpinning the Act had changed little: the board would continue to rule in favour of the applicant when sound medical evidence was present that linked a disability to service. The ‘insurance principle,’ however, was an unsustainable policy that arose out of circumstances unique to the wartime period. A more careful phrasing that placed the burden of proof squarely on the shoulders of the applicant would reward those ex-servicemen who had the documentary evidence to prove that their disability was related to or aggravated by military service, while simultaneously thwarting illegitimate claims and potential exploitation.³⁸ If the army’s physicians and pension medical officers had done their due diligence, few cases would fall between the cracks. Surely soldiers with genuine disabilities would have been identified before or shortly after their discharge. It was difficult to conceive how service conditions could continue to affect men who had left the military in a state of good health.

As veterans became aware of the alleged change in interpretation, they were infuriated. In May 1922, the secretary of the GWVA’s Dominion Command, C.G. MacNeil received an anonymous letter containing a minute from a private meeting of the pension commissioners. The minute in question, according to MacNeil, “laid down

³⁷ *Pensions, Insurance, and Re-establishment: Proceedings of the Special Committee appointed ... to Consider Questions Relating to the Pensions, Insurance and Re-establishment of Returned Soldiers, and any Amendments to the Existing Laws in Relation thereto which may be Proposed or Considered Necessary by the Committee, etc* (Ottawa: King’s Printer, 1921), 104-105. Hereafter cited as *Special Committee (1921)*.

³⁸ *Special Committee (1922)*, 126-27.

definitely and unequivocally” the board’s decision to scrap the insurance principle in favour of a more restrictive interpretation of attributability.³⁹ The Secretary was livid. His years of experience managing difficult pension cases and lobbying for the rights of veterans with post-discharge disabilities convinced him that a new pattern in the board’s decision-making had emerged. After gaining possession of the minute, MacNeil tactfully interrogated the pension board’s representatives for the remainder of the 1922 special committee in hopes of exposing them. Finally, in June 1922 during a private conference with Colonel Thompson, he revealed his trump card. Thompson was dismissive of the Secretary’s concerns, and maintained that the document was merely a crystallization of what had been the board’s practice all along. MacNeil was unconvinced and unappeased. With the report of the 1922 special committee ready to be submitted before the House of Commons, the GWVA took the matter to the public. A telegram directed at Prime Minister Mackenzie King but ultimately intended for the eyes of the Canadian press was leaked. Among its numerous complaints, the GWVA accused the pension commissioners of “contemptible and cold-blooded conspiracy” to disqualify soldiers from their pension rights. The new language of the Act, the GVWA contended, was no simple matter of legal semantics: it was a fundamental breach of the faith between veterans and the country for which they had served so valiantly.⁴⁰

The GWVA’s claim of an insidious conspiracy was sensationalized, but the telegram nevertheless shone a spotlight on how Canada’s pension law was undercutting veterans and their families. Under the revised Section 11, for example, the widow of a

³⁹ *Ralston Commission I*, 123.

⁴⁰ *Ralston Commission I*, 5.

deceased pensioner could be denied her own compensation if a clear medical link could not be established between death and service.⁴¹ Even more troubling was how the revisions affected a growing number of soldiers discharged as ‘A1’ (medically fit), but due to latent disability, carelessness on the part of military physicians, or as a result of deteriorating health, had developed symptoms long after leaving the military. These ‘missing link’ cases, including men who were exposed to poison gas or suffered undocumented illnesses in the trenches, could easily be refused because there was no recorded medical evidence connecting post-war symptoms to exposure on the battlefield, the disability was not attributable to military service “as such.”⁴²

The same was true of nervous casualties. While a veteran with a history of neurasthenia or shell shock during the war could lay claim to compensation (usually meagre) for a recurring nervous illness, there was little chance of obtaining a pension if the documentary record offered no clues on its first appearance. Sergeant Keith H., for example, received a pension in 1918 for defective hearing after an artillery shell explosion left him partially deaf. Thanks to a vocational training course Keith was able to find work and return to civilian life with relative economic security, but the scars of war continued to haunt him long after leaving the trenches. Following a routine medical examination in 1923, a DSCR physician gave the following description of the ex-Sergeant’s symptoms:

Nervous and more easily upset than normal. States this condition was noticed shortly after shell concussion in August 1917. States any physical over exertion or

⁴¹ *Ralston Commission I*, 16-17.

⁴² *Ralston Commission I*, 13-16.

mental excitement or strain causes him to become nervous and at times tremulous and emotionally unstable, and will frequently precipitate a sick headache.⁴³

According to the physician's diagnosis, Keith appeared to be suffering from "traumatic neurasthenia," which he recommended be pensioned at an additional 10 per cent on top of his existing award.⁴⁴ The BPC interpreted the case differently. Keith had no record of hospitalization for any nervous disorder during his service, and a follow-up investigation by the district pension office suggested that although he may have suffered from occasional nervous symptoms, there was no indication that they had any impact on his ability to work. In light of this information, his application for an additional award was rejected.⁴⁵

There were other restricting aspects of the Act that did little to endear it to the GWVA and its supporters. Under the terms of the 1919 legislation, for example, the widow of a pensioner whose marriage took place after the appearance of his disability was ineligible for widows' benefits.⁴⁶ As an alternative to universal widows' pensions, at the recommendation of a parliamentary special committee the Meighen government passed the Returned Soldiers Insurance Act (1920), a life insurance scheme that offered veterans between \$500.00 and \$5000.00 in coverage at premiums well below the cost of typical insurance.⁴⁷ Initially, all returned soldiers were eligible irrespective of their health, but with the time limit for most pension applications set to expire, in 1922 the BPC began

⁴³ Pension File, Keith H., VAC.

⁴⁴ Pension File, Keith H., VAC.

⁴⁵ Pension File, Keith H., VAC.

⁴⁶ *The Pension Act, Statutes of Canada* (1919), C.43.

⁴⁷ For a full overview of the benefits provided through the Act, see *Explanation of the Principal features of the Returned Soldiers' Insurance Act: Together with Forms of Policy, Options Available on Surrender of Policy, Table of Premium Rates, etc.* (Ottawa: King's Printer, 1920).

introducing more restrictive medical qualifications that blocked men in a poor state of health from purchasing a policy.⁴⁸ To veterans already disillusioned with the board's performance and supposedly parsimonious attitude towards pension claims, there was a growing sense that something deeply disconcerting was happening behind closed doors in Ottawa.

III. THE RALSTON COMMISSION, 1922-24

For the newly minted Liberal government of William Lyon Mackenzie King, the intensifying public dispute between the pension board and the GWVA presented a ripe opportunity to evaluate the efficacy of existing legislation and the ongoing challenges facing Canada's ex-servicemen. Shortly after the release of the GWVA telegram, King announced the formation of a Royal Commission on Pensions and Re-establishment, which would carry out an unprecedented national investigation of all matters of concern to Canadian veterans, including the charges put forth by the GWVA. To lead the inquiry, King selected Lieutenant-Colonel J.L. Ralston, a Nova Scotia Liberal and former commander of the 85th Battalion (Nova Scotia Highlanders).⁴⁹ Joining Ralston were Walter McKeown, a Toronto physician and former member of the Canadian Army Medical Corps, and Arthur Eduoard Dubuc, a Montréal engineer and one-time commander of Québec's vaunted 22e Battalion.

⁴⁸ *Pensions and Re-establishment: Proceedings of the Special Committee Appointed to Consider the Question of Continuing the War Bonus to Pensioners, and any Amendments to the Pension Law which may be Proposed; also to Continue the Inquiries Instituted by the Committee on Civil Re-establishment, Last Session, etc.* (Ottawa: King's Printer, 1920), 15-17.

⁴⁹ Morton and Wright, 166.

Over the next two years, the three-member commission left no stone unturned. Pensions, medical treatment, insurance, soldier settlement, ‘problem cases,’ and employment were all thoroughly surveyed. By February 1923, the commission’s report on the first part of the investigation was complete. After careful analysis of the charges laid out in GWVA’s June 1922 telegram, Ralston and his fellow commissioners could find no evidence that Colonel Thompson and the BPC had knowingly conspired to defraud veterans of their right to compensation under the Pension Act.⁵⁰ MacNeil’s evidence was flimsy, but the GWVA knew that the more important objective was to draw public attention to the broader shortcomings of the Pension Act than the alleged biases of the pension board’s leadership. After 29 sittings in Ottawa and multiple rounds of compelling testimony, the Ralston Commission had seen ample evidence to suggest that Canada’s elaborate pension legislation was doing more to exclude certain categories of veterans from fair compensation than empowering them.

With the first part of its investigation complete, the commission embarked on a highly publicized tour of the Dominion that began in Halifax on 24 January 1923. Over the following months, members travelled from Nova Scotia to British Columbia, holding nearly 40 public sittings and hearing testimony from some 150 witnesses, including veterans, widows, physicians, returned soldiers’ advocates, and government officials. Hundreds of pension claims were scrutinized in an effort to learn more about the BPC’s decision-making process. What Ralston discovered was that in spite of the board’s claim that its rulings adhered strictly to the provisions of the Pension Act and the accompanying

⁵⁰ *Ralston Commission Report I* (1923), 122-30.

Table of Incapacities, there was ample evidence to indicate that some pension rulings failed to take reasonable and fair account of the medical evidence presented. The perception amongst returned soldiers was that few—if any—cases were being considered fairly.

In addition to hearing countless complaints from veterans whose claims had been rejected, the commission also encountered many instances where a pensioner's award fell well short of his apparent degree of incapacity. Though many details of the testimony were omitted from the commission's reports, examples from the sample group offer an indication of typical cases the commission likely encountered. Private Percy M., for example, was discharged in July 1919 after undergoing lengthy treatment for a gunshot wound to the face.⁵¹ The 24-year-old private was fortunate to have survived the ordeal, the bullet having passed through his jaw, fracturing it and destroying seven bottom teeth in the process.⁵² A farmer before enlistment, Percy returned to his hometown of Picton, Ontario after the war, taking up a position as a truck driver. In spite of facial scars and limited mobility in his neck from a damaged cervical spine, the ex-private was awarded a miniscule 10 per cent pension of \$7.50 per month.⁵³ Private Donald G., a woodworker by trade, lost partial function of his hand after receiving a gunshot wound while serving overseas.⁵⁴ His original pension award was 15 per cent, but was reduced in 1922 to 10 per cent on the basis that his mobility had improved slightly since his last medical

⁵¹ Personnel File, Percy M., RG 150, Accession 1992-93/166, Box 6193 – 43, LAC.

⁵² Personnel File, Percy M., RG 150, Accession 1992-93/166, Box 6193 – 43, LAC.

⁵³ Pension File, Percy M., VAC.

⁵⁴ Personnel File, Donald G., RG 150, Accession 1992-93/166, Box 3799 – 39, LAC.

examination.⁵⁵ A more common case was Corporal Frederick R., a veteran who served for over four years in the CEF, including a lengthy tour overseas. Like thousands of Canadian soldiers, Frederick suffered from a pre-existing foot condition (in this case fallen arches), which eventually forced him to undergo treatment in hospital. Years of marching and life in the trenches took an immense toll on Frederick's feet. A medical examination showed that he had a 40 per cent disability in the open labour market, but because it predated service, the pension board only granted him an award of 20 per cent.⁵⁶

To commission members, the pension board's stringent adherence to the Pension Act raised deep concerns over the powers granted to the BPC and the adequacy of existing legislation. Thompson and his fellow commissioners had performed a difficult task since the end of the war, but Ralston knew that veterans demanded additional accountability and transparency, even if it meant proposing drastic changes to the structure of the system. After a year of investigation the commission had collected enough evidence to propose a multitude of reforms. 'Missing-link' cases and their widows were to be granted the benefit of the doubt unless definitive medical evidence proved that the disability was not incurred on or aggravated by military service.⁵⁷ Pensions that the board had discontinued or decreased on the argument that the degree of aggravation by military service was minimal, or had disappeared in its entirety, were to be fully re-examined.⁵⁸ As a proactive measure to educate ex-servicemen of their rights and

⁵⁵ Pension File, Donald G., VAC.

⁵⁶ Pension File, Frederick R., VAC.

⁵⁷ *Ralston Commission I* (1923), 129.

⁵⁸ *Ralston Commission I* (1923), 130.

clear up public confusion over the inner-workings of the pension system, a detailed handbook on veterans' benefits was also proposed.⁵⁹

For Ralston, however, the most egregious shortcoming of Canada's pension law was the lack of a formal and independent appeal process. From its inception, the BPC had enjoyed supreme authority as judge, jury and executioner. If a claimant found a ruling objectionable, he had the right to appear before a quorum of the commissioners at Ottawa within one year's time to plead his case.⁶⁰ Few seized this opportunity, and those who did faced the unenviable challenge of convincing the board's leadership that they had made a substantial error in judgement. This centralization of power made the Canadian system distinct from its counterparts in the United States and Britain, each of which relied on district-based tribunals to decide pension claims. Veterans in both nations also had access to a fair and quasi-independent appeal process at the district level, whereas in Canada the pension board remained the final authority.⁶¹ Neither approach was immediately adaptable to the Canadian situation, but each country's experience underscored the feasibility of operating a pension system that provided veterans with the right to appeal while still maintaining its authority and impartiality.

To suit the Canadian context the Commission proposed a two-tiered system. Under the new scheme each of the DSCR's nine districts would establish an independent review board comprised of three ex-servicemen—one a physician, one a lawyer, and one layman. The review boards would deal with appeals within the district and forward their

⁵⁹ Royal Commission on Pensions and Re-establishment, *First Interim Report on Second Part of Investigation* (Ottawa: King's Printer, 1923), 9. Hereafter cited as *Ralston Commission II* (1923).

⁶⁰ *The Pension Act, Statutes of Canada* (1919), C.43.

⁶¹ *Ralston Commission II* (1923), 16-22.

decisions to a “Federal Appeal Board” in Ottawa for scrutiny and final ruling. If a conflict between the review board and the federal board emerged, the federal body had final authority. To facilitate appeals, district offices of the DSCR would be responsible for assigning an official “Soldier Adviser” to help research, prepare, and present a veteran’s case, all at the government’s expense.⁶² If the true spirit of Canadian pension law was to endure, Ralston was convinced it needed to be more equitable and accommodating. In 1924 two additional reports on the second part of the investigation called for increased pensions and treatment benefits to the amputees, neurasthenia cases, and the blind.⁶³ In addition, widows who were previously denied their husband’s pension because of their marriage date were to receive the same consideration as those who had married before the appearance of the pensionable disability.⁶⁴ The only way to restore faith in the system was to repair the broken trust between the state and those citizens it had wronged.

After two years of interviews, four reports, hundreds of exhibits, and nearly 6000 pages of evidence, the commission’s work was complete. Ralston’s unprecedented investigation into the efficacy of civil re-establishment had convinced the House of Commons to support a comprehensive package of reforms. The Senate, however, was far less enthusiastic. Wary of adding significant costs to the treasury and additional bureaucracy, members of the upper chamber stripped Ralston’s reforms down to the

⁶² The appeal system was first laid out in *Ralston Commission II* (1923), 16-22, and later elaborated on in second interim report. See Royal Commission on Pensions and Re-establishment, *Second Interim Report on Second Part of Investigation* (Ottawa: King’s Printer, 1924), Hereafter cited as *Ralston Commission III* (1924).

⁶³ Royal Commission on Pensions and Re-establishment, *Final Report on Second Part of Investigation* (Ottawa: King’s Printer, 1924), 46-81. Hereafter cited as *Ralston Commission IV* (1924).

⁶⁴ *Ralston Commission III* (1924), 31.

studs. An appeal system coordinated through a single Federal Appeal Board at Ottawa and a permanent continuation of the 50 per cent pension bonus were all that the country could afford.⁶⁵ The pension board was encouraged to show greater respect for the ‘insurance principle’ underpinning the Pension Act—something they had claimed to be doing all along—but in light of the administrative bedlam certain statutory amendments would undoubtedly create, most of the proposed reforms were simply abandoned.⁶⁶

The Senate’s decision to gut the Ralston Commission’s reforms was a devastating, albeit temporary, blow to the veterans’ movement in Canada. No one knew what to expect of the new Federal Appeal Board, nor did the creation of a formal appeal process resolve the ongoing difficulties veterans faced with respect to conflicts over statutory interpretation. The future of the GWVA was also in doubt after it became mired in a scandal over the misappropriation of government money granted through the Canteen Fund and Disablement Fund.⁶⁷ With its finances in shambles and reputation tarnished, Canada’s leading populist veterans’ organization was on the verge of collapse. Amalgamation seemed the only sensible solution, and in 1925 under the banner of Earl Haig’s British Empire Service League, the GWVA was merged with rival organizations to form the Canadian Legion.⁶⁸

⁶⁵ Morton, “Resisting the Pension Evil,” 217-18.

⁶⁶ Morton, “Resisting the Pension Evil,” 217-18.

⁶⁷ See *Reports and Proceedings of the Special Committee Appointed to Inquire into the Administration of the Canteen Fund and the Disablement Fund, and the Manufacture and Sale of Paper Poppies* (Ottawa: King’s Printer, 1925).

⁶⁸ Morton and Wright, 193-201. Numerous accounts of the Legion have been written, largely from both an institutional perspective. See Clifford Bowering, *Service: The Story of the Canadian Legion, 1925-1960*. Ottawa: Legion House, 1960); Alex Cairns and A.H. Yetman, *The History of the Veteran Movement, 1916 to 1925 and of the Canadian Legion, 1926 to 1935* (Winnipeg: Manitoba Veteran, 1961); James Hale, *Branching Out: The Story of the Royal Canadian Legion* (Ottawa: Royal Canadian Legion, 1995).

IV. CONFRONTING UNEMPLOYMENT AND MATERIAL HARDSHIP IN THE 1920S

The new Legion maintained the GWVA's populist approach, but its leadership was comprised primarily of senior officers who had little firsthand experience of the material hardships that many ex-servicemen had faced since the war's end. Unemployment increased rapidly during a worldwide economic recession in 1920-21, and veterans, many of whom had little recent work experience, were often the first to be thrown out of work. The effect of the economic downturn on the disabled was especially acute, but was softened in some countries by proactive state intervention. The Germans for instance, adopted a compulsory employment scheme that required both private businesses and public agencies to maintain a certain percentage of disabled veterans (in addition to industrial disabled) on their payroll.⁶⁹ In France, any business with 10 or more employees (or agricultural enterprise with over 15) was similarly obliged to hire at least 10 per cent of their workers from the country's population of disabled ex-servicemen.⁷⁰ The British meanwhile opted for a voluntary approach, whereby businesses who hired a pre-arranged quota of disabled veterans could apply to be listed on the "King's Honour Role" and use its badge for promotional purposes.⁷¹

The scale and anticipated success of Canada's vocational training scheme led authorities to believe that a compulsory system was too costly and wholly unnecessary. As had been the case in 1915, the federal government was also unwilling to encroach on a matter of provincial jurisdiction. Veterans' employment, despite its national importance,

⁶⁹ *Ralston Commission IV* (1924), 29-30.

⁷⁰ *Ralston Commission IV* (1924), 30.

⁷¹ *Ralston Commission IV* (1924), 26-27.

was ultimately a provincial responsibility, and employment conditions varied so widely by region that no single program could remedy the emerging crisis. British Columbia, for example, had experienced an unpredicted influx of thousands of CEF veterans following the war, many of them pensioners who were physically unsuited for the rigorous demands of the province's manufacturing sector or resource extraction industries, but had nonetheless emigrated to the province in hopes of benefiting from its climate.⁷² During the 1920-21 recession statistics showed that between 50 and 70 per cent of all unemployed men in the Ontario's major industrial cities were veterans, presumably a large portion disabled.⁷³ In the Prairie Provinces, thousands of soldier settlers faced a devastating drought and an agricultural recession that saw grain prices plummet. Burdened by debt and with no means of recovering their losses, by 1923 nearly 20 per cent of Canada's 25,000 soldier settlers had abandoned their farms.⁷⁴

Federal authorities remained optimistic that the industrial and agricultural downturn would correct itself once the economy returned to full capacity. In the meantime, several short-term solutions were arrived at to alleviate the hardships faced by returned soldiers. Combat veterans were given priority for vacant civil service positions in every government department, especially the DSCR. By 1923, 20,000 of the country's 55,000 civil servants were ex-servicemen, nearly 50 per cent of them pensioners, but few of these were permanent positions.⁷⁵ The majority of veterans would have to find their way in the open labour market. To encourage the private sector to hire and keep on

⁷² *Special Committee (1928)*, 25-26.

⁷³ *Special Committee (1922)*, 219-20.

⁷⁴ Morton and Wright, 151-53.

⁷⁵ *Ralston Commission IV (1924)*, 15.

disabled veterans long-term, the DSCR instituted a policy to cover the full costs of any workmen's compensation claim filed by a veteran injured on the job, provided that his disability qualified for at least a 20 per cent pension.⁷⁶ These measures did little to alleviate the devastating unemployment situation. In 1922 alone the DSCR administered relief to 22,941 disabled veterans, two thirds of them with dependents.⁷⁷ At the height of the unemployment crisis in March 1922, over 10,000 disabled ex-servicemen were receiving assistance.⁷⁸

The Canadian economy recovered steadily throughout 1923 and 1924, but the puzzle of finding suitable occupations with sufficient pay for the war's disabled continued to frustrate veterans' authorities.⁷⁹ One of the chief recommendations of the Ralston Commission had been the creation of special rehabilitation committees in major industrial cities across the country. In addition to matching soldiers with prospective employers, these committees would arrange on-the-job training and maintenance for the disabled men, organized much in the same way as the DSCR's vocational training program.⁸⁰ To their credit, several of these voluntary committees (especially those in Toronto and Montréal) were instrumental in finding temporary or permanent employment for hundreds of veterans whose pension awards were too meagre for even short-term subsistence. Indeed, a detailed follow-up study conducted by the Toronto Rehabilitation Committee found that over a three-year period between 1925 and 1927, around half of all veterans

⁷⁶ *DSCR Report* (1922), 126-28.

⁷⁷ *DSCR Report* (1923), 46.

⁷⁸ *DSCR Report* (1924), 17.

⁷⁹ *Ralston Commission IV* (1924), 36.

⁸⁰ *Ralston Commission IV* (1924), 21-22.

registered with the committee were able to find ‘permanent work.’⁸¹ The cases they encountered, however, also pointed to a deeper problem in the machinery of civil re-establishment that could not be remedied by simply matching a disabled man with a sympathetic employer. When faced with the humiliation of accepting unemployment relief or pursuing work, irrespective of whether it was suitable for their disability, veterans most often chose work. If they broke down on the job, the pension board was not obliged to compensate them for any aggravation they experienced. If their health was faltering, aged veterans and those suffering from latent diseases were especially prone to cycles of unemployment. One disabled veteran who came before the Toronto rehabilitation committee in 1925 had been through 15 different jobs since his discharge. A further five cases interviewed had each gone through eight.⁸² Between 1925 and 1927 the Toronto committee alone handled 1784 unemployment cases. According to one report, of the 935 veterans still registered with the committee in March 1927 some 74 per cent were “serious problem cases” that had become “practically unemployable.”⁸³

When planning for the post-war period, the DSCR had failed to anticipate the number or complexity of the ‘problem cases’ throughout the veteran population. Vocational experts and department medical authorities forecasted that some categories of disabled such as epileptics, the elderly, or tubercular ex-soldiers would require sheltered employment, but the number would likely fall within the hundreds at any given time.⁸⁴

⁸¹ *DSCR Report (1927)*, 23-26.

⁸² “Placed 310 Disabled in Jobs During Year,” *Toronto Daily Star*, June 12th, 1925, 29.

⁸³ *DSCR Report (1927)*, 24-25.

⁸⁴ See for example the DSCR’s discussion of ‘incurables’ and problem cases in *DSCR Report (1919)*, 16-17.

Within a few years of the war's conclusion, however, the DSCR encountered thousands of ex-servicemen with little prospect of stable work. Private James F. was one of these men. A Toronto native and butcher by trade, James enlisted in March 1915, serving overseas for two years before losing his left leg below the knee from a shrapnel wound. After undergoing nearly a year of rehabilitation in Canada, he was discharged from the CEF in September 1918 with a 40 per cent pension. James returned to work at a packing company in Toronto, a position he held for two years until he grew dissatisfied and opted to try his hand at sausage making in a local processing plant. James excelled as a worker, but the job required him to labour long into the night and stand at a bench for the duration of each shift. His leg ached frequently, and after three months of sticking it out, he grew too frustrated to continue. He applied vocational training course through the DSCR (now granted to 'special cases' only), but was rejected on the argument that he was physically capable of continuing this position without undue hardship.⁸⁵

Several months later James was hospitalized for a suppurating stump. Upon entering Christie Street Hospital for treatment, he also began to exhibit a multitude of nervous symptoms, including auditory hallucinations, delusions, tremors, headaches, and loss of appetite. Although his physical condition improved quickly, James' wife reported that he had been acting in a "peculiar" and highly paranoid manner after he returned home from the hospital. A follow-up examination showed that his nervous symptoms persisted:

⁸⁵ Pension File, James F., VAC.

No delusions, no hallucinations, judgement appears good—cheerful to-day, although sometimes depressed. He is not insane at present but is obviously quite neurotic. Restless, rubs his hands and constantly twitches his fingers while talking. Sleep is disturbed probably by pain in his leg. Some tremor of the hands. He looks 50 years old, 15 years older than his age. Hair is gray. Appears nervous.⁸⁶

James F. personified the category of ‘problem case’ that the DSCR had struggled to guide towards civil re-establishment since the war’s end. When combined with his physical handicap, James’ nervous condition left him nearly unemployable. His pension, however, only provided compensation for his original disability: there was no clear link between his nervous symptoms and military service. In order to support his family and pay the high Toronto rental rates, a veteran like James required steady work, but the likelihood of finding remunerative employment in an environment that would not aggravate his physical disability or delicate mental state was slim. As such, DSCR physicians recommended the ex-private for a position at the Toronto Vetcraft shop.⁸⁷

Established in 1919, the Canada’s Vetcraft shops were a cooperative venture between the DSCR and the Canadian Red Cross Society that offered sheltered employment to severely disabled veterans. Based on a similar model to the ‘curative workshops’ utilized in military and convalescent hospitals during the war, these shops were initially intended to serve as a temporary refuge for ‘problem cases’ in need of extra income and additional training so that they could re-enter the open labour market. By 1924, Canada’s seven Vetcraft facilities employed nearly 350 disabled men across the country, with the largest concentration in Toronto and Montreal.⁸⁸ Among the chief

⁸⁶ Pension File, James F., VAC.

⁸⁷ Pension File, James F., VAC.

⁸⁸ Morton and Wright, 139.

products they produced were kitchen tables, washboards, juvenile furniture, as well as children's toys and playthings, all of which were made available through department stores and veterans' bazaars. The shops were also given the exclusive right to manufacture poppies, wreaths, and other memorabilia to raise money for the Poppy Fund on Armistice Day.⁸⁹

During its investigation the Ralston Commission lauded the Vetcraft model of sheltered employment as a necessary means of accommodating the rising number of aged and destitute ex-soldiers accumulating in major industrial centres.⁹⁰ In spite of its revered status, however, the harsh reality facing Vetcraft was that the market for veteran-produced goods was simply too small in Canada to make further expansion sustainable. Toys and Armistice Day memorabilia appealed largely to the patriotic sympathies of the public rather than genuine consumer demand. Neither the DSCR nor the Red Cross was willing to operate the shops at a substantial financial loss, meaning that growth, like in any business, was contingent upon revenue. At any given time the shops could only accommodate around 300 disabled men, many of them returning veterans who suffered a relapse in their disability.⁹¹ For these men, the shops increasingly became a last resort to stave off homelessness or starvation.

The ongoing unemployment problem amongst disabled ex-servicemen continued to frustrate veterans' groups and state authorities throughout the 1920s. On the eve of the Great Depression, a peak period of prosperity in inter-war Canada, more than 4000

⁸⁹ *DSCR Report (1927)*, 27.

⁹⁰ *Ralston Commission II (1924)*, 36-42.

⁹¹ *Report of the Work of the Department of Pensions and National Health* (Ottawa: King's Printer, 1929), 18. Hereafter cited as *DPNH Report*.

pensioners were still receiving departmental unemployment relief.⁹² But what of the thousands of disabled men who were able to eventually find gainful employment? Unfortunately, since neither the DSCR nor the pension board catalogued the occupations of pensioners on an annual basis, it is impossible to ascertain just how many found stable careers or what their average earnings were. Pension records provide only a partial picture, but some of the individual stories illustrate the unrelenting determination of the disabled to capitalize on the opportunities presented to them and carry on as best they could.

One such case was Sapper Ervin B. After developing chronic arthritis and sciatica while serving overseas, Ervin found himself unable to resume his pre-war occupation as a locomotive engineer. Instead, he relied on his knowledge of the railway to obtain a much lighter position as a level crossing watchman, a job he held until his retirement in 1942.⁹³ Shrapnel left Private Herbert G with permanent weakness and frequent pain in his left arm, but his years of experience in bookkeeping translated easily into a well-paying job as a merchandising manager with the Hudson's Bay Company in Vancouver. In addition to a steady paycheque, Herbert collected a 25 per cent disability pension for the remainder of his working life.⁹⁴ Private Ernest S. received a 40 per cent pension for a similar wound, earning his livelihood by driving a mail delivery truck in Hants Country, Nova Scotia.⁹⁵ Remarkably, after losing his left leg to amputation at just 19 years of age, Dorwin S. of

⁹² *DPNH Report* (1929), 18.

⁹³ Pension File, Ervin B., VAC.

⁹⁴ Pension File, Herbert G., VAC.

⁹⁵ Pension File, Ernest S., VAC.

Wellington, Ontario was able to establish himself in a life-long career as an auto mechanic.⁹⁶

As the above examples illustrate, disability was not the sole determinant of a veteran's material wellbeing once he returned to civilian life. Age, experience, education, location, tenacity, and the contingency of 'opportunity' all played a substantial part in the career trajectories of these ex-soldiers. The road to civil re-establishment and economic independence varied widely from veteran to veteran, but even those who had attained this lauded, often unrealistic ideal, faced the daunting challenge of balancing their health with the need to make ends meet. Lieutenant James C. of Crossfield, Alberta, for example, was able to return to his pre-war career as a bank clerk, but found himself laid up in hospital for two months in early 1921 suffering from excruciating leg pain caused by an old gunshot wound.⁹⁷ In early 1924, Trooper James B. of Grande Mère, Québec was left with no choice but to take a three-month leave of absence from his position as a night watchman in order to receive treatment at St. Anne's Hospital for chronic gastritis.⁹⁸ On various occasions between December 1921 and February 1923, Private Charles H. spent a total of six months in hospital suffering from the debilitating effects of nephritis and digestive troubles.⁹⁹ Private Harry H., a Manitoba postal clerk had to spend six weeks undergoing treatment in Winnipeg General Hospital after a severe attack of bronchitis.¹⁰⁰ Work in comparatively light occupations might have prevented these men from

⁹⁶ Pension File, Dorwin S., VAC.

⁹⁷ Pension File, James C., VAC.

⁹⁸ Pension File, James B., VAC.

⁹⁹ Pension File, Charles H., VAC.

¹⁰⁰ Pension File, Harry H., VAC.

significantly aggravating their disabilities, however all ex-soldiers were still subject to unpredictable fluctuations in the state of their health.

As it had done during the war, the DSCR issued treatment allowances to veterans in lieu of pension payments if a disability pensioner required hospital care. In rare circumstances, veterans admitted on compassionate grounds were also granted pay and allowances.¹⁰¹ Since these small monthly allowances were not tied to the degree of a soldier's pension or income, however, hardship often confronted men with large families and modest means. Ex-servicemen who were fortunate enough to find steady work at a fair wage, or by virtue of their disability received a full disability pension were still faced with the high cost of living in many Canadian cities. Following the 1920 amendments to the Pension Act and the institution of the 50 per cent bonus, a disabled veteran with a wife and three dependent children could receive up to \$1644.00 per year in pension payments for a 100 per cent disability.¹⁰² According to statistics from the Department of Labour, however, the average cost of living for that same family of five between 1920 and 1924 averaged \$1774.60.¹⁰³ The median disability pension held by a disabled veteran between 1921 and 1928 was 20 per cent, the equivalent of \$28.17 per month for a family of five.¹⁰⁴ Based on the Department of Labour's cost of living measurements, a veteran and his dependents would need to accumulate nearly \$120.00 per month of additional income from other sources to meet the cost of living. In the mid 1920s a full-time position

¹⁰¹ *DSCR Report* (1919), 137-47.

¹⁰² See 1920 pension rates in Appendix IV.

¹⁰³ *Proceedings (revised) of the Special Committee Appointed to Consider Questions Relating to the Pensions, Insurance and Re-establishment of Returned Soldiers* (Ottawa: King's Printer, 1924), 346. Hereafter cited as *Special Committee (1924)*.

¹⁰⁴ Derived from rates set out in Appendix IV.

(44-48 hours per week) at a competitive wage of 65 to 75 cents per hour would allow a single breadwinner to surpass this threshold, but as veterans' advocates frequently pointed out, loss of time at work from ill-health or short-term unemployment could devastate the family budget.¹⁰⁵

The state's inability to resolve the ongoing financial difficulties confronting disabled ex-servicemen exposed a deepening contradiction between the idealized narrative of civil re-establishment and the material realities of living with disablement in an able-bodied world. Wartime propaganda presented work as a conduit through which disabled men of all social standings and degrees of ability could reclaim their manliness and independence. Once firmly re-established, the same masculine virtues of discipline, loyalty, and perseverance that made them ideal citizen-soldiers would propel the disabled to a respectable life free from want or trepidation. For its part, the state mobilized an unprecedented arsenal of public resources and personnel to aid the disabled in achieving this end. However, as the list of unemployables, 'problem cases,' and un-pensioned or under-compensated disabled men grew larger, confidence in the system began to wane. Speaking before a sitting of the Ralston Commission in April 1923, Major Bert Wemp, a decorated veteran of the Royal Naval Air Service and Toronto school trustee, derided the state for failing to fulfil its wartime promises to Canada's war disabled:

May I be permitted in all due reverence to call your attention to the sacrifices made by the disabled man walking our streets to-day, and note the comparison with the great sacrificial life of our Lord and Master, of whom it was said: 'He

¹⁰⁵ For a comprehensive list of wages across Canadian industries see Department of Labour, *Wages and Hours of Labour in Canada, 1920 to 1924* (Ottawa: King's Printer, 1925). For the period covering the whole decade see Department of Labour, *Wages and Hours of Labour in Canada, 1920 to 1929* (Ottawa: King's Printer, 1930).

saved others, himself he cannot save.’ These men sacrificed all to serve king and country, and unfortunately their reward to-day is starvation, not only for themselves, but for their loved ones. In the war they saved others; to-day, they cannot save themselves. The state owes these men and their dependents every possible assistance and facility at its disposal to overcome their perplexing problems and thereby eliminating discontent and red outbursts against the government. By doing this they will also be helping towards a contented and loyal Canada.¹⁰⁶

Wemp’s use of religious symbolism was no mere coincidence. As Jonathan Vance has illustrated, the imagery of self-sacrifice and martyrdom appealed to English Canadians’ crystallizing memory of the Great War as a noble and just crusade.¹⁰⁷ Death and disability were the price Canada’s citizen-soldiers paid to preserve the benign influence of British civilization over German militarism.¹⁰⁸ In exchange for this sacrifice, the state was obliged to do its utmost to console the bereaved, assuage the grieving, and where necessary, provide for those veterans and dependents who through no fault of their own could no longer carry on due to disability. As the state began to diverge from the generosity of post-war civil-reestablishment, veterans seized on shortcomings in government policy as evidence that the war’s ideals were being abandoned. Wemp’s address followed a similar pattern to others presented before the Ralston Commission and other public forums throughout the 1920s. Veterans’ advocates highlighted compelling and disturbing cases of ex-soldiers who had slipped through the cracks of the pension system, had broken down while on the job, or had found themselves impoverished and

¹⁰⁶ “Has Biting Sarcasm for Teeth-Pulling,” *Toronto Daily Star*, April 11th, 1923, 2.

¹⁰⁷ Jonathan F. Vance, *Death So Noble: Memory, Meaning and the First World War* (Vancouver: UBC Press, 1997), 7.

¹⁰⁸ Vance, 7.

alienated from broader society.¹⁰⁹ Some died prematurely in destitute circumstances, having arrived at an early grave “by worry and not being able to provide the necessities of life.”¹¹⁰ The most desperate cases resorted to vagrancy, or worse, suicide.¹¹¹

The Canadian press often sensationalized the dire circumstances disabled men experienced and the extreme lengths they went to escape destitution. In August 1926 *Toronto Daily Star* reported the case of Private William C., an American from Massachusetts who had enlisted in the CEF in 1918 and returned with significant (but unlisted) health issues that required 22 different operations. The DSCR had refused to treat him, supposedly on the grounds that his disabilities were not attributable to service, and in a desperate attempt to end his suffering (or perhaps avoid outstanding medical bills), he attempted to take his own life by slashing his wrists with a razor blade. He survived and was subsequently prosecuted for his attempted suicide.¹¹² Some veterans were more successful, avoiding the personal—and often very public—humiliation of having to atone for their transgression. Jack L., a CEF veteran who had allegedly suffered from shell shock while serving in France, hanged himself while alone in his garden one afternoon in early July 1922. His sister discovered his lifeless body not more than an hour later.¹¹³ Between January and June 1922, at least 11 known cases of suicide were reported among Toronto ex-servicemen alone.¹¹⁴

¹⁰⁹ “Has Biting Sarcasm for Teeth-Pulling,” *Toronto Daily Star*, April 11th, 1923, 2.

¹¹⁰ “Has Biting Sarcasm for Teeth-Pulling,” *Toronto Daily Star*, April 11th, 1923, 2.

¹¹¹ “Has Biting Sarcasm for Teeth-Pulling,” *Toronto Daily Star*, April 11th, 1923, 2.

¹¹² “Suffers Many Wounds: ‘What Price Glory?’,” *Toronto Daily Star*, August 10th, 1926, 1.

¹¹³ “Shell-Shocked Veteran Hangs Himself in Garden,” *Toronto Daily Star*, July 8th, 1922, 4.

¹¹⁴ “Veterans End their Lives to Aid Family Finances,” *Toronto Daily Star*, June 25th, 1927, 2.

For many soldiers, the rationale to end one's life was cold and calculated. In one report to the *Star*, an official representing a Toronto veterans' aid organization described the case of an ex-soldier who had requested information on how his family might be cared for in the event of his death. After examining his current financial affairs, the former soldier, who was no longer capable of supporting his family because of an unnamed disability, determined that the mothers' allowance payable to his widow and children would allow them to live better off than in their current circumstances. Allegedly he committed suicide a short time later. "You talk about suicide being cowardice," the official remarked, "I can't see it—not the way these men are doing it."¹¹⁵

True to its populist style, the *Star* eagerly disseminated these stories because of their resonance with English Canada's increasing empathy towards the plight of the war disabled. The phenomenon, however, was national, and while it is impossible to determine how many veterans took their own lives following the war, or what their primary motivations were, recent evidence from John C. Weaver's study of suicide in New Zealand suggests that a confluence of physical disability, personal strife, trauma, and financial worry drove Great War veterans of that country to commit suicide at a much higher rate than their civilian counterparts. In Weaver's study, data extracted from official coroner's records shows that the disparity was especially pronounced in the sample years 1920, 1922, and 1924, when the average rate of suicide for overseas combat veterans was 40.0/100,000 (1920), 26.5/100,000 (1922) and 29.0/100,000 (1924). The corresponding rates for New Zealand males of military age who did not serve overseas (or did not serve

¹¹⁵ "Veterans End their Lives to Aid Family Finances," *Toronto Daily Star*, June 25th, 1927, 2.

at all), was markedly lower at 8.7/100,000 (1920), 11.5/100,000 (1922), and 14.0/100,000 (1924) respectively.¹¹⁶

V. VETERANS' HEALTH AND THE POLITICS OF ATTRIBUTABILITY IN THE 1920s: A BALANCE SHEET

The prevalence of suicide amongst Canadian war veterans, although unquantifiable and often sensationalized in the press, nevertheless contributed to a growing public awareness that the Great War's lingering side effects were having a profound impact on the wellbeing of ex-soldiers. In the years immediately following the war these anxieties were bolstered by the high number of deaths amongst disability pensioners compared to the civilian population. As one study conducted by the Department of Pensions and National Health (DPNH) suggested, pensioner mortality was proportionately high compared to the male civilian population during the early 1920s.¹¹⁷ Figure 2.3 in the Statistical Appendix reproduces the findings of the study, while Figure 2.4 and 2.5 offer an overview of total pensioner deaths ruled attributable to military service between 1921 and 1942. As both illustrate, deaths related to a pensionable disability steadily declined throughout the inter-war years, though the number of deaths gradually increased as pensioners aged.

If mortality and hospitalization rates amongst pensioners had more or less stabilized during the 1920s, in what other ways might we be able to measure the

¹¹⁶ John C. Weaver, *Sorrows of a Century: Interpreting Suicide in New Zealand, 1900-2000* (Montréal and Kingston: McGill-Queen's University Press), 163. For a general discussion of suicide amongst returned men see pp. 153-166.

¹¹⁷ F.S. Burke, "Death Among War Pensioners," *Canadian Medical Association Journal* 29, no. 11 (November 1939): 457-65.

collective wellbeing of Canada's Great War disabled? Changes in average pension rates (Figure 2.6, Statistical Appendix) and the proportion of increases versus decreases in rates (Figure 2.7, Statistical Appendix) both offer a way of assessing shifting patterns in compensation, and to a certain degree, the overall health of disabled veterans as an aggregate population.

The period 1921 to 1928 contains the best data for gauging the overall health of pensioners in the 1920s based on pension rates. After the pension board introduced the lump sum gratuity payment amendment for minor disabilities the total number of pensioners decreased dramatically from 69,203 in 1920 to 51,452 in 1921.¹¹⁸ For the next two years the pensioner population continued to decline at a more gradual pace, reaching a low point in 1923 with 43,263 awards in force, before rising to 50,635 in 1928 at an average increase of 1229 awards each year.¹¹⁹ Thereafter, several amendments to the Pension Act and awarding practices—especially the 1930 decision to repeal the gratuity system—obfuscate the data. During this eight-year period where Canadian pension law remained comparatively static, the mean pension award held by Canadian veterans increased from 30.0 (Class 15) in 1921 to 36.1 (Class 14) in 1928.¹²⁰ As Figure 2.6 illustrates, while the mean award held by veterans in the sample group was slightly lower than those of the entire pensioner population, pension increases followed a similar upward curve. Thereafter, legislative changes and several new pensions awarded to cases

¹¹⁸ See Table 2.3 in Statistical Appendix.

¹¹⁹ See Table 2.3 in Statistical Appendix.

¹²⁰ See Table 2.4 in Statistical Appendix.

of latent disease (including two 100 per cent pensions for tuberculosis) make the sample data incongruent with the broader pensioner population.

A unique feature of pension records is that they afford us the opportunity to compare the compensation rate determined by the pension board against the full medical extent of a veteran's disability. In other words, we can assess if a substantial gulf emerged between the class of pension a veteran was awarded or held, and the actual assessment provided by a physician. Given that thousands of Canadian veterans received pensions for aggravated pre-enlistment conditions and latent diseases, one might expect the gap between compensation and disability to widen. The sample, however, shows that for the period 1921-28 there was in fact only a minor disparity—on average 1.4 per cent—between the veteran's pension award and the assessed degree of incapacity. In part, this is explained by the pension board's general reluctance to *officially* grant awards for 'aggravation,' which were prone to extensive criticism from veterans and the public. Instead, successful applications were more commonly labelled simply as 'attributable.' The findings from the sample group also suggest that although 'problem cases' may have been prevalent, for official purposes the disparity between their pension rates and the actual state of their health was not formally acknowledged. From the pension board's perspective, this category of veteran suffered from an occupational handicap that was only partially, if at all related to his war disability, and therefore was not eligible for a substantial pension increase.

Interestingly, Figure 2.7 in the Statistical Appendix reveals that in spite of the growing public disapproval of the pension system in the 1920s, the BPC was far more

likely to increase a pensioner's award than decrease it. According to official statistics, the most significant increases occurred amongst the upper range of pension awards (Classes 1-11). In 1921, for example, only 14.9 per cent of pensions were rated above 50 per cent (Class 11). By 1928 that proportion had risen to 21.4 per cent. One of the most significant increases occurred with 100 per cent disability pensioners, of whom there were 2693 in 1921, rising to 3813 in 1928.¹²¹ The official statistics unfortunately fall short in providing data that show how substantial the increases were for the average pensioner. Here the sample group offers crucial insight into the material circumstances facing disabled ex-servicemen. Of the 41 veterans who held a pension throughout the entire period of 1 January 1921 to 31 December 1928, 15 obtained permanent increases from their 1921 award, 21 went unchanged, and five were decreased. The average increase for the 15 pensioners was 17.6 per cent. On the whole, pensioners affected by deteriorations in their health appear to have been compensated accordingly. Though compensation may not have satisfied veterans' demands, the pension board and its medical staff responded proactively to the health challenges imposed by disability.

Nevertheless, during the 1920s veterans' organizations and their allies expended immense effort and resources to lobby for improved pension rates and more flexible assessment criteria. But what frustrated veterans most was the incompleteness of existing legislation and the pension board's supposed duty to go above and beyond its defined legislative responsibilities. The Ralston Commission, parliamentary special committees, and the popular press all highlighted case after case of despondent veterans who had

¹²¹ See Table 2.4 in Statistical Appendix.

failed to convince the pension board that their disability resulted from military service. These stories fostered a widespread belief that the bureaucracy and dogmatic policies of the pension board were undermining the fundamental tenets of civil re-establishment. Veterans, as C.G. MacNeil proclaimed before a sitting of the 1924 parliamentary special committee, were simply not getting a “square deal.”¹²² There were definite grounds for such criticism. The sample group data explored in Chapter 3 illustrated that the success rate for pension applications between 1914 and 1920 was an impressive 75 per cent. Awards were relatively small, but few veterans were barred from receiving compensation if they could prove that their disability was incurred during or aggravated by military service. Following the 1920 and 1921 amendments to the Pension Act, however, veterans’ advocates were convinced that the pension board had put in place substantial obstacles that barred many veterans from receiving an award. Table 2.2 in the Statistical Appendix illustrates that although overall success rates certainly decreased, a majority of applications submitted were still granted some manner of compensation during the remainder of the decade. Faced with a complex new challenge of differentiating between obvious cases of ex-servicemen who had fallen through the cracks and those unfortunate individuals whose health suffered as a consequence of factors unrelated to their military service, pension officials again proved to be at least moderately responsive despite mounting popular resentment.

How well were these successful applicants compensated? Furthermore, did pension authorities accept their applications with reluctance and a measure of parsimony?

¹²² *Special Committee (1924)*, 350.

Official statistics again provide no clear answers, but data from the sample group presented in Tables 5.1 and 5.2 offer important revelations. Of 17 veterans in the sample who applied for their first pension between 1921-1929, eight were granted an award while nine were rejected. A total of 23 veterans (including six second-time applicants) submitted a claim and 11 received an award, an overall success rate of 47.8 per cent, well below the average indicated in Table 2.2. The median pension award rate granted was 10 per cent (Class 19), and with the exception of two 100 per cent awards for tuberculosis, all were 20 per cent (Class 17) or less. Three of the pensions were granted for gunshot/shrapnel wounds, while the remainder included conditions such as defective hearing, flat feet, chronic bronchitis, and arthritis.

TABLE 5.1 – MEAN AND MEDIAN PENSIONS AWARDED BETWEEN 1 JANUARY 1921 AND 31 DECEMBER 1929 (FIRST APPLICATION)

	DISABILITY RATING	PENSION RATING
Pension Mean	32.50%	34.38%
Pension Median	10.0%	10.0%
Standard Deviation	41.918	40.834
Total Cases	8	8

TABLE 5.2 – MEAN AND MEDIAN PENSIONS AWARDED BETWEEN 1 JANUARY 1921 AND 31 DECEMBER 1929 (ALL APPLICATIONS)

	DISABILITY RATING	PENSION RATING
Pension Mean	27.73	26.36
Pension Median	10.0%	10.0%
Standard Deviation	36.219	36.816
Total Cases	11	11

VI. CONCLUSION

The preceding discussion offers a more balanced appraisal of the pension board's performance during the 1920s than typically acknowledged by contemporaries. This statistical evidence observed with the benefit of hindsight, however, should not overshadow the importance of popular perception, the very real hardships that thousands of pensioned veterans faced on a daily basis, or the frustration and desperation experienced by ex-soldiers who were excluded from the system entirely during this turbulent decade. As this chapter has demonstrated, the 1920s presented unique challenges for veterans that the state had only partially anticipated when planning for post-war reconstruction. In spite of its extensive experience facilitating and coordinating vocational retraining, the DSCR was too underfunded and poorly equipped to respond effectively to the unemployment situation facing ex-soldiers. Veterans, both disabled and physically fit, returned home to a country on the precipice of an economic recession. When the downturn hit, thousands of recently hired ex-servicemen were thrown out of work in favour of retaining more experienced employees. With the exception of civil service appointments and a small number of positions at sheltered workshops for 'problem cases,' federal authorities deferred responsibility for solving the ongoing unemployment problem to local agencies and volunteer initiatives. Through careful coordination and additional training, local employment committees were eventually able to match some veterans with eager employers, but the number of chronic unemployment cases, especially amongst older disabled men, illustrated that a sizable portion of Canada's ex-soldier population was unsuited for a life of ordinary labour.

Pensions provided a slight measure of security for disabled veterans, but as had been the case during the war, a typical award was no replacement for a steady income. Eligibility criteria for disabled men and dependents also remained highly restrictive, a deliberate attempt by the architects and stewards of Canada's pension legislation to circumvent post-war exploitation. Modest reforms and a permanent rate increase initiated in the wake of the Ralston Commission aided the material circumstances of some pensioners, but offered little consolation for families whose pension income was already stretched thin. Having been exonerated of any wrongdoing, the BPC continued its practices. For veterans who remained outside the system, the creation of the Federal Appeal Board brought with it hope that their case might be ruled upon more favourably, but as we shall see in the next chapter, it too drew the ire of veterans for its bureaucracy and stringent requirements. Despite mounting public criticism and a litany of complex pension cases that exposed the shortcomings of existing legislation, Canada's system of veterans' benefits remained largely unchanged after 10 years. Politicians expressed reluctance to expand programs that had already proven to be far more costly than originally envisioned. Pension authorities had little choice but to adhere to the existing regulations to the best of their ability, though unsurprisingly, the pension board showed little enthusiasm for reforms that would upset its day-to-day practices or limit its supreme authority.

The onset of the Great Depression, coupled with the evolving demographics of the pensioner population, stimulated a decade-long period of reform and intense public debate over the role of the state in the lives of its former citizen soldiers. Familial

circumstances evolved rapidly throughout the decade and had a substantial affect on the federal government's fiscal and medical responsibilities. In 1921, 44.1 per cent of Canadian pensioners were married, and even fewer had dependent children. The average veteran was 31.2 years of age.¹²³ By 31 March 1928 72.9 per cent of all pensioners were married.¹²⁴ The average veteran was nearing the age of 40. Most importantly, over 180,000 Canadians were now receiving pension or survivor benefits. By 1931, that number had grown to over 230,000.¹²⁵ The state had taken on an unprecedented role in the lives of its citizens, one that required it to respond expeditiously in times of crisis to sustain its legitimacy.

The final chapter of this dissertation investigates the scope of this response, in addition to the unique challenges ex-servicemen, government authorities, and the public confronted during a period of unprecedented economic upheaval. While the 1920s was characterized by political inertia and public frustration, the decade that followed was one of rapid and often reactionary decision-making. The Depression exacerbated existing crises and also brought to light new dilemmas that stretched the limits of conventional medical knowledge, and forced politicians to fundamentally reconsider government's long-term role in the lives of disabled veterans. The 'insurance principle,' problem cases, widows' benefits, unemployment, and the growing number of prematurely aged veterans commonly labelled as 'burn out' cases all figured prominently in debates on veterans' health and the future shape of policy. For their part, politicians responded cordially,

¹²³ Calculated based on the birth dates of all veterans from the sample group.

¹²⁴ *BPC Report* (1928), 12.

¹²⁵ *BPC Report* (1928), 12; *DPNH Report* (1931): 58.

eagerly sponsoring new programs and amendments to the Pension Act that veterans' organizations conceived in the hopes of making the system more accessible and responsive to those who had fallen through the cracks of civil re-establishment.

What seemed like transformative changes on paper, however, had a much less desired effect when put into practice. The core tenets of Canadian pension law could not be altered if the system was to retain its legitimacy, and although new procedures could be introduced to add accountability and provide avenues for appeal, just as they had in the 1920s, veterans continued to face the perennial challenge of demonstrating the link between their military service and their ill health. The politics of attributability remained alive and well. At the same time, however, alternatives to pensions, including the War Veterans Allowance, marked the beginning of a renegotiation between veterans and the state on matters of entitlement. Though government authorities stopped short of extending universal benefits to all veterans, the hardships of the Depression years led to a gradual re-conceptualization of veterans' entitlement from being a privilege of military service, to an inherent right of citizenship.

Chapter 6: ‘In Forma Pauperis’: Disability, ‘Burning out,’ and the Limits of Reform, 1929-39

Following the Great War Private William B. of the 177th Battalion returned to Canada in the hopes of beginning a small produce farm north of Toronto. William, who we have met previously in this dissertation, was discharged in March 1919 after receiving a minor gunshot wound to the face and contracting a mild case of chronic bronchitis during his time with the Canadian Corps in France. Upon arrival in Canada, the Board of Pension Commissioners (BPC) ruled that William had made a good recovery but would continue to face respiratory issues if he over-exerted himself. Despite uncertainty about his own health, the ex-soldier continued to pursue his goal of establishing a farm, and after several months was granted a small plot of land through the Soldier Settlement Board. On the surface, William appeared to have all of the ingredients for a successful return to civilian life. His disabilities were comparatively minor, he had previous experience in farming, and at 21 years of age, his strength and vitality would surely continue for many years. A 20 per cent pension award would serve as an important safety net.¹

Unfortunately, the former private was never able to readjust to demands of farming life and in 1922, he was forced to sell off his farm and pursue other lines of work. William spent much of the 1920s travelling across Southern Ontario in search of stable

¹ Pension File, William B., Veterans Affairs Canada [hereafter ‘VAC’].

employment. With no transferable skills, and limited work experience, like many ex-servicemen he usually came up empty handed. On the eve of the Great Depression, William and his family of five were subsisting entirely on casual earnings and unemployment relief provided by the Department of Pensions and National Health (DPNH). Out of concern for the wellbeing of his family, in 1930 the DPNH recommended William for a vocational retraining course in electric and gas meter repair. Eager to return to work, William took to the course with enthusiasm, successfully completing it in eight months after which he found a position with a local hydro utility in Owen Sound, Ontario.²

The Depression and William's declining health, however, gradually conspired against his recent run of success. In 1931 he was admitted to Christie Street hospital with symptoms of 'nervousness,' and a year later, was treated once more for the frequent digestive pain. Neither condition was found to be attributable to military service. Indeed, upon medical examination DPNH physicians suggested that the otherwise healthy 33-year-old's infrequent attacks of pain and weakness likely resulted from the stress of trying to provide for a wife and seven children on a modest income. Unable to obtain an increase in his pension rate, William continued to work to the best of his ability but in 1937 was forced to quit because of his persisting stomach issues. For the next three years his family struggled to survive on a pension of \$25.00 per month and whatever other

² Pension File, William B., VAC.

means they could scrounge together. It was not until outbreak of the Second World War that he was able to find employment again.³

William B.'s case typifies the common challenges faced by Canada's Great War disabled during the Great Depression. Like tens of thousands of veterans who sacrificed their health in the line of duty, William returned to Canada in search of a new beginning and a life of prosperity. The reality of civil re-establishment, however, increasingly fell short of expectations. As Chapter 5 illustrated, throughout the 1920s a growing number of outliers, unemployables, and chronically ill veterans began to challenge the notion that Canada had successfully restored the majority of its war disabled to a state of self-sufficiency. When the Depression hit, the plight of these veterans was thrust into the public spotlight as thousands came forward seeking assistance from the state. War disability took on new meaning as a political and rhetorical tool that could explain the connections between military service and prevailing veterans' issues such as unemployment, premature aging, and mortality. Politicians reacted with a mix of haste and reluctance, ushering in a series of new reforms and programs intended to placate the powerful veterans' lobby and ease popular anxieties about the treatment of the disabled and their families. Throughout the decade these patterns of unrest and reform were replayed on several occasions as the Legion and its allies mounted sustained pressure on the federal government to offer aid to ex-soldiers who remained excluded by Canada's pension legislation.⁴

³ Pension File, William B., VAC.

⁴ Desmond Morton, "Resisting the Pension Evil: Bureaucracy, Democracy, and Canada's Board of Pension Commissioners, 1916-1933," *Canadian Historical Review* 68, no. 2 (1987): 199-224; Desmond

The reform push at the outset of the 1930s began with high expectation but ultimately garnered underwhelming results for veterans. Critical amendments to the Pension Act and the introduction of new programs like the War Veterans Allowance (WVA) granted an unprecedented number of disabled and aging ex-servicemen theoretical access to financial assistance. Improved accessibility, however, did not necessarily equate to enhanced elasticity or efficiency. The rapid expansion of the veterans' benefit system quickly overwhelmed existing infrastructure, pushing authorities to rescind or redefine eligibility criteria and dismantle layers of bureaucracy in a reactionary fashion. Believing that the liberal principles of wartime pensioning had been restored, ex-soldiers responded with disappointment and frustration as their claims continued to be rejected by pension officials. Seemingly little had changed.⁵

The challenges of the Depression years, however, are too complex to reduce to a narrative in which ex-servicemen waged a relentless campaign against a parsimonious pension system. It must be remembered that politicians and veterans' organizations were the key stakeholders in creating and revising legislation. Elected officials responded earnestly to the demands articulated by the veterans' lobby, but did so on the basis that entitlements would only go to individuals whose material circumstances and wartime experiences justified state assistance. Veterans' benefits, as Lara Campbell reminds us, were envisioned as a contract between state and citizen, not a set of inalienable universal

Morton and Glenn Wright, *Winning the Second Battle: Canadian Veterans and the Return to Civilian Life, 1915-1930* (Toronto: University of Toronto Press, 1987), especially chapters 8 and 10.

⁵ For a full administrative account of the legislative changes of the 1930s, see *Minutes of Proceedings and Evidence of the Special Committee on the Pension Act and War Veterans' Allowance Act* (Ottawa, King's Printer, 1941), Appendix A. Hereafter cited as *Special Committee (1941)*.

rights.⁶ Wholesale revisions to pension legislation and other programs were not only fiscally impracticable, it is also clear that parliamentarians were unwilling to initiate reforms that could undermine civil re-establishment's broader objective of returning soldiers to a state of self-sufficiency.⁷ The leadership of the veterans' movement understood limits of state affluence, but like their American counterparts who infamously marched on Washington in 1932, they sought to leverage as much as possible from the state during a time of crisis. Whereas many American veterans resorted to radicalism, however, Canadian ex-servicemen's protestations continued to be directed squarely at pension authorities and elected representatives whose leadership was necessary to effect change.⁸

War disabilities were certainly common within the returned soldier population, but as this chapter will illustrate, post-war lifestyle, socio-economic status, aging, and the hardships imposed by the Depression all worked in concert to affect the trajectory of a veteran's wellbeing, as well as their eligibility for entitlements. War service, no matter how convenient a culprit, could not always explain why some ex-soldiers thrived and others 'burnt out' or broke down under the strain of civilian life. Demographic changes, for example, had a substantial impact on a veteran's employability, while certain

⁶ Lara Campbell, "'We who have wallowed in the mud of Flanders': First World War Veterans, Unemployment, and the Development of Social Welfare in Canada," *Journal of the Canadian Historical Association* 11, no. 1 (2000): 126-28; also see Peter Neary, "'Without the Stigma of Pauperism': Canadian Veterans in the 1930s," *British Journal of Canadian Studies* 22, no. 1 (2009): 31-62.

⁷ Morton and Wright, 202.

⁸ Lucy Barber, *Marching on Washington: The Forging of an American Political Tradition* (Berkeley: University of California Press, 2002), 75-107. For a revisionist history of American veterans' politics in the 1930s and 1940s, see Stephen R. Ortiz, *Beyond the Bonus March and GI Bill: How Veteran Politics Shaped the New Deal Era* (New York: New York University Press, 2010).

occupations made veterans more susceptible to respiratory illnesses or chronic diseases. Most Canadian studies of social welfare only give cursory attention to how these proximate factors influenced the health of ex-servicemen during the inter-war years, or the ways in which their experiences contributed to ongoing development of Canadian social policy.⁹ Those Canadian and international studies which have touched upon the ‘burn out’ phenomenon or the exigencies of the Depression have also tended to uncritically hone in these interrelated forces in an effort to explain veterans’ disenchantment with post-war life or to underscore the terrible legacy the war left behind.¹⁰

This chapter seeks to strike a more balanced interpretation of the Depression years by illuminating the effects of policy changes while also exploring the diverse experiences veterans encountered. As the evidence suggests, programs that have either been ignored or dismissed as failures by historians were an essential social safety net for disabled ex-servicemen.¹¹ Deteriorating health remained a potent issue within veterans’ politics, but

⁹ Major studies include James Struthers, *No Fault of their Own: Unemployment and the Canadian Welfare State 1914-1941* (Toronto: University of Toronto Press, 1983); Michael Gauvreau and Nancy Christie, *A Full-Orbed Christianity: The Protestant Churches and Social Welfare in Canada, 1900-1940* (Montréal and Kingston: McGill-Queen’s University Press, 1996); Nancy Christie, *Engendering the State: Family, Work, and Welfare in Canada* (Toronto: University of Toronto Press, 2000); Shirley Tillotson, *Contributing Citizens: Modern Charitable Fundraising and the Making of the Welfare State* (Vancouver: UBC Press, 2008).

¹⁰ Morton and Wright, chapter 10; Marina Larsson, *Shattered Anzacs: Living with the Scars of War* (Sydney: University of New South Wales Press, 2008), chapter 7; Lara Campbell, *Respectable Citizens: Gender, Family, and Unemployment in Ontario’s Great Depression* (Toronto: University of Toronto Press, 2009); especially chapter 5; Peter Neary, *On to Civvy Street: Canada’s Rehabilitation Program for Veterans of the Second World War* (Montréal and Kingston: McGill-Queen’s University Press, 2011), chapter 2.

¹¹ On the failure of veterans’ policies after the Great War see Morton and Wright, 222-25; Introduction to Peter Neary and J.L. Granatstein, eds., *The Veterans Charter and Post-World War II Canada* (Montréal and Kingston: McGill Queen’s University Press, 1998); Alvin Finkel, *Social Policy and Practice in Canada* (Waterloo: Wilfrid Laurier University Press, 2005).

the degree to which latent disabilities were a consequence of military service remained highly contestable. As many examples indicate, war service was not always a compelling explanation for poor health, though it often served as a politically expedient explanation. That many Canadians and veterans firmly believed the Great War had negatively impacted them should not be dismissed as a fabrication of post-war memory, but should instead be recognized as symptomatic of a broader evolution of disability's post-war meaning. What also becomes clear from the forthcoming discussion is that Canadian ex-servicemen continued to support the state as the primary means of achieving their objectives. Indeed, in spite of widespread discontent during the Depression years, like their British counterparts Canadian veterans served as powerful but largely benign source of political stability, mobilizing popular sentiment and their social status to press for improvements to benefits and legislation.¹²

II. STIRRING THE POT: THE 1928 SPECIAL COMMITTEE AND THE FEDERAL APPEAL BOARD

Reform plodded along an uncertain path in the aftermath of the Ralston Commission's final report. Partisan turmoil in the House of Commons between 1924-27 kept veterans' issues off the legislative agenda almost entirely. With the Legion still in a period of reorganization, little sustained pressure could be placed on parliamentarians to pick up where Ralston had left off. Though the amendments to the Pension Act spearheaded by the commission brought additional accountability to the pension system through the introduction of an appeal body, a number of longstanding problems facing

¹² Deborah Cohen, *The War Come Home: Disabled Veterans in Britain and Germany, 1914-1939* (Berkeley: University of California Press, 2001), 189-90.

disabled veterans remained. In a period of unprecedented economic prosperity, one in ten pensioners subsisted on departmental relief while thousands of ‘problem cases’ remained jobless.¹³ ‘Missing link’ veterans and un-pensioned widows continued to wage a steep uphill battle against the obstinate practices of the pension board. Stories of these marginalized veterans and kinfolk, rather than the propagandized heroism and fortitude of the blind or maimed, captivated the public’s attention and prompted a renewed effort to salvage Canada’s once-promising civil re-establishment scheme.

In 1927 widespread rumours of political manipulation and infighting within the DSCR compelled the Mackenzie King government to establish a Royal Commission to investigate the management and organization of the department. Led by failed Liberal parliamentary candidate Colonel A.T. Hunter, the commission rapidly descended into a Tory witch-hunt, offering few constructive solutions on how to halt the expanding bureaucracy and resolve the administrative inertia that had plagued the department in recent years.¹⁴ A more penetrating and even-handed investigation initiated by the Department of Finance confirmed what most politicians and veteran clientele already knew: the DSCR was over-staffed, over-organized, and plagued by conflict between medical officers and senior administrators.¹⁵ The committee’s solution was sweeping and uncompromising. The DSCR and its staff were to be merged with the Department of

¹³ *Report of the Work of the Department of Pensions and National Health* (Ottawa: King’s Printer, 1930), 7. Hereafter cited as *DPNH Report*.

¹⁴ Morton and Wright, 203. Also see *Report of the Royal Commission Appointed to Investigate Charges of Political Partisanship in the Department of Soldiers’ Civil Re-establishment* (Ottawa: King’s Printer, 1927).

¹⁵ Morton and Wright, 203. Also see *Report of G.W. Scott on investigation of Department of Soldiers’ Civil Re-establishment* (Ottawa: King’s Printer, 1928).

Health. Promising a savings of almost \$100,000 in administrative costs (a roughly 7 per cent decrease over existing expenditures), and a guarantee that the same level of services would be available to veterans, the report stirred little opposition.¹⁶ An order-in-council was pieced together, and on 12 December 1927, the new Department of Pensions and National Health was formally established. Dr. John H. King retained his post as minister, while former assistant-deputy minister Ernest Scammell was demoted to secretary in favour of J.W. McKee of the Soldier Settlement Board. Dr. Ross Millar, a Great War veteran and frontline surgeon with the army medical corps, succeeded Colonel W.C. Arnold as Director of Medical Services.¹⁷

With a new leadership in place, expectations were high that the amalgamated department could serve ex-soldiers with courtesy and efficiency while simultaneously reducing long-term costs to the federal government. A dedicated Pensions Division absorbed the majority of the former DSCR's responsibilities, but in doing so, it also inherited the unsavoury reputation of the pension laws it was charged with administering. With veterans suffering from recurring illnesses submitting pension applications at a rate not seen since the end of the war, the King government could ill-afford to delay an inquiry into the state of Canada's re-establishment policies any longer. In the spring of 1928, a ninth parliamentary special committee on pensions and returned soldiers' problems was summoned, the first in nearly four years. Charles Gavin 'Chubby' Power, a

¹⁶ *Report of the Work of the Department of Soldiers' Civil Re-establishment* (Ottawa: King's Printer, 1927), 8-9. Administrative expenditures for the DSCR totalled 1,447,127 during the previous fiscal year. When including pensions and other payments, the DSCR was had annual expenditures of nearly \$50 million by the time the DPNH was created.

¹⁷ *DPNH Report* (1928), 4.

highly respected veteran and winner of the Military Cross, served as chair. As with the Ralston Commission that came before it, no stone was to be left unturned: pensions, insurance, soldier settlement, medical treatment, and importantly, the recently established appeal system were all deserved scrutiny.

To no one's surprise pensions dominated the committee's agenda. Veterans continued to lobby for an authentic reinstatement of the insurance principle that would shift the burden of proof remained on the BPC rather than the applicant.¹⁸ Of equal importance was the growing number of widows barred from receiving a pension because their marriage took place after the appearance of their deceased husband's disability.¹⁹ One of the most egregious cases presented before the committee was that of Private Benjamin Ross Swenerton, a blind veteran who had lost his sight after receiving shrapnel wounds to the face and head in 1917. While still in England Swenerton attended St. Dunstan's before returning to work as an aftercare specialist at the Canadian National Institute for the Blind (CNIB) office in Toronto.²⁰ By all accounts, the ex-private was in good health and had made a full recovery, but in early July 1924 Swenerton died suddenly after a short illness. An autopsy revealed that he had succumbed to a malignant cerebral abscess related to his head injury in 1917.²¹ Swenerton married while he was still

¹⁸ "Who Has Kept Faith With Veterans? Not Tory Government or Its Senate," *Toronto Daily Star*, August 12th, 1926, 4.

¹⁹ *Pensions and Returned Soldiers' Problems: Reports, Proceedings and Evidence of the Special Committee on Pensions and Returned Soldiers' Problems, Comprising Proposed Amendments to the Pension Act, Returned Soldiers' Insurance Act, Land Settlement Act, Employment and Care of Problem Cases* (Ottawa: King's Printer, 1928), 181-82. Hereafter cited as *Special Committee (1928)*.

²⁰ Serge Durflinger, *Veterans With a Vision: Canada's War Blinded in Peace and War* (Vancouver: UBC Press, 2010), 74.

²¹ *Special Committee (1928)*, 183. Also see "Ross Swenerton Dead, Was Worked for Blind," *Toronto Daily Star*, July 10th, 1924, 3.

undergoing treatment at St. Dunstan's, but because the union took place after the appearance of his brain injury—even though it had yet to be identified—the BPC denied his widow a pension. At no point did either the veteran or his wife have reason to believe that the shrapnel wound had resulted in significant and life-threatening damage. Unable to make ends meet, and with no possibility of future pension support, Swenerton's widow was forced to sell the family's Toronto home and return to England with her young daughter.²²

To committee members the Swenerton case laid bare the callousness of the pension board and its stringent adherence to the Pension Act, as well as the political risk of perpetuating a regulation that did far more to alienate veterans than protect the public purse from exploitation. The 1928 committee's final report proposed amendments to these and dozens of other inflexible features of Canada's pension scheme. Widows would now receive pensions irrespective of the date of their marriage or the date of application. Further benefits were also added for the dependent children or parents of deceased pensioners. A special tribunal would review 'compassionate pensions' for especially meritorious cases.²³ Applicants able to provide new evidence in support of their pension claim also earned the right to a second appearance before the Federal Appeal Board. For the first time in four years, legislators and veterans' advocates had produced tangible results for the disabled and their kin.

But the 1928 committee had only just begun to uncover the widespread disorder and recurring injustices ex-servicemen experienced at the hands of the pension

²² *Special Committee (1928)*, 183.

²³ *DPNH Report (1929)*, 44-52.

bureaucracy. During the proceedings the Legion's representative, J.R. Bowler, argued vigorously for an end to the lump-sum gratuity system. Seasoned committee members readily pointed out that the GWVA had originally lobbied for the gratuities against the advice of the 1920 special committee in the first place.²⁴ Concern surrounding the effectiveness and efficiency of the Federal Appeal Board also figured in the deliberations. Testimony revealed that from its inception the FAB had clashed with the pension board. The FAB's chair, Colonel C.W. Belton, was a known critic of the BPC's Colonel Thompson, and the antagonistic relationship between the two often led to particularly difficult cases being forwarded to the Department of Justice, a practice that only added to the misery of a veteran stuck in the appeal process.²⁵ Statutory limitations on the FAB's power created further problems. The appeal board could not dispute the details of the BPC's original medical assessment, nor was it permitted to hear new evidence from veterans. In effect, the board's sole purpose was to uphold or reverse the decision of the pension board using the same body of evidence.²⁶ Only two basic questions were relevant. First, was the disability attributable to, or aggravated by military service? And second, if no apparent disability was present at discharge, could the appellant demonstrate continuity between an incident or symptoms reported in his service records and the condition that developed following the war? Two cases from the sample group illustrate just how difficult it was for veterans to provide compelling answers to these questions.

²⁴ *Special Committee (1928)*, 54-56.

²⁵ Morton and Wright, 205. Also see *Special Committee (1928)*, 303-15. Belton was the senior medical advisor to the BPC until he was ousted in late 1921.

²⁶ *Special Committee (1941)*, Appendix A.

Private Joseph D., a painter from Montréal, served overseas with the French Canadian 22e Battalion before falling victim to a shrapnel wound in the fall of 1918. After returning to England for treatment Joseph made a full recovery and was discharged from the CEF with a clean bill of health. Several years after his discharge, however, he developed an acute kidney infection (later diagnosed as nephritis), as well as pyorrhoea and valvular disease of the heart. According to the testimony of co-workers and friends, Joseph—who was still in his early 30s—suffered regularly from spells of weakness and excruciating back pain. Eventually, his sickness grew so frequent that his employer was forced to let him go. Joseph immediately applied for a pension, but the BPC could find no evidence in his service records to substantiate his claim. The young man's condition was unfortunate, but there was no medical paper trail connecting his ailments with service overseas.²⁷ He appealed the decision, but the FAB confirmed the BPC's original ruling. In spite of his poor health, a 'missing link' existed between Joseph's present disability and wartime experiences. In the absence of documented medical evidence, neither the FAB or BPC was willing to grant the benefit of the doubt.²⁸

Thomas L.'s encounter with the FAB presents a more complex account of the challenges many veterans faced when trying to prove the relationship between war service and their disability. After three and a half years of overseas service with the Canadian Corps, in March of 1919 Thomas returned to Vancouver where he resumed his pre-war occupation as a fire fighter. In the years that followed Thomas showed no

²⁷ Personnel File, Joseph D., RG 150, Accession 1992-93/166, Box 2421 – 8, Library and Archives Canada [hereafter 'LAC'].

²⁸ Pension File, Joseph D., VAC.

appreciable signs of disability and carried on his duties as normal, but in 1926 he fell severely ill with a cough and high fever. To his family's shock, an x-ray showed that the 33-year-old veteran had an acute case of pulmonary tuberculosis.²⁹

During his military service Thomas remained fairly healthy, having been hospitalized once for a minor gunshot wound to the buttocks and on a separate occasion for inflammation in his knee. However, on the morning of 7 March 1918 his company faced a heavy bombardment from German artillery, which included mustard gas shells. Dozens of casualties were evacuated from the trenches, but many who had been exposed remained to hold the line and were never recorded ill. With the battalion's regular medical officer on leave, an inexperienced replacement had failed to take full account of the casualties and left several men undocumented after the fighting subsided. Thomas was one of them.³⁰

Gassing cases were always difficult to prove, but the veteran was fortunate to have a number of sworn affidavits from comrades who stayed with him after the exposure took place. In spite of this evidence the BPC ruled against his claim. Indignant over the decision, Thomas, who was now undergoing treatment at a private sanatorium, penned a letter chastising the pension board for its seemingly reprehensible decision. "Now that I have knowledge of the insidiousness of this plague," he wrote, "I have no hesitation in stating that my present condition is due to the effects of gas, and aggravated by continued service and not receiving treatment when I was withdrawn from the line, and no doubt

²⁹ Pension File, Thomas L., VAC.

³⁰ Pension File, Thomas L., VAC.

had I been give a proper thorough examination by a chest specialist on being discharged from the army, my lungs would have been found affected.”³¹ He went on:

I cannot over emphasize my very serious predicament having my wife and five little children to support, which, should I not receive just consideration, will spell ruin and disaster to my home and destitution to my family, and will necessitate their whole and sole reliance upon public charitable organizations.

Here, to-day, I find myself a civilian—a charitable patient in a public institution—Tranquille Sanatorium—unable to raise a hand to help my family or meet my obligations, and having been recently informed of the pathetic news that my oldest son has active pulmonary tuberculosis and the others have been reacted to the tuberculosis test, which indicated the presence of, or susceptibility to, T.B.

Gentlemen—I ask you—do you think it possible for one in my condition and circumstances to regain health and maintain a peaceful contented mind (which is said to be most essential to the cure of this disease) when I have the troubles and trials as briefly stated, which is no fault of my own.³²

In his own mind, Thomas had more than done his bit for his country. He was an experienced combat veteran who had returned to a productive occupation and fulfilled his masculine role as breadwinner. The alleged neglect he had experienced on the Western Front and, more recently, at the hands of the pension board was a miscarriage of justice, inconsistent with the spirit of civil re-establishment. By granting him the benefit of the doubt and recognizing his “very just and legitimate claim to compensation,” the BPC had the opportunity to rectify its mistakes and prevent him and his family from becoming a public burden.³³

Thomas had the good fortune of clear oral and written testimony highlighting the battlefield conditions that may have precipitated the onset of his symptoms. He was equally fortunate to have an indefatigable soldiers’ adviser working on his behalf, Ian

³¹ Pension File, Thomas L., VAC.

³² Pension File, Thomas L., VAC.

³³ Pension File, Thomas L., VAC.

Alistair Mackenzie, who used his influence in the Liberal Party to bring the veteran's case straight to the Minister of Soldiers' Civil Re-establishment. Both were crucial if the case was to be successful. By his own admission, Thomas' family had a history of TB, and the hazards inherent to his occupation cast doubt on whether poison gas was the primary factor that led to the infection. In 1927 a renewed claim was submitted to the BPC, but the ruling was again upheld. Almost two years after his first application, Thomas' case was finally brought before a quorum of the FAB in Kamloops, British Columbia. Devastatingly, the appeal board upheld the pension commissioners' ruling.

Unshaken, Thomas continued his fight for a pension, collecting a statement from a private physician who treated him in 1920 for a respiratory condition in addition to further affidavits from former comrades that confirmed he had been gassed but not hospitalized. The commissioners, through compulsion or concern that the case could soon spiral into a public relations nightmare, accepted the evidence and reversed their own decision. Thomas' experience was unfortunate, but as an impartial body both the BPC and FAB were bound to the statutory limits of the Pension Act. In the absence of sufficient evidence, they could not grant the benefit of the doubt. After more than two years of lengthy proceedings and dozens of statements from friends, family, comrades and co-workers, Thomas was finally awarded a 100 per cent disability pension.³⁴ His case was a rare exception.

When the Ralston Commission introduced the Federal Appeal Board in 1923, its supporters envisioned an appeal system that would serve as an effective counterbalance to

³⁴ Pension File, Thomas L., VAC. One of the documents submitted to the pension board was a petition signed by 173 members of the Firemen's Benefit Association.

the BPC. More importantly, it also gave veterans the unique opportunity to present their case in person. However, in spite of the uneasy relationship between the two adjudicating bodies, the FAB was normally unable to find fault with the pension board's rulings. Oral testimony, no matter how dynamic or enlightening, would only be considered if it aligned with the documentary record forwarded by the pension commissioners.³⁵ Complex cases like Thomas L.'s might warrant substantial attention, but most veterans and Soldiers' Advisers had less than an hour to present their appeal. Only a portion of cases ever reached that point. Of the 20,973 appeals received by the FAB up to 31 March 1930, fewer than 50 per cent resulted in a final decision, and over 3000 cases remained unprocessed.³⁶ Misinformation and incompetence on the part of Soldiers' Advisors plagued the board. Some 4000 applications were thrown out because they fell outside of the FAB's jurisdiction, including countless instances where a veteran who was already receiving a pension wished to contest his level of compensation.³⁷ Hundreds more experienced lengthy delays as appeal board members struggled to keep pace with the increasing workload. In seven years of operation, the FAB was able to reach a final verdict on 9857 appeals. Only 1557 were allowed, a success rate of 15.8 per cent.³⁸

³⁵ *Special Committee (1928)*, 355-56. Until the mid 1920s the BPC also forwarded their own précis of a veteran's case to the FAB, but later discontinued this practice in the belief that the appeal board was overturning some pension rulings because of the presence of inaccurate or misinterpreted information in the précis. See *Special Committee (1928)*, 331-42.

³⁶ *DPNH Report (1930)*, 57-59. Among the cases were 567 second appeals (following revisions to the Pension Act made in 1927) and 456 applications under the 'meritorious clause' laid out in Section 21 of the Pension Act. In the final six months of its operation (1 April 1930 to 30 September 1930), the board handled an additional 2080 appeals.

³⁷ *DPNH Report (1930)*, 59.

³⁸ Total of successful appeals is derived from tables found within the annual reports of the Board of Pensions Commissioners, 1924-1928, and Department of Pensions and National Health, 1929-1930.

The results were disappointing but hardly surprising. From its inception limited resources and insufficient personnel hampered the FAB, and the quality of legal support for appellants was inconsistent at best. A more fundamental problem lay in the limitations of the Pension Act. While veterans could chide both bodies for their obstinacy, the fact remained that each was responsible for upholding a standard consistent with the legislation they were charged with administering. Existing regulations left cases like Thomas L.'s only a slim possibility of success if conclusive medical evidence was not present, something parliamentarians and government officials grew increasingly aware of as a surge of latent disability cases came forward in search of compensation. Indeed, from 1 April 1928 to 31 March 1930, the BPC handled over 23,000 pension claims, nearly the same amount as the previous eight years combined. Only 1 in 5 received an award.³⁹ Rising unemployment certainly played a part in the increase, but what most applicants shared in common was a conviction that military service had sapped their youth and vitality. What perplexed pension officials most was how to retain the legitimacy of the system while upholding the core tenets of the Pension Act. Veterans, no matter how compelling their case might be, still had to demonstrate attributability.

III. 'BURN OUTS' AND BROKEN MEN: ESTABLISHING THE WAR VETERANS ALLOWANCE

Emboldened by its expanding membership and its successes arising out of the 1928 special committee, the Legion set its sights on a new round of reforms when parliament resumed at the beginning of 1930. Mackenzie King obliged, announcing that a

³⁹ See Table 2.2 in Statistical Appendix.

new parliamentary special committee on pensions and returned soldiers problems would convene in March. Pensions would be a major part of the conversation, but special attention was needed to address the unique challenges facing a growing number of veterans physically unfit for employment.⁴⁰ Commonly referred to in the popular lexicon as ‘burn outs,’ these ex-soldiers exhibited diverse symptoms and conditions, from respiratory and digestive troubles to unexplained pains, fatigue, or ‘bad nerves.’ What was most striking about these cases is that many appeared to be 10 or more years older than their actual age despite having returned from service overseas in a fine state of health.⁴¹ Psychological trauma undoubtedly left an indelible mark on some veterans, but as Mark Humphries has illustrated, government physicians were often able to deny pension claims to veterans suffering from mental illness on the grounds of predisposition.⁴² Somatic conditions were a whole other matter. Veterans’ authorities were well aware of the imprecision of military medicine, the rushed nature of final medical exams, and the terrible conditions most frontline soldiers endured. It was possible that some veterans’ health issues were entirely of post-war origin. Others, however, may have simply gone undetected. The state had yet to account for all of the war’s victims, and as time passed it became increasingly more difficult to discern where a particular disability originated and whether the war was to blame. These facts posed a critical

⁴⁰ “Onus is on Public to Secure Remedy for Veterans’ Ills,” *The Globe*, December 3rd, 1929, 13.

⁴¹ Marina Larsson’s study of Anzac veterans presents a useful photographic comparison of several veterans who appeared to age at an accelerated rate. See Larsson, 210.

⁴² Mark Humphries, “War’s Long Shadow: Masculinity, Medicine, and the Gendered Politics of Trauma, 1914–1939,” *Canadian Historical Review* 91, no. 3 (2010): 503-31.

challenge to the practicalities of Canadian pension law and the medical principles underpinning it.

Crucially, at this moment of doubt and conflict the Legion had the support of a Canadian war hero on its side: Sir Arthur Currie. Following his victory in a bitter libel suit against Garnett Hughes and the Port Hope *Evening Examiner*, the former commander of the Canadian Corps was elected as the new Dominion President of the Canadian Legion. Shortly after his appointment a stroke forced Currie to relinquish his post to the younger and more capable Léo Richer LaFlèche, however Currie remained committed to the Legion's mandate, taking on an honorary role as 'grand president.' The general had sometimes been a polarizing figure amongst the veteran population, but he was adored and respected by both the Canadian public and elected officials. Having experienced the Great War with his own eyes, Currie could also attest to the horrors and strains of life at the front, a fact that enabled him to speak on matters of veterans' welfare with an incontrovertible degree of sincerity and authority. His address to the November 1929 Legion convention in Regina, penned from his sick bed in Montréal and read on his behalf, is notable for its frank assessment of the war's legacy on the soldiers who experienced it firsthand:

That word disability brings forcibly to my mind one of the greatest difficulties. Men are now suffering greatly from disabilities which pensions authorities refuse to admit arose from war service. That is a contention on their part which, I think, is made too often. To me a Medical Board takes a great deal upon itself when it declares that war service contributed in no way to present disability. I contend that almost every man who experienced the hardships of war is paying some penalty. His resistance powers have been impoverished, and many of the breakdowns coming comparatively early in life are surely attributable to war service. As years go on these breakdowns will become more numerous, and no Pensions Board or

Medical Board will be free from the charge of callous indifference unless they are sympathetically regarded.⁴³

Currie's address was part political theatre, part cathartic autobiography. Despite his numerous accomplishments on the battlefield, military service had taken a toll on the general's health. Throughout his pre-war life Currie had struggled with chronic digestive issues that only grew worse during his time overseas. The 1928 libel suit and the stroke that followed dealt a blow from which he never fully recovered.⁴⁴ Broken but not defeated, a weathered Currie was welcomed as the opening witness before the 1930 special committee, an opportunity he used to lambaste the pension board and shore up support for the Legion's proposed allowance program for broken down and indigent ex-servicemen.⁴⁵ It would be one of his last major appearances on behalf of Canadian veterans. His death in December 1933 at the age of 57 came as a shock to the nation, but it also validated what Canadians already knew about their country's most famous veteran: Currie was himself a 'burn out' case.

Currie's testimony made an immediate impact, yet it was the stories of ordinary soldiers who had fallen into destitution because of previously unrecognized disabilities that impressed upon the committee members the urgency of the crisis at hand. Most would never be able to obtain a pension due to insufficient medical evidence, but if the state expected to retain its legitimacy amongst the veteran population, some manner of

⁴³ "The Currie Challenge," *The Globe*, November 28th, 1929, 4.

⁴⁴ Mark Humphries, *The Selected Papers of Sir Arthur Currie: Diaries, Letters, and Report to the Ministry, 1917-1933* (Waterloo: LCMSDS Press, 2008), 30-31.

⁴⁵ *Pensions and Returned Soldiers' Problems: Reports, Proceedings and Evidence of the Special Committee on Pensions and Returned Soldiers' Problems, Comprising Amendments to the Pension Act, Soldiers' Insurance Act, Land Settlement Act, the Establishment of a Pension Tribunal and a Pension Appeal Court for War Veterans, also Evidence Respecting Bill 19, An Act to Provide for War Veterans' Allowance* (Ottawa: King's Printer), 1-9. Hereafter cited as *Special Committee (1930)*.

action was required. The Legion's idea of a small monthly allowance based on the recently introduced Old Age Pension presented a unique solution.

Formally dubbed the War Veterans Allowance, the new program came into effect on 1 September 1930. It offered means-tested allowances of \$20.00 and \$40.00 per month for single and married veterans in financial need. Walter S. Woods, a prominent member of the now defunct GWVA and, most recently, director of the embattled Soldier Settlement Board (SSB), was appointed Chairman of the WVA's Ottawa headquarters.⁴⁶ Supporting Woods were three additional members, a secretary, and a dedicated medical adviser. In a gesture of good faith, the committee granted the Legion's General Secretary, J.R. Bowler, an exclusive advisory position to relay veterans' concerns on matters of policy and the functioning of the program. The day-to-day administration of the Act and handling of initial applications would be carried out by the DPNH's social service and medical branches, or in certain rural areas, the Soldier Settlement Board.⁴⁷

The WVA was a seminal development in Canadian veterans' policy, but was not without limitations. Indeed, the program incorporated several key stipulations designed to exclude as many 'unworthy' applicants as possible and guard against exploitation. Initially, only two categories of veteran could qualify: those who had reached the age of sixty (WVA1), or who could demonstrate conclusively that they were medically incapable of working because of premature aging or disability (WVA2). A veteran was only entitled if he had served "in a theatre of actual war" or was in receipt of a pension.

⁴⁶ Jeff Keshen, *Saints, Sinners, and Soldiers: Canada's Second World War* (Vancouver: UBC Press, 2004), 258-59.

⁴⁷ *DPNH Report* (1930), 45-46

He also had to demonstrate chronic financial need; temporary unemployment was not sufficient.⁴⁸ If successful, a WVA award-holder's earnings from all sources were capped at \$365.00 for a single man or \$630.00 for a married man, about 60 per cent less than a full disability pension, and well below the amount required to meet the average cost of living.⁴⁹ Surplus income would be deducted from the allowance.

To determine eligibility for the allowance, WVA officials conducted a thorough investigation of the personal, financial, and occupational history of each applicant. During the first part of the application process a veteran was normally interviewed in his home where a social service representative or department investigator made detailed inquiries into his current domestic situation, past and current employment, military service, and health. A complete financial profile was also completed, including an assessment of all sources of income, liabilities, insurance, savings, or other assets. If a veteran claimed that he unable to work as the result of premature aging or infirmity, a mandatory medical examination was arranged to ascertain the nature and extent of his disabilities. In certain cases neighbours or acquaintances were consulted to vouch for the moral character of the veteran, confirming details about his (and his family's) history, personal habits, and reputation within the community. Successful applicants were not restricted in the use of their allowance, but annual home visits in the same fashion described above were obligatory in order for the allowance to be continued. Award-holders—including widows—suspected of moral impropriety, fraud, or who had earned excessive income,

⁴⁸ Awards were also restricted to CEF veterans who resided in Canada or Imperial veterans were both currently residing in Canada and had done so prior to the outbreak of the war. For the full provisions of the Act, see *The War Veterans Allowance Act, Statutes of Canada* (1930).

⁴⁹ *Special Committee (1930)*, 166.

could have their allowance suspended indefinitely or cancelled without the opportunity for appeal.⁵⁰

The WVA allowed the state to intervene in the private lives of Canadian veterans and their families to a degree many were unaccustomed to, but it was by no means unprecedented. For more than a decade pensioners had shouldered a growing number of routine responsibilities necessary to satisfy the expanding administrative bureaucracy of the pension system. Annual medical examinations, interviews with departmental social workers, and frequent paperwork were all obligatory in order to satiate officials wary of potential malingering or fraud. The extent of government involvement varied drastically on a case-by-case basis. What was significant about the WVA program was that it formalized, standardized, and institutionalized the state's right to intervene in the private lives of veterans for as long as they continued to draw benefits. Importantly, the Act also served to normalize and legitimize popular—and only partially accurate—assumptions about the health of veterans, as well as their masculinity. Indeed, as Lara Campbell has noted, popular discourse surrounding the WVA laid bare the noticeable contradictions between the heroic masculinity of the youthful citizen soldier and the “fractured manhood” of the weathered veteran.⁵¹ By privileging the experience of the combat veteran and his propensity to ‘burn out,’ the Legion and its allies were configuring a potent narrative of the war's legacy that both legitimized its campaign for reform, and also reified the experiences and sentiments of many ex-soldiers. As we shall see later in

⁵⁰ All of this information has been gleaned from a careful examination of standardized forms filled out in veterans' pension records from the sample group.

⁵¹ Campbell, *Respectable Citizens*, 164.

this chapter, throughout the 1930s veterans and their kin embraced this narrative to assert their entitlement to benefits, even if it meant complying with the WVA's intrusive practices.

IV. TWO STEPS FORWARD AND ONE STEP BACK: PENSION REFORM IN THE 1930s

The WVA was a first step towards alleviating the hardships faced by veterans who fell outside existing pension legislation. But what of the tens of thousands who were ineligible for the new scheme? In its first year, only 3049 applicants qualified for the WVA, and only a portion of award holders were able to satisfy departmental means tests year after year.⁵² A pension, whatever the size and however difficult to obtain, offered a more reliable and dignified source of support. It was an ideal that was becoming increasingly difficult to attain. Neither the pension board nor the appeal board was willing to bend statutory limitations placed on pensions. In almost all cases, veterans still had to submit conclusive proof that their condition was connected with military service, a practice that only strengthened critics' conviction that the BPC was far more interested in its role as "guardian of the public treasure" than as a caretaker of disabled men and bereaved families.⁵³ Veterans had compelling reasons to approach the pension board with mistrust or even disdain, but as the brief history of the Federal Appeal Board had demonstrated, the true culprit was the Pension Act and its strict requirements for determining 'attributability.'

⁵² *DPNH Report* (1931), 9.

⁵³ *Special Committee* (1930), viii.

By the time of the 1930 special committee, veterans' frustrations had reached a boiling point. With rising unemployment and the 'burn out' crisis serving as a backdrop, the Legion presented parliamentarians with an unprecedented list of reforms targeting every layer of the pension system.⁵⁴ Veterans would simply no longer tolerate the "relentless legalism" practiced by the commissioners.⁵⁵ Improved accessibility, increased transparency, a more robust appeal process, and a meaningful reassertion the Pension Act's foundational principles were presumably the only way the state could undo a decade of perceived indifference. Every veteran, no matter his circumstances, deserved to have "his day in court."⁵⁶

The dilemmas faced by the BPC were more complicated than its critics were willing to acknowledge. Throughout the 1920s pension authorities struggled to balance minor adjustments to pension regulations while maintaining the impartiality of the system. Wholesale revisions or 'activist' rulings that went beyond existing statute could set a dangerous precedent and throw the entire process into disarray. With medical knowledge still in remarkable state of uncertainty, and a list of mounting complaints from veterans, what was needed most was leadership from parliamentarians. How, for instance, could the pension board realistically determine the degree to which a latent case of bronchitis or heart disease was related to conditions overseas? Did veterans who 'broke down' due to physical exhaustion or mental frailty years after the war ended deserve a pension? What of old injuries that were aggravated by a life of hard labour? Should

⁵⁴ *Special Committee (1930)*, 95-96. For full recommendations of the committee see pp. viii-xix.

⁵⁵ Morton, "Resisting the Pension Evil," 219.

⁵⁶ *Special Committee (1930)*, ix.

gratuities be abandoned in order to offer fairer treatment to veterans with minor disabilities? Pension authorities could—and often did—offer recommendations on these crucial questions of policy, but it was ultimately parliamentarians and veterans' advocates that served as the primary negotiators.

With a summer election fast approaching, the King government could ill-afford to ignore the Legion's demands any longer. Three months of unflattering testimony and intense public scrutiny resulted in the most substantial revisions to Canada's pension law since the end of the war. The Federal Appeal Board was scrapped and replaced by a new, two-tiered appeal procedure. A Pension Tribunal consisting of nine members would henceforth serve as the first avenue of appeal against a BPC ruling, offering veterans the opportunity to present their case in-person or through a representative to a travelling quorum.⁵⁷ Both the appellant and the BPC had the right to contest the Pension Tribunal's decision to a final judicial authority in Ottawa, the Pension Appeal Court (PAC). In an important departure from past policy, either body could revise the rate of a pension award if they found it inconsistent with the ex-soldier's degree of incapacity. Veterans also gained the right to introduce new evidence at any stage of their claim, a move officials hoped would substantially reduce the number of repeat appeals.⁵⁸ The ad-hoc system of Official Soldiers' Advisers was also abandoned. Support for pension applications would now come from a dedicated Veterans Bureau, administered by the DPNH and staffed by

⁵⁷ *DPNH Report* (1931), 7-9.

⁵⁸ *Special Committee* (1930), xiv-xvii.

expertly trained pension advocates. A commission counsel appointed to each case would provide legal advice in support of the pension board's initial ruling.⁵⁹

In addition to these new administrative bodies, the Legion's reforms resulted in critical revisions to some of the most notorious sections of the Pension Act. Time limits were removed on all applications, allowing soldiers and widows who had previously been barred from submitting a claim to finally present their case. The lump-sum gratuities introduced in the 1920 amendments were repealed, a move that would greatly hinder the pension board's ability to manage an accumulating backlog of claims.⁶⁰ As many as 23,000 veterans had accepted a final payment in lieu of a pension over the preceding decade, and although not all would seek reinstatement, any veterans who did come forward would require a full medical re-examination, possible hospital treatment, and most importantly, a full re-evaluation by the commissioners.⁶¹ Significantly, the 1930 amendments also introduced a new clause to the Pension Act, which expressly stated that all applicants were to be granted the 'benefit of the doubt' upon application:

Notwithstanding anything in this Act, on any Application for pension the applicant shall be entitled to the benefit of the doubt, which shall mean that it is shall not be necessary for him to adduce conclusive proof of his right to pension applied for, but the body adjudicating on the claim shall be entitled to draw and shall draw from all the circumstances of the case, the evidence adduced and medical opinions, all reasonable inferences in favour of the applicant.⁶²

The floodgates were now open. Thousands of ex-servicemen who were previously rejected by the pension board, had been barred by statutory restrictions, or sought to have

⁵⁹ *DPNH Report* (1931), 7-9.

⁶⁰ *DPNH Report* (1931), 49-50.

⁶¹ See *Report of the Work of the Board of Pension Commissioners for Canada* (1921), 11, and (1922), 17. In subsequent years only a few hundred veterans accepted these gratuities.

⁶² *DPNH Report* (1930), 10-11.

their commuted pension reinstated, rushed to submit claims. Pension authorities encountered a diverse assemblage of cases, some of which had slipped through the cracks. Lance-Corporal George C. re-applied for a pension in early 1931, claiming to have suffered from the continuing effects of rheumatism and valvular disease of the heart since leaving the army. George's service records showed that he had been hospitalized three times while overseas: once for a fractured right leg, once for myalgia, and once for VDH. However, at the time of his discharge a medical board ruled that neither the leg injury nor the two illnesses were a permanent source of disability.⁶³ He made his first application for a pension shortly thereafter but was denied an award. After returning to his pre-enlistment career as a farmer in Northern Alberta his condition worsened. For the next 10 years George struggled with frequent bouts of exhaustion, shortness of breath, and debilitating pain in his leg before submitting a new application after the 1930 amendments took effect. A medical examination confirmed that the veteran's complaints were legitimate. George's disability was rated at 40 per cent, however, the pension board ruled that both conditions pre-dated enlistment, and as a consequence, his pension was reduced to 18 per cent for 'two-fifths' aggravation. Three years later George was considered 'fully disabled' with a 100 per cent disability, but his pension only amounted to 40 per cent.⁶⁴

The statutory time limit on applications in place before the 1930 amendments meant that hundreds of veterans who had been discharged during the war period with single-payment awards were unable to apply for reinstatement, even if their disability had

⁶³ Personnel File, George C., RG 150, Accession 1992-93/166, Box 1700 – 41, LAC.

⁶⁴ Pension File, George C., VAC.

worsened. Private Ellis H., for example, was first granted a pension in December 1917 after contracting a severe case of rheumatic fever while serving overseas. His disability was initially assessed at 40 per cent but improved quickly after returning to Canada. In June 1918 he was granted a final gratuity payment of \$100.00 and went on to establish a farm as a soldier settler. At 46 years of age, Ellis' best years were behind him. Nevertheless, he continued to work hard, erecting a house and barn, planting fruit trees, and raising livestock with a good deal of initial success. But the strain of Ellis' war service soon caught up with him, and in 1923 he suffered a nervous breakdown from which he never fully recovered. When examined by a pension physician Ellis appeared tremulous, anxious, was perspiring freely, and seemed "emotionally unstable."⁶⁵ According to the final medical assessment the veteran was suffering from a clear case of neurasthenia accompanied by "a large element of anxiety neurosis."⁶⁶ The pension board ruled in favour of Ellis' application, granting him a 20 per cent pension that was later increased to 30 per cent after doctors discovered he was coping with a degenerative heart condition.⁶⁷

The common factor affecting the success of the two cases presented above was that each veteran had been able to demonstrate continuity between their post-discharge disability and conditions experienced while on active service. Although Ellis H. was officially diagnosed with a different disability, the symptoms he exhibited mirrored several which were contained in his service records, and furthermore, could also be

⁶⁵ Pension File, Ellis H., VAC.

⁶⁶ Pension File, Ellis H., VAC.

⁶⁷ Pension File, Ellis H., VAC.

reasonably linked to his bout of rheumatic fever in 1916.⁶⁸ Despite the introduction of the new ‘benefit of the doubt’ clause, pension records suggest that most applicants were still obliged to demonstrate a clear linkage between military service and the onset of symptoms. Private Arthur D., for example, was denied a pension for bronchitis after authorities could find no clear link between his chest troubles and an alleged incident of exposure to poison gas.⁶⁹ Private James E. applied to have his commuted pension reinstated, but was rejected after the pension board ruled that the weakness he was experiencing in his arm was due to a fracture the ex-soldier had suffered several years prior to his enlistment.⁷⁰ A particularly tragic case was that of Private Vincent A., a former POW who was denied a pension for pulmonary and abdominal tuberculosis in August 1932. Although the BPC had encountered countless cases of POWs who had returned in poor health, the delayed onset of Vincent’s symptoms convinced physicians that the disease was of post-discharge origin. He died one month later at the age of 40, leaving behind a devastated wife who continued to lobby for compensation. Her claim was similarly denied.⁷¹

As the Depression worsened, many veterans rightfully suspected that their pension applications were being rejected due to subjective factors such as their financial circumstances or moral virtue. Private Percy F., a Saskatchewan postmaster who had failed as a soldier settler, first submitted his application for a disability pension in February 1931. During the war Percy had been hospitalized on several occasions for

⁶⁸ Personnel File, Ellis H., RG 150, Accession 1992-93/166, Box 3964 – 5, LAC.

⁶⁹ Pension File, Arthur D., VAC.

⁷⁰ Pension File, James E., VAC.

⁷¹ Pension File, Vincent A., VAC.

gunshot and shrapnel wounds. A medical examination revealed that he was “neurotic” and suffering from an obvious case of neurasthenia, a disorder that Percy and numerous witnesses claimed to have originated on the battlefield. The BPC initially struck down the veteran’s application, but the Pension Tribunal ruled in his favour. Using its own right of appeal, the BPC challenged the Tribunal’s decision. A three-year counter-appeal ensued involving multiple witnesses and detailed evidence from the SSB on Percy’s performance as a farmer. The settlement board’s account painted the veteran as too “easy going” in his work habits, while those advocating on his behalf suggested that Percy had suffered extensively from the effects of frontline service. Medical evidence was scrutinized thoroughly by all three levels of the pension system, until finally, in March of 1934, the Pension Appeal Court ruled in favour of the BPC, citing insufficient evidence in Percy’s claim to justify an award.⁷²

The experiences of Percy F. and Ellis H. illustrate how the legal infrastructure introduced by the 1930 amendments affected the expediency of the pension system, and furthermore, cast doubt on the allegedly scientific principles upon which Canadian pension policy had been founded. Both cases involved veterans who had experienced combat on the Western Front, both were hospitalized on multiple occasions for debilitating illnesses and injuries, and each veteran had only partial evidence to confirm that their conditions continued to affect them after leaving the army. Nevertheless, each outcome was very different—one veteran was expeditiously awarded a modest but

⁷² Pension File, Percy F., VAC.

comparatively fair pension, while the other languished within the appeal process only to be rejected.

Contrary to the hopes of the Legion, the 1930 amendments only added further to the bureaucracy of the pension system. The reforms seem to have been doomed from the start. The Pension Appeal Court only began operations in 1931, resulting in a six-month delay in appeals from the outset of the amendments. The Veterans Bureau had also unscrupulously forwarded thousands of applications of dubious merit on to the Pension Tribunal at the insistence of veterans.⁷³ One BPC report suggested that upwards of 93 per cent of all outstanding claims clogging the system were from repeat applicants, including existing pensioners seeking further compensation for pensioned and un-pensioned disabilities. According to the estimation of pension officials, fewer than 25 per cent of these claims—by 1933 numbering some 16,000—had any chance of receiving a favourable ruling.⁷⁴

A veteran could hardly be blamed for seeking compensation on the one hand, while on the other, it was the state's responsibility to scrutinize all claims in a thorough and systematic fashion. This meant providing adequate machinery to facilitate that process.⁷⁵ As veterans soon discovered, every level of the pension system was unprepared to weather the storm unleashed by the confluence of economic depression and legislative reform. From 1 April 1930 to 31 March 1933, the pension board and its appeal bodies

⁷³ Morton and Wright, 212.

⁷⁴ *Report of the Committee Appointed to Investigate into the Administration of the Pension Act* (Ottawa: King's Printer, 1933), 21-23. Hereafter cited as *Special Committee Report (1933)*.

⁷⁵ Morton, "Resisting the Pension Evil," 221-22.

handled more than 46,000 new or appealed disability pension claims.⁷⁶ Over that same three-year period pension authorities reinstated 17,109 awards, the majority of which belonged to veterans who had accepted a final gratuity under the 1920 amendments.⁷⁷ Nearly 21,000 disabled veterans were added to the disability pension list, which now approached 78,000.⁷⁸ When dependents and widows are included, the number of Canadians receiving benefits through the provisions of the Pension Act had grown to a staggering 265,000.⁷⁹ For every veteran or widow whose pension was awarded or reinstated, countless others were rejected. Indeed, success rates for pension applications plummeted from an average of 58.6 per cent for the period 1 April 1920 to 31 March 1928 to only 27.1 per cent for the period 1 April 1929 to 31 March 1933. Between 1 April 1930 and 31 March 1933 alone—one of the worst periods of unemployment during the Great Depression—the pension board handled 18,121 applications, but refused 16,209, a rejection rate of nearly 90 per cent.⁸⁰

Canada had reached a critical juncture in its unfolding relationship with the Great War's disabled. Less than two years after the 1930 amendments, veterans' organizations and pension authorities were forced to return to the drawing board. A new special committee, this time consisting of five veterans' representatives and six senior-ranking pension officials was formed with the express purpose of investigating the administration of the Pension Act and finding a means to remedy the sluggish performance of the three-

⁷⁶ See Table 2.2 in Statistical Appendix.

⁷⁷ See Table 2.2 in Statistical Appendix.

⁷⁸ See Table 2.3 in Statistical Appendix.

⁷⁹ *DPNH Report* (1933), 51.

⁸⁰ *DPNH Report* (1933), 45-46.

tiered system. Between August 1932 and February 1933 the committee produced four conflicting reports, including a final version laced with partisan finger-pointing and harsh criticisms towards the short-sightedness of the 1930 special committee. Everyone—veterans included—shared some of the blame for the present fiasco, but the report, undoubtedly influenced by the BPC's Colonel Thompson, took particular aim at the Pension Tribunal for its supposedly antagonistic attitude towards the pension commissioners. Despite the good intentions of the Legion's reforms, the two-tiered appeal procedure had failed miserably, resulting in a "multiplication of work absolutely unnecessary to obtain the ends of justice or the aims of the Pension Act."⁸¹

The committee's solution was a partial reversal of the 1930 legislation, but the objectives remained much the same. The goal of reform had always been to make the pension system more responsive to legitimate claims, while also granting pension authorities the power to filter out questionable cases as efficiently as possible. Despite the best intentions of the 1930 committee, the Pension Tribunal had proven to be a major barrier to achieving this end. Accordingly, the 1933 amendments scrapped the tribunal altogether, leaving the Pension Appeal Court as the primary authority to which a veteran would appeal. To save face, politicians reorganized the remaining personnel of the tribunal and the BPC into a new agency dubbed the Canadian Pension Commission (CPC). Although liberated from the namesake of its much-maligned predecessor, the CPC was ostensibly old wine in new bottles. Colonel Thompson maintained his position as Chairman, and only one of commission's eight members was incorporated from the

⁸¹ *Special Committee Report (1933)*, 8.

Pension Tribunal.⁸² In practice, the CPC picked up where the tribunal left off, travelling across the country in quorums to hear new claims in convenient locations.

Even so, there were some profound differences between the two models that proved of supreme value to pension authorities. The removal of an entire layer of administration and the addition of statutory limitations on applications allowed the commission to perform its duties more swiftly and with a greater degree of finality. The Veterans Bureau would now serve as the primary facilitator for all applications, blocking repeat claims with no new evidence while simultaneously prioritizing compelling cases for hearing before the commission. After a thorough assessment of all outstanding claims, the bureau was also able to remove nearly 7000 inactive disability claims. Within 18 months of the amendments, the commission—now increased to 12 members—and Veterans Bureau had successfully processed 20,000 outstanding claims and virtually eliminated the backlog of applications.⁸³ Improved efficiency, however, was no guarantee an increased chance of winning an award, nor was that the intention. On the contrary, veterans quickly discovered that the new commission's interpretation of the Pension Act and its willingness to grant applicants the 'benefit of the doubt' differed little from the BPC. The Act from the outset had been designed to limit long-term access to state benefits, and while reform offered the promise of gradual liberalization, only a small portion of applicants had sufficient medical evidence to link their disabilities to military service. In the years that followed the 1933 amendments, over 85 per cent of all disability

⁸² *DPNH Report* (1934), 11-14.

⁸³ *DPNH Report* (1934), 13.

pension claims were rejected. The ‘insurance principle’ was simply incompatible with the medical and administrative realities of the post-war period.⁸⁴

V. FROM SERVICE TO SURVIVAL: CANADIAN VETERANS AND THE GREAT DEPRESSION

Pensioned or un-pensioned, Canada’s Great War veterans, like most Canadians, had to be resourceful to make ends meet during the Depression years. While the decade immediately following the war exposed the limitations of the Pension Act, it was the economic disarray of the 1930s that ultimately revealed how inadequate its provisions were for the average disability pensioner. In a system that was predicated on the belief that the vast majority of beneficiaries would find work, a monthly award of \$5.00 or even \$10.00 would be welcomed as a measure of reassurance during periods of temporary financial hardship. Over time veterans’ pensions would increase as their health deteriorated, but under normal economic circumstances most would remain at least partially employable. Canada’s pension rates were already the most generous in the world, and there was little political will to increase them. Indeed, in 1930 the median pension award held by Canadian veterans was 20 per cent.⁸⁵ With a value of \$15.00 per month for an unmarried ex-private, even if a veteran were unemployed he would still be receiving more assistance than most ordinary civilians on public relief.

Could ex-servicemen be expected to survive on such meagre assistance if they fell into a state of chronic unemployment? The experience of ‘problem cases’ in 1920s suggested ‘no,’ a fact that had bolstered the Legion’s case for the creation of the War

⁸⁴ *Special Committee (1941)*, 35.

⁸⁵ Calculated from annual pension statistics. See Table 2.4 in Statistical Appendix.

Veterans Allowance program. When the Depression hit, disability pensioners could turn to departmental relief from the DPNH to supplement their pensions, but their conditions and, increasingly, their advancing age precluded most from finding any form of remunerative work. Non-pensioners had no choice but to turn to other sources. Charity provided through organizations such as the Red Cross and the Poppy Fund offered temporary, piecemeal support, but was usually insufficient to pay bills and debts. Municipal relief and public works projects presented a humiliating last resort that many veterans were reticent to pursue.

Unemployment amongst the veteran population swelled rapidly into a national crisis during the 1930s, but individual experiences varied widely. Alexander A., a 20 per cent disability pensioner from Portage la Prairie, Manitoba, lost his job as a caretaker in 1933, spending the next seven years unemployed. Subsisting on a pension of \$23.00 per month and any other sources of income they could scrape together, Alexander, his wife and two children still managed to keep a roof over their heads, living out of the second floor of a dilapidated house at a cost of \$14.00 per month.⁸⁶ Benjamin H. was more fortunate than many other disability pensioners, receiving a substantial retroactive payment of nearly \$800.00 in 1929 for a ventral hernia that had gone unnoticed at the time of his discharge. On top of this one-time payment, Benjamin collected a 15 per cent pension totalling \$17.25 per month, an amount that was hardly sufficient to support his young wife and daughter. Unable to work and hospitalized frequently, his pension was increased in 1932 to \$28.75 per month, a material improvement that offered the family

⁸⁶ Pension File, Alexander A., VAC.

additional security.⁸⁷ After losing his job at a local hydro utility, Edward P. found temporary shelter at an acquaintance's farm where he completed chores in exchange for a room and meals. Tragically, the 54-year-old ex-private mysteriously drowned in the early morning hours of July 1st, 1933, after taking a small boat out on to the Grand River near Dunnville, Ontario. Authorities ruled the drowning an accident, but could offer no explanation as to why the veteran had taken the boat out on the water at such an early hour without the owners' knowledge.⁸⁸

For every story of hardship or tragedy, however, there were manifold examples of resourcefulness and perseverance. Despite suffering from painful arthritis, Private Henry B. was able to keep his small shoe-repair shop afloat throughout the worst years of the Depression, supplementing his income with a small 10 per cent pension.⁸⁹ Although Corporal Alfred C. was hospitalized for nearly three months during the winter of 1936-37, he was able to keep his position as a streetcar conductor in Toronto, earning a modest 10 per cent disability pension for recurring pain and weakness in his left leg.⁹⁰ In 1934 Private Percy M., who had been severely wounded in the face and neck while serving overseas, abandoned his farming ambitions and became a minister at a Methodist Church in rural Central Ontario, a role he would continue for the remainder of his working life.⁹¹

⁸⁷ Pension File, Benjamin H., VAC.

⁸⁸ Pension File, Edward P., VAC.

⁸⁹ Pension File, Henry B., VAC.

⁹⁰ Pension File, Alfred C., VAC.

⁹¹ Pension File, Percy M., VAC.

At the peak of the unemployment crisis over 14,000 disability pensioners were receiving relief from the DPNH.⁹² Though exact figures were impossible to come by, surveys conducted by the Legion suggested that many as 50,000 un-pensioned veterans living in Canada were unemployed, many of them chronic cases who had been out of work for years.⁹³ By passing the WVA Act the federal government had enshrined its responsibility to provide long-term income support to a particular category of economically vulnerable veterans who fell outside of the pension system, but a universal unemployment relief scheme was an entirely different matter. In the absence of disability, joblessness and poverty were considered ‘personal failures.’ The state owed veterans only what their war service had demonstrably taken away. Those who had returned to civilian life in good health and had fallen on hard times as a result of the same economic forces affecting civilians could not be treated as a more deserving class of citizen without undermining the structure and ideology of post-war civil re-establishment. Ottawa’s “rigid and conservative approach” to social welfare held just as true for veterans as it did for civilians.⁹⁴ Through persistent pressure the Legion was able to solicit some minor concessions, such as free hospital treatment and the establishment of a Veterans Assistance Commission that would help unemployed ex-servicemen find new career opportunities.⁹⁵ But until the introduction of Unemployment Insurance in 1940, most veterans were forced to make do with whatever assistance they could cobble together.

⁹² *DPNH Report* (1934), 11.

⁹³ Neary, “Without the Stigma of Pauperism,” 40-41.

⁹⁴ Neary, “Without the Stigma of Pauperism,” 54.

⁹⁵ A summary of the Veterans’ Assistance Commission’s activities during its 18 months of operation is given in *DPNH Report* (1938), 89-93.

VI. UNDER THE STATE'S WATCHFUL EYE: THE WAR VETERANS ALLOWANCE IN THE 1930s

For federal authorities the more fiscally appealing and politically expedient solution to addressing veterans' discontent was to enhance its existing programs, specifically the War Veterans Allowance. As predicted, ex-servicemen responded to the WVA Act with enthusiasm—or perhaps desperation—submitting nearly 10,000 applications within the first 18 months of its introduction. Between 1 April 1931 and 31 March 1938, WVA officials handled a further 25,000 applications from veterans of all walks of life, including officers, nursing sisters, chronic unemployment cases, and even some ex-soldiers who had reached their 80s.⁹⁶ The vast majority of allowance recipients, however, were combat veterans who were now in their late 50s or early 60s and unable to find meaningful employment.

Private James J. offers a typical example of a veteran who was no longer able to carry on due to advancing age. A farmer his whole life, James enlisted in the CEF in February 1917, serving overseas as an ambulance driver in the CAMC. At 43 years of age and suffering from kyphosis, the private was hardly an ideal candidate for frontline service, but with recruitment drying up on the home front his physical condition was probably easily ignored. Although he was only a driver, James was still subjected routinely to the dangers, and indeed, the horrors of the battlefield. In 1918 he was hospitalized after a bomb explosion left shrapnel in his back and right shoulder.⁹⁷ The wound healed, but following the war he was treated on several occasions for symptoms of

⁹⁶ See Table 2.6 in Statistical Appendix.

⁹⁷ Personnel File, James J., RG 150, Accession 1992-93/166, Box 4942 – 53, LAC.

neurasthenia and insomnia. Neither the gunshot wound nor the nervous condition resulted in a disability pension. In 1920 James returned to rural Saskatchewan where he purchased a 320-acre farm using a loan from the Soldier Settlement Board. The farm was successful at first, but as James' health declined so too did his productivity. Unable to carry on, in 1930 he leased the property in hope of using the income to pay off outstanding debts. To care for his own needs he opened a small barbershop in a nearby town.⁹⁸

Like many soldier settlers in the prairies, the Depression hit James hard. The devastating drought of 1933 and the failure of the wheat crop led to a mass exodus of local settlers. The value of his farm plummeted. By 1936 he was nearly \$7000.00 in debt, living out of a boarding house, and scraping by on only a few dollars a month. He had barely enough to keep his barbershop afloat and was on the verge of living on the streets. A hardworking combat veteran who was now 61 years of age, James' experience represented the model example of an ex-soldier who had earned the right of state assistance. Indeed, the WVA investigator sent to interview James offered an overwhelmingly positive and sympathetic appraisal of the veteran's James situation in his final report to officials in Ottawa:

Veteran is a very nice old gentleman. Small in stature, with a heart condition. Perfectly white hair, extremely quiet in speech, gait, and movement. Round shouldered, and anything but strong looking. Good intellect, a man with good ideals, and moderate in living. He is decidedly out of the labour market, and any prospective employer would be very courteous, and say, Sorry Dad, we cannot do anything for you, you know, you shouldn't [sic] be working at your age. When speaking he has a habit of using just small sentences, as though short of breath. I should imagine that his breathing was quite shallow. Very neat, clean and tidy in dress, and habits.⁹⁹

⁹⁸ Pension File, James J., VAC.

⁹⁹ Pension File, James J., VAC.

The investigation revealed that James J. was a veteran who, though no fault of his own, had succumbed to the disastrous convergence of economic hardship and failing health. Irrespective of his unpaid debts, time and again James had demonstrated an entrepreneurial spirit, a commitment to frugality, and sound moral character. With no hope of recovering the losses from his farm (which was now valued at only \$3200.00), and a heart condition preventing him from working steadily, the WVA board accepted his application for an allowance.¹⁰⁰

Between 1930 and 1936 cases like James' accounted for the majority of WVA awards, and while over 11,000 applications had been successful, a startling number had also been rejected, usually because applicants misinterpreted or disregarded the strict eligibility criteria or because WVA investigations raised significant doubts on the merit of the case.¹⁰¹ One of these rejected applicants was Private Austin J., an overage soldier who applied for his first WVA award in 1935 at the age of 68. In his initial correspondence with a representative of the WVA board, Austin claimed to have been out of work for seven years, but an audit of his personal finances revealed that he had until only recently earned a weekly commission of \$5.00 to \$13.00 as a tire salesman. More importantly, Austin had never served in a theatre of actual war, having remained exclusively in England after medical officers discovered he was unfit for frontline duty.¹⁰² Private Clyde A. similarly had his application rejected when the WVA committee learned that his army service was confined to England. Over the previous 12 months the 50-year-old widower

¹⁰⁰ Pension File, James J., VAC.

¹⁰¹ See Table 2.6 in Statistical Appendix.

¹⁰² Pension File, Austin J., VAC.

had only been able to earn \$25.00 through casual employment.¹⁰³ Despite clear financial need and supportive testimony from members of his community, Private Wilfred L., an aboriginal veteran and former soldier settler, was rejected for an award after physicians found no evidence of chronic disability. At the time of application Wilfred was just 43-years-old and was struggling immensely to provide for his family.¹⁰⁴

To the dismay of policymakers and veterans' advocates who had lauded the WVA Act as an important step forward in the social welfare of returned soldiers, the early history of the program was plagued by the same bureaucratic technicalities and confusion that existed in the pension system. Hundreds of applications were rejected each year because veterans did not meet basic eligibility criteria, particularly the stipulation that required them to have served in a 'theatre of actual war.' In a testament to how poor the economic situation was, comparatively few veterans failed the initial means test. Most were rejected because their physical or mental condition did not preclude them from obtaining employment. With no appeal system, veterans grew frustrated, sometimes submitting a new claim every other year in the hope that a sympathetic physician might write a favourable report.¹⁰⁵ Few obliged.

The state had no intention of allowing the WVA program to develop into a general service pension, but elected officials were keenly aware that the bloated number of rejected applications was a political powder keg. Some manner of reform, however minor, was needed. The first revisions to the Act came in the wake of the 1936 special

¹⁰³ Pension File, Clyde A., VAC.

¹⁰⁴ Pension File, Wilfred L., VAC.

¹⁰⁵ Daniel L., for example, submitted seven separate WVA claims before he was finally granted an award in 1947. See Pension File, Daniel L., VAC.

committee on returned soldiers' problems. The key amendment involved the creation of an additional eligibility category (dubbed 'WVA3') that would apply to veterans who had attained the age of 55 and, although not "permanently unemployable," were found to be incapable of maintaining themselves due to "pre-aging, disability, and general unfitness."¹⁰⁶

The results were underwhelming. In total, only 1285 veterans qualified as 'WVA3' in the two years following the amendment.¹⁰⁷ The reality was that few un-pensioned veterans who had served in a combat theatre were sufficiently disabled from an objective medical standpoint to warrant a favourable ruling under the existing Act. A 55-year-old ex-private with rheumatism or bronchitis might present a compelling story to a sympathetic newspaper editor, but as the 1930s progressed and the employment situation improved, the WVA committee was obliged to make sure that awards were disbursed to only the most helpless cases. Indeed, notwithstanding the 1936 amendments, success rates for the two original classes of allowances (WVA1 and WVA2) were polarized. Up to 31 March 1938, 74.5 per cent of veterans who applied for a WVA1 award were successful, compared to a mere 34.3 per cent for WVA2 applicants.¹⁰⁸ Between 1 April 1937 and 31 March 1938 alone, 2050 veterans under the age of sixty were rejected because they were "not considered permanently unemployable."¹⁰⁹

¹⁰⁶ *DPNH Report* (1938), 84.

¹⁰⁷ *DPNH Report* (1938), 84.

¹⁰⁸ See Tables 2.8 and 2.9 in Statistical Appendix.

¹⁰⁹ *DPNH Report* (1938), 85. Hundreds more were barred from receiving an allowance for other reasons.

At the advice of the Veterans Assistance Commission, in 1938 the WVA was amended a second time and the WVA3 category broadened to encompass cases where “economic handicaps combined with disabilities” prevented a veteran from maintaining himself.¹¹⁰ Age restrictions were eliminated, and although applicants still had to have served in a ‘theatre of actual war,’ the emphasis of the revised WVA3 category on ‘economic disability’ had an immediate impact. Within the first year nearly 5000 veterans were granted awards under this category, and by 1944 the number of WVA3 recipients reached over 10,000.¹¹¹ One of the first recipients of the new award was Walter C., a four-year combat veteran who had served overseas as a driver with the 31st Battery, Royal Canadian Artillery. At only 53 years of age, in 1937 Walter was admitted to the Home for the Aged and Infirm in Hamilton, Ontario suffering from an unidentified health condition. Upon medical examination, the furrowed veteran appeared malnourished and showed every indication of a man who had “led a fairly strenuous life.”¹¹² Walter exhibited all the hallmarks of a burn out case, but his condition and past medical history gave no clues as to the origins of his infirmity—he had never been hospitalized overseas, and there was little to no information available on his post-war health or lifestyle.¹¹³ Given the state of his condition and the poor living arrangements he occupied the WVA immediately granted Walter a \$20.00 allowance which he used to rent a room out of his niece’s home until his death in 1943.¹¹⁴

¹¹⁰ *DPNH Report* (1939), 86.

¹¹¹ See Table 2.8 in Statistical Appendix.

¹¹² Pension File, Walter C., VAC.

¹¹³ Personnel File, Walter C., RG 150, Accession 1992-93/166, Box 1580 – 34, LAC.

¹¹⁴ Pension File, Walter C., VAC.

Any veteran who received a WVA award was subject to the same obligatory annual reviews by department investigators. Because of the subjective and ambivalent characteristics of their cases, WVA3 recipients attracted the most scrutiny. After receiving his allowance in April 1939, Private Joseph D. began a vital relationship with veterans' authorities that lasted until his death in 1954. Having been previously rejected for a pension by both the Federal Appeal Board and the Pension Appeal Court, Joseph broke down in 1938 after continuing too long in his position as a painter. At just 43 years of age, the former member of the 22e Battalion was completely debilitated by a combination of bronchitis, nephritis, and a deteriorating cardiac condition. With no other means of supporting himself, his small \$20.00 allowance was a timely saviour, but one that was accompanied by the watchful eye of the state. Each year investigators inspected Joseph's living arrangements, audited his earnings, remarked upon the state of his health, and appraised his overall condition. These annual home visits revealed that Joseph was a modest and honest ex-soldier whose working years were well behind him. By 1947 he was a frequent in-patient at Montréal's Queen Mary Veteran Hospital where he received free treatment until his death in 1954.¹¹⁵

Cases like Joseph D. and Walter C. embodied the true spirit of the WVA Act. From its inception, however, the state had resisted calls from veterans to broaden the scope of the program, relying instead on the authority of medical science to determine eligibility. As with the pension system, the records and objective symptoms of a veteran did not always tell the full story. Outlier cases were commonplace. To a great extent the

¹¹⁵ Pension File, Joseph D., VAC.

1938 amendments reaffirmed the original tenets of the burn out narrative by accepting a more holistic concept of veterans' welfare. In certain contexts 'economic' disablement was tantamount to a war wound or debilitating illness, a fact politicians recognized could no longer be fully ignored. As was often the case in the history of Canada's nascent welfare state, policy-makers and administrators viewed recipients with caution if not outright suspicion.¹¹⁶ There were occasional examples of fraud, but these paled in comparison to the tens of thousands of needy veterans that the program aided during its early history. In addition to material security, the WVA also bolstered the social status of veterans by differentiating their experience from that of ordinary citizens. With nearly 65,000 applications submitted and over 24,000 active awards in force at the beginning of 1942 it is clear that veterans embraced this special status.

VII. VETERANS' HEALTH IN THE 1930s: A BALANCE SHEET

At its core, the War Veterans Allowance program was a tacit acknowledgement that war service, in all of its forms, presented a constellation of medical and economic impediments to the reintegration of veterans into civilian society. The most extreme interpretations of the 'burn out' narrative held that service on the Western Front had unequivocally shortened the lives of Canadian veterans by as much as a decade. It was for this reason that the default age for a WVA1 award was set at 60, whereas the recently introduced Old Age Pension was 70. That thousands of veterans came forward, and were accepted as WVA2 and especially WVA3 cases only confirmed Canadians' suspicions

¹¹⁶ Dennis Guest, *The Emergence of Social Security in Canada* (Vancouver: UBC Press, 1980);

that a pandemic of disability existed amongst the former ranks of the CEF. But to what degree were these popular and, increasingly, institutionalized assumptions about the collective health of ex-servicemen correct? While evidence for the entire population of veterans is unattainable, data compiled from official statistics and veterans' pension records present some interesting clues into the scope and severity of the alleged 'burn out' crisis, as well as other issues affecting the wellbeing of ex-soldiers throughout the 1930s and the inter-war period more broadly. What the following discussion reveals is that demographic changes had a far greater impact on the trajectory of veterans' health than is typically acknowledged.

Statistics compiled by the War Veterans Allowance Board (renamed in 1936) offer some intriguing insights into the variety of disabilities exhibited by veterans who applied for an allowance. As Figure 2.8 in the Statistical Appendix illustrates, a majority of veterans under the age of 60 who received WVA2 awards were diagnosed what would typically be classified as age-related illnesses. Many WVA2 recipients, including some 1300 cases of mental disability and 850 tubercular veterans, contracted illnesses that may have had their origins in pre-war life or were simply undiagnosed at the time of their discharge, it is important to consider that most of applicants who received WVA awards were already past the middle stages of their lives. In 1938, for example, 68 per cent of the 13,244 WVA award holders were over the age of 60. Of all WVA2 and WVA3 recipients, 79 per cent were between the ages of 45 and 59.¹¹⁷ By 1940, the proportion of WVA2 and

¹¹⁷ *DPNH Report* (1938), 87.

WVA3 recipients between 45 and 59 increased to 89 per cent.¹¹⁸ While this increase can partly be explained by the advancing age of existing award-holders, it also suggests that many ex-servicemen in their late 40s and 50s were developing health complications that prevented them from participating in the labour force towards the end of the decade.

Was this deterioration in the health of Canada's ex-soldiers due to the irreparable legacy of war service? What role could post-war lifestyle and the hardships of the Depression era have played? The frequency of pension applications might serve as a possible indicator, but due to the amendments of 1928 and 1930—which had a profound impact on eligibility criteria—and the economic strains placed on veterans during the Depression, the data is largely unreliable. Nevertheless, it is worth noting that after 1933, a year in which over 18,000 applications were submitted to the pension commission, application rates fell steadily until reaching a nadir of just 1330 in 1942. Success rates, as discussed earlier, remained exceedingly low.

Another notable trend is the number of pension rate increases versus decreases. Despite the large number of pensions granted between 1928 and 1933, the frequency of award increases granted by pension officials actually began to decline throughout the decade, from a peak of 5055 in 1928 to just 3341 in 1939. When viewed as a proportion of total awards in force, the drop is far more dramatic: 1 in 10 pensioners received a rate increase in 1928, but only 1 in 24 did in 1939.¹¹⁹ As Figure 2.9 in the Statistical Appendix illustrates, the proportion of pensioners who held an award of 40 per cent or more also

¹¹⁸ *DPNH Report* (1940), 82.

¹¹⁹ See Figure 2.7, and Table 2.3 in Statistical Appendix.

remained stable.¹²⁰ Most pensions that were added, unsurprisingly, were for minor illnesses, old wounds, or aggravated conditions that fell below 20 per cent. While we must be cognizant that administrative changes and pensioner deaths affected fluctuations in aggregate pension rates, we can discern generally from the data that pension applications trended downward after the early 1930s (See Figure 2.10 in Statistical Appendix), and with some obvious exceptions (such as TB cases), veterans’ disabilities gradually stabilized.

The experience of the sample group presents a microcosm of this trend. Without including the several veterans who had their commuted pensions reinstated after the 1930 amendments to the Pension Act, only 22 veterans applied for pensions throughout the entirety of the 1930s. Three veterans applied on two separate occasions. One was making his third application of the post-war period. Of these 25 total applications, 14 were ruled ‘not attributable to service,’ while 11 were ruled attributable or aggravated. Ten veterans received a pension, and one received two awards—the first a \$100.00 gratuity for a 2 per cent disability, and the second a standard Class 20 pension for a 5 per cent disability. Sixteen veterans were submitting a pension for the first time, only five of whom received an award.

TABLE 6.1 – SAMPLE GROUP DISABILITY PENSION APPLICATIONS, 1930-1939

	Disability Rating	Pension Rating
Pension Mean	27.91	24.64
Pension Median	15.0%	10.0%
Standard Deviation	33.107	33.110
Total Applications	11	11

¹²⁰ See Figure 2.9 in Statistical Appendix.

Successful applications encompassed a range of disabilities, but as with the WVA2 cases presented above, pensions were granted primarily to veterans suffering from chronic, congenital or age-related illnesses. These included three cases of heart disease, two cases of chronic bronchitis, in addition to arthritis, varicose veins, and otitis media. The average age of the 10 veterans who received a pension was 43, and the median application date was October 1933.

Mortality statistics arguably offer the best method of measuring how the Great War continued to impact the health of veterans during the inter-war years. If military service had shortened the life expectancy of many veterans by a decade or more, then pension statistics and evidence from the sample group would certainly confirm this trend. According to official statistics, between 1919 and 1939, 13,832 disability pensioners died while receiving compensation under the Pension Act. Of this total, at least 5048 deaths (42.2 per cent) were ruled attributable to military service or a pensionable disability, including 1329 between 1914 and 1922.¹²¹ As figure 2.5 in the Statistical Appendix indicates, mortality amongst pensioners gradually increased throughout the inter-war period, however, the frequency of deaths related to pensionable disabilities declined steadily from a peak of 8.3/1000 in 1924 to a low of 3.8/1000 in 1938.¹²² A major limitation of these mortality figures is that they can only reveal trends within the pensioner population, rather than offering a comparison of veterans versus non-veterans.

¹²¹ In 1939, 26 cases were still pending ruling, most likely from the previous year. Previous rulings could also be overturned in the years that followed if new evidence was presented to pension authorities. Statistics compiled from BPC Reports, 1923-28 and DPNH Reports, 1928-39.

¹²² Statistics for the period 1914 to 1922 are not available by year.

A 1939 study published in the *Canadian Medical Association Journal* by physicians from the DPNH explored this matter in detail. Utilizing official pension statistics and mortality data for a comparable male population, the study found that in the years immediately following the Great War the mortality rate amongst disability pensioners was three times higher than the average for non-pensioners and civilians. Gradually, however, this discrepancy narrowed as the number of premature deaths due to advanced diseases declined, and deaths from natural causes or age-related illness increased. By 1936—the final year examined in the study—pensioner mortality was only 1.2 times higher than the corresponding male population.¹²³ The legacy of military service continued to impact the longevity and wellbeing of veterans, but the reality was that the perceived burn out crisis of the 1930s had been influenced to a marked degree by demographic changes—and arguably, lifestyle as well—rather than the protracted effects of ‘invisible wounds.’

In the absence of other longitudinal studies, the dissertation sample group, which includes death information for both pensioners and non-pensioners, offers some further insight into the life trajectories of Canada’s Great War veterans. Of 384 veterans in the sample, some manner of death information was obtained for 162 cases. Specific information on the cause of death and contributing factors was obtained for 98 cases. The most common cause of death amongst these veterans was heart failure ($n=36$), typically emanating from some form of chronic heart disease or age-related coronary degeneration. Other common sources of mortality included strokes ($n=7$), cancer ($n=11$), and various forms of respiratory failure resulting from chronic disease or acute infection ($n=16$). Six

¹²³ F.S. Burke, “Deaths Among Pensioners,” *Canadian Medical Association Journal (CMAJ)* 29, no 11 (November 1939): 457-65.

veterans died from accidents, and one was killed fighting in the Spanish Civil War. In spite of advances in the treatment and management of the disease, eight veterans succumbed to the effects of pulmonary tuberculosis, having an average life span of 49.9 years.

While an exact measurement of the quality of life veterans enjoyed is not possible, we can use life tables assembled by the Dominion Bureau of Statistics (DBS) to measure the longevity of the sample against the general male population. For example, life expectancy for a 32-year-old Canadian male in 1921 was 71.1 years.¹²⁴ The median age of the 154 veterans from the sample who survived past this point was remarkably similar, with a median life expectancy of 71.2 years and mean life expectancy of 68.9 years. This pattern continued throughout the inter-war period. Of 144 veterans who survived past 1931, the median life expectancy climbed to 72.5 and the mean 70.9—the male population as per the DBS's life table, was 72.3.¹²⁵ Of 127 who survived past 1941, median life expectancy climbed to 75.5 and the mean to 73.7. The Canadian average was 73.9.¹²⁶

Though by no means a comprehensive sample of Canada's Great War veterans, when combined with the other data presented in the preceding discussion, the sample figures raise questions over the scope and severity of the 1930s 'burn out' crisis. As this

¹²⁴ Dominion Bureau of Statistics, *Canadian Abridged Life Tables, 1871, 1881, 1921, 1931* (Ottawa: 1939), 14. The median birth date of the 154 veterans was 13 June 1890. The mean was 30 April 1889. These figures for the next two life table dates (1931 and 1941) changed by only a few months, therefore a median age of 52 is assumed for all life expectancy calculations.

¹²⁵ Dominion Bureau of Statistics, *Canadian Abridged Life Tables*, 15.

¹²⁶ Federal Bureau of Statistics, *Life Tables for Canada & Regions, 1931 and 1941* (Ottawa: 1947), 7. Based on life expectancy of a 52-year-old.

chapter has illustrated, veterans, whether pensioned or non-pensioned, disabled or able-bodied, faced common hardships during the Depression years. The contradictions between the burn out narrative and what scattered evidence we can glean on the collective health of veterans arguably says much more about the social and cultural resonance of disability in the collective consciousness of Canadians during the 1930s than it does about the lived experiences of the disabled. The notion that the Great War continued to affect the majority of those who had served in it fulfilled a collective desire to make sense of a world mired in economic disarray and seemingly destined for another international conflict. Every ex-soldier who died prematurely, every disabled veteran whose family struggled to make ends meet presented a microcosm of the tragedy and futility of modern war, though as Jonathan Vance has illustrated, few Canadians were willing to rebuke the sacrifices borne by a generation of citizen soldiers.¹²⁷ The fault lay with the post-war order. By the 1930s it was clear that reconstruction had failed to provide soldiers and workers with long-term economic security

VIII. CONCLUSION

The preceding discussion should not be seen as an attempt to invalidate or trivialize the very real physical, psychological, emotional, and material legacy the Great War inflicted on those who witnessed it firsthand, or the families who experienced its lasting impact. Though often overshadowed by the sacrifices borne by other nations, or the scale of the world conflict that followed it, it is nonetheless imperative to remember

¹²⁷ Jonathan F. Vance, *Death So Noble: Memory, Meaning and the First World War* (Vancouver: UBC Press, 1997).

that the Great War was the most cataclysmic event in Canada's short history. By the height of the Depression a quarter of a million Canadians young and old were receiving direct compensation for injury, illness, or death resulting from the war. By 1939, with the expansion of the WVA program, that figure had grown to over 300,000. From its humble beginnings as the Military Hospitals Commission and the Board of Pension Commissioners in 1915-16, Canada's wartime rehabilitation scheme had evolved into the most complex and expensive foray into social welfare the country had ever seen.

This unprecedented expansion and redefinition of the state's role in the lives of its citizens did not come easily, nor was it universally inclusive. As Lara Campbell has pointed out, the 1930s "witnessed an uneasy co-existence between the burgeoning number of those who sought benefits on the basis of rights and entitlement, and older notions of charitable aid based on the distinction between the deserving and undeserving poor."¹²⁸ Though often ignored or underemphasized in historical accounts of the Depression, as this chapter has illustrated, ex-servicemen were at the vanguard of the broader push for increased state intervention in matters of social welfare. The government's response was hesitant and conditional, but nonetheless substantial given the ideological and fiscal constraints of the period. Pension reform allowed tens of thousands of veterans to regain entitlements they had lost in the aftermath of the war, while the WVA granted un-pensioned elderly and disabled veterans the opportunity to live their remaining years with a modicum of dignity rather than as paupers or charitable cases. Far from being treated with "shabby indifference," government officials, responding to

¹²⁸ Campbell, "'We who have wallowed,'" 127.

mounting public pressure and an increasingly powerful veterans' lobby, were willing to grant comparatively generous concessions to the nation's veterans who served in theatres of war at a time when they were most vulnerable.¹²⁹

The devil, however, was in the details. Revisions to the Pension Act were welcomed with enthusiasm but quickly disappointed. Insufficient infrastructure and a bloated appeal system meant that many veterans remained in limbo for years as their applications were shuffled between the BPC, tribunals, and Pension Appeal Court. When a ruling was finally reached, most veterans were disappointed to discover that authorities continued to privilege hard medical evidence and their military service documents over compelling personal narratives or testimony from former comrades. For the entirety of the 1930s, only one in seven pension claims—16,201 of 104,984 total—resulted in an award.¹³⁰ Most were a mere pittance. Even so, a pension was still coveted, and amidst widespread unemployment, it was not surprising that veterans sought any opportunity available to them to avoid the ignominy of subsisting on public relief or charity. Despite intense pressure from the Legion and grassroots activists federal politicians declined to take any meaningful action on the employment situation, preferring instead to dangle the carrot by opening up the WVA program to new classes of veteran, while also pushing to gradually restrict access to pensions after a brief and largely failed attempt at liberalization.¹³¹ Though often given limited attention in the historical literature on social security in Canada, the WVA is arguably one of the most important social welfare

¹²⁹ Morton and Wright, 222.

¹³⁰ See Table 2.2 in Statistical Appendix.

¹³¹ Morton and Wright, chapter 10.

measures introduced during this period.¹³² By blurring the line of distinction between worthy disabled and unworthy disabled, the ‘burn out pension’ legitimized the popular idea that war and disability were inseparable. What disability actually entailed remained highly ambiguous and varied widely from case to case, but it was nonetheless assumed that few, if any veterans had escaped the war without some physical, psychological, or economic injury.

More importantly, the WVA served as a model of how the state could offer a select category of underprivileged citizens a modest degree of social assistance that was both amenable to the public and fiscally sustainable. For over a decade the Canadian government had adopted a conservative approach to its rehabilitation measures for veterans, clawing back all manner of benefits possible in the wake of the war, though often with only short-term success. Canadians had been able to avoid the ‘pension evil’ but a system that granted entitlement along strict medical lines proved unsustainable.¹³³ The limitations of wartime medicine and the unpredictability of veterans’ health exposed cracks that ran deep in the foundations of Canadian rehabilitation policy, and especially the pension system. The latter could not be radically reformed without contradicting the very principles upon which it was created, leaving pension authorities to bear the burden of administering legislation that often bred widespread dissatisfaction amongst ex-servicemen. The WVA represented a first attempt by a new generation of reform-minded veterans’ advocates to repair this strained relationship between the state and its citizen soldiers. When Canada entered into a second terrible world conflict, these same

¹³² See Campbell, *Respectable Citizens*, chapter 5; Guest, 96-97.

¹³³ Morton and Wright, 222-23.

personalities would figure prominently in the push to re-imagine the state's role in the lives of a new generation of veterans.¹³⁴

¹³⁴ Neary, *On to Civvy Street*, chapters 1 and 2.

Conclusion: Learning through Failure? Canada's Great War Disabled in Context, 1914-44

Did civil re-establishment ultimately fail Canada's Great War disabled? A common observation presented in the literature on veterans and social welfare in Canada is that the policy shortcomings of 1919-39 offered valuable 'lessons learned' for future generations of social planners.¹ During the Second World War, these visionary politicians, public intellectuals, and civil servants combined to conceptualize and build a more robust, equitable, and flexible program for veterans' rehabilitation and post-war reconstruction. Some have even suggested that this crucial period paved the way for the creation of the modern welfare state.² While it is beyond the scope of this study to interrogate this hypothesis through a comparative analysis of both eras, it is important to take a step back and consider the inaugural and evolutionary character of Canada's first large-scale attempt to care for tens of thousands of disabled veterans before arriving at a conclusion about its efficacy. When Canada went to war in 1914 the state remained a distant and ambivalent force within the lives of most citizens. With only a tiny national

¹ See Robert England, *Discharged: A Commentary on Civil Re-establishment of Veterans in Canada* (Toronto: Macmillan, 1943); Introduction to Peter Neary and J.L. Granatstein, eds., *The Veterans Charter and Post-World War II Canada*. Montréal and Kingston: McGill-Queen's University Press, 1998); Jeff Keshen, *Saints, Sinners, and Soldiers: Canada's Second World War* (Vancouver: UBC Press, 2004); Peter Neary, *On to Civvy Street: Canada's Rehabilitation Program for Veterans of the Second World War*. Montréal and Kingston: McGill-Queen's University Press, 2011).

² Desmond Morton and Glenn Wright, *Winning the Second Battle: Canadian Veterans and the Return to Civilian Life, 1915-1930* (Toronto: University of Toronto Press, 1987); idem, "The Canadian Veterans' Heritage from the Great War," in *The Veterans Charter and Post-World War II Canada*, eds. Peter Neary and J.L. Granatstein (Montréal and Kingston: McGill-Queen's University Press, 1998), 15-33.

army, Canadians were neither experienced at war making nor accustomed to caring for large populations of ex-soldiers. Veterans of previous campaigns such as the 1885 Rebellions or the Boer War who fell victim to disability or disease had few options but to seek assistance from family or private charity.³ Disablement remained first and foremost an individual misfortune.

However, by 1919 dramatic shifts in Canadians' attitudes towards citizenship and social entitlement were taking place. The Great War, as numerous writers have demonstrated, nurtured a widespread belief that Canada was on the precipice of a new age of reform and regeneration. The savagery of the fighting on the Western Front and its reverberating effects at home accelerated calls for government intervention into the lives of soldiers and their kin for the future benefit of the nation. A vital proving ground for progressivism quickly took shape. In a little over a year of planning, a small group of public officials, medical experts, intellectuals, and businessmen had developed the basic framework upon which Canada's plans for veterans' rehabilitation would be based for the next century. During the war, politicians and veterans' advocates worked diligently to revise these core programs—medical treatment, retraining, and pensions—expanding their reach to suit the evolving needs of the country's disabled soldiers. Voluntarism was gradually superseded by a more robust, managerial system of rehabilitation administered by the federal state and supported by local agencies. Citizens remained eager to contribute, and the humanitarian spirit of care giving persisted, but as the war reached its

³ Morton and Glenn Wright, 9-14.

conclusion, a noticeable rift had emerged between the liberal ideals of reconstruction and the practicalities of returning over half a million men to civilian life.

The war engendered expectations that the state would do its utmost to care for, compensate, and guide ex-servicemen towards prosperity in civilian life. Healthy soldiers were disappointed to find that few entitlements would be offered past their time in service. Land settlement schemes, housing incentives, and compensation were all contingent on a veteran's financial standing, work experience, or physical abilities. The disabled were cared for in a far more generous manner—perhaps more charitably than any other allied nation—but they too discovered that their own benefits were a fleeting outcome of wartime generosity, rather than a permanent commitment to ensure their post-war success.

In the years that followed, popular sentimentality towards the disabled began to wane and access to programs became more restrictive as successive governments sought to rein in federal expenditures. Hospitals, treatment clinics, and sanatoria were rapidly closed down or transferred to local authorities. Vocational retraining (with the exception of special cases) was ended in 1923 after steady decreases in enrolment, leaving thousands of graduates without sufficient after-care once they entered the job market. Disability pensions served as a vital safeguard against absolute destitution, however, they were also a persistence source of frustration. Believing that the liberal spirit of wartime pensioning had been abandoned, veterans grew increasingly hostile towards the pension board's requirement that they demonstrate a conclusive medical link between military

service and their disability.⁴ This crucial question of ‘attributability’, as Chapters 5 and 6 of this study have shown, would come to dominate veterans’ politics after 1920.

It was not until 1930 that politicians began to respond in earnest to veterans’ demands for reform. By this time special committee investigations, veteran conventions, and the popular press had each uncovered countless examples of disabled ex-servicemen who had fallen through the cracks of the pension system. The Great Depression provided a catalyst for legislative changes that appeared substantial on the surface, but ultimately served only a small group of individuals who had previously commuted their pensions, were barred by legal technicalities from applying, or had neglected to seek out compensation for latent diseases. New programs such as the War Veterans Allowance offered a glimpse of what the state could provide for a special class of veteran who became impoverished through no fault of their own, but access was contingent on satisfying strict eligibility criteria and means-tests. Neither unemployment nor abject poverty was sufficient to warrant special assistance from the state unless a veteran could demonstrate that it had resulted from a dramatic deterioration in his health.⁵ For the hundreds of thousands of CEF veterans who fell outside the scope of these core programs, municipal relief and charity were the few options available.

In spite of extensive planning during the war, policy-makers proved unable to fully anticipate the multitude of medical and economic challenges disabled veterans

⁴ Desmond Morton, “Resisting the Pension Evil: Bureaucracy, Democracy, and Canada’s Board of Pension Commissioners, 1916-1933.” *Canadian Historical Review* 68, no. 2 (1987): 199-224.

⁵ Peter Neary, “‘Without the Stigma of Pauperism’: Canadian Veterans in the 1930s,” *British Journal of Canadian Studies* 22, no. 1 (2009): 31-62.

would face in peacetime. To suggest that these miscalculations are tantamount to failure, however, would be a disingenuous critique made from the benefit of hindsight.⁶ To rebuild the system from the ground up during the worst economic crisis in the nation's short history would have put at risk nearly 15 years of policy development, and stretched federal resources to the brink. As later chapters of this dissertation illustrate, the reforms that did take place between 1928 and 1933 revealed what many already knew about disabled veterans who had allegedly been failed by the system. Their cases, while unfortunate, showed little evidence of a connection between military service and ill health. Even with a more efficient appeal system and unprecedented aid from pension advocates, four in five pension applications after 1930 resulted in a negative ruling. For most of these outliers, it was extraneous factors such as aging, a life of hard labour, and the strains of economic degradation were beginning to take their toll.

Yet with few exceptions, both the Canadian and international literature on disability and the Great War has presented veterans' reintegration as a medical and social calamity. Maimed, chronically ill, or broken in mind and spirit, the Great War devastated a generation of young men who managed to survive its carnage but could not escape its lingering scars. The decision to incorporate a random sample of pension records has been especially useful in bringing about a much-needed reassessment of this common theme within the existing historiography. As the preceding chapters have illustrated, Canada's citizen soldiers confronted and experienced disability in very diverse ways that defy easy categorization. Social status, familial support, and economic circumstances all had a

⁶ Morton and Wright, 222-25.

direct impact on an individual's ability to reintegrate into civilian life. James B., for example, returned to Canada in 1918 suffering from the mild effects of chronic gastritis, but became unemployable after developing numerous other disabilities, including conjunctivitis, eczema, and pulmonary tuberculosis, all of which were unrelated to his war service. The latter eventually claimed his life in February 1951.⁷ Combat veteran Alexander A. spent most of his post-war life out of work and battling alcoholism. For years his only means of supporting his family was a 20 per cent pension.⁸ Unable to compete in the open labour market because of an amputation, James F. spent eight years working for a local Vetcraft shop before his familial situation turned violent and authorities committed him to Westminster Hospital's neurological ward. He would spend the remaining 20 years of his life as an institutional patient suffering from what physicians described as 'dementia praecox' (schizophrenia).⁹

But examples of perseverance and determination were just as abundant within the sample as those of hardship. Edwin S. survived several acute infections of tuberculosis to live a long and modest life as a postman, passing away in 1986 at the age of 87.¹⁰ Percy M. continued as a minister in a small Ontario town well into his later years, collecting a pension until his death at the age of 93.¹¹ William C. spent his whole career as a successful mechanic, earning a small 5 per cent pension for an old gunshot wound until

⁷ Pension File, James B., Veterans Affairs Canada [hereafter 'VAC'].

⁸ Pension File, Alexander A., VAC.

⁹ Pension File, James F., VAC.

¹⁰ Pension File, Edwin S., VAC.

¹¹ Pension File, Bert T., VAC.

¹² Pension File, Percy M., VAC.

his death in 1977 from metastatic cancer.¹³ While their lives were not free from hardship, these veterans were all able to piece their lives back together on their own terms.

In addition to revealing the overall complexity of the veterans' experience, data extracted from the sample group, official sources, and the individual stories of veterans have also helped expand our understanding of the Great War's medical legacy. Physical injuries caused by combat naturally dominated the focus of wartime medicine and have long captivated historical researchers interested in the history of the body, masculinity, and disability. By 1939, however, nearly 60 per cent of all disability pensions held by Canadian veterans were for non-combat injuries and chronic illnesses.¹⁴ Given that over 85 per cent of disability pensioners served in a combat theatre, these figures are particularly striking.¹⁵ The reality was that a significant number of recruits who enlisted in the CEF brought with them existing disabilities and illnesses that either escaped the scrutiny of military medical examiners, or were simply ignored once they arrived overseas. The state had little choice but to offer soldiers' compensation: a 19-year-old recruit with an undiagnosed case of tuberculosis or a middle-aged labourer who broke down while on the front lines due to a congenital heart condition could not be blamed for their medical misfortune. It was ultimately the army's responsibility to decipher who was fit and unfit.

The squalid conditions many soldiers faced while serving on the Western Front also contributed to the spread of diseases that would continue to affect them long after the

¹³ Pension File, William C., VAC.

¹⁴ See Table 2.5 in Statistical Appendix.

¹⁵ *Report of the Work of the Department of Pensions and National Health* (Ottawa: King's Printer, 1939), 65.

return to civilian life. By the 1930s, many veterans and public officials presumed that the conditions on the Western Front had caused a wholesale deterioration in the health of men who had served there. The reality, however, was that disablement within the veterans' population—at least from a conventional medical perspective—was far less pervasive than Canadians believed. Some 560,000 members of the CEF survived the Great War. Only one in five received a disability pension. Nearly three quarters of all ex-servicemen either never qualified for pension or WVA benefits, or never came forward to seek compensation. Similar patterns were found in the sample group. Over 120 veterans applied for a pension or War Veterans Allowance between 1915 and 1944, however, only two-thirds received awards. Out of the entire sample group of 384 cases, over 180 had no VAC pension record at all, indicating that the individual likely had little to no interaction with veterans' authorities over the course of post-war lives. Many of the non-pensioners within the sample group only began relying on federal veterans' services when they reached an age where they were no longer able to take care of themselves.

Why then did disability seem so pervasive to contemporaries and serve as such a crucial element of veterans' politics in Canada? Economic and demographic factors offer a compelling explanation. Throughout the 1920s the prevalence of chronically unemployed 'problem cases' in major urban centres served as mounting evidence that Canada's soldiers had returned to civilian life at a fundamental disadvantage in the open labour market compared to ordinary civilians. Over time, the physical and mental strain of war service presented an increasingly powerful, pseudo-medical explanation for why ex-servicemen who had been discharged as medically fit were 'breaking down' in greater

and greater numbers. This ‘burn out’ phenomenon, discussed at length in Chapter 6, included many genuine cases of undiagnosed disability, but it was by and large a sensationalized reaction to the economic exigencies of the period. It was also reflective of unavoidable demographic changes that were taking shape. By the 1930s, the vast majority of Canada’s veterans were over 40 years of age. It is only reasonable to expect that within a large population, several thousand would begin succumbing to lingering illnesses and injuries, most of them the consequence of heredity, lifestyle, or post-war occupation. In fact, as data in Chapter 6 illustrated, deaths that were related to pensioned disabilities dramatically decreased throughout the 1930s, while the life expectancy of veterans became more congruent with that of ordinary civilians.

Some historians of war and disability have made a point of highlighting trauma as one of the primary factors influencing popular anxiety over veterans’ health during the inter-war years. To this day ‘shell shock’ is one of the most culturally potent symbols of the Great War’s enduring legacy. A grandfather, father, uncle, or brother who returned from the Western Front and refused to talk about his experiences is a common but powerful trope invoked to denote the irreparable psychological damage combat etched on the lives of those who served on the Western Front. In the Canadian context, however, trauma remains remarkably difficult to quantify. This is due in large part to the shifting medical and cultural meanings of mental illness, as well as the effect Canadian pension policies had on legitimizing veterans’ claims for compensation. As many as 6,000 CEF veterans received pension awards for some manner of ‘nervous disorder’ or war neuroses,

but only a portion of these cases received long-term assistance.¹⁶ Complicating matters further is that many of these veterans were eventually discovered to have genuine physiological conditions such as heart disease. Added to the mix were thousands of soldiers who had enlisted with a lengthy history of mental illness, suffered from neurological disorders (such as epilepsy) or, in some rare cases, had a developmental disability. Not all could be conveniently denied a disability pension and swept under the rug, especially those that, according to contemporary medical practice, necessitated ‘institutional care.’ Unfortunately, because of these complexities we can never truly know how many ex-servicemen came forward seeking assistance, or how many suffered in silence.

Even so, the pension records that were used as the basis of this study offer a unique opportunity for historians to begin systematically interrogating questions surrounding trauma and other disabilities that affected veterans’ lives in the aftermath of the Great War. By linking these individual histories to the study of policy, this dissertation has revealed important new insights on the evolving role of the state in the lives of its citizen, its power, and its limitations. Since the linguistic turn many Canadian historians have expended great effort to interrogate the social and culturally constructed meanings of gender, class, race, disability, and a broad gamut of other important analytical categories. Private collections, personal writings, cultural artefacts, and popular literature are frequently turned to as the most useful way of interrogating these histories from the ‘bottom up.’ This study owes a great debt to their path-breaking scholarship, but

¹⁶ See Table 2.5 in Statistical Appendix.

it also illustrates the merits of deriving the best available qualitative and quantitative evidence from official sources. As new digital initiatives make case files and official documents more accessible than ever to historians and the general public, it is worth considering their enduring utility, and the new questions we can ask of them.

In 2014 Canadians are still asking many fundamental questions about the role of the state in the lives of its veterans. A key lesson that this study provides for policy-makers is that need for long-term planning, for flexibility, and mutual respect. War, for most, does not end when the guns fall silent and combat uniforms are exchanged for civilian attire. The current epidemic of Post-Traumatic Stress Disorder (PTSD) among veterans who have served in Afghanistan, Iraq, and other operations has amply demonstrated that psychological injuries can be just as damaging as physical ones. While much research has been completed on approaches to treating these conditions, medical authorities have been reticent to admit that we still understand comparatively little about the genesis of traumatic stress injuries and the impact they will have over the course of a lifetime. To meet this challenge, politicians and veterans' authorities must be prepared to work closely together to craft and revise programs that address both the immediate and long-term needs of Canada's soldiers and their families, rather than the fiscal or political imperatives of the day.

The completion of this study also comes at a timely point in our present social and cultural history. The Centenary of the Great War has helped spark renewed interest in the stories of Canada's fighting men and the families that they returned home to. It is hoped that this study reminds readers of war's brutality, complexity, and, most importantly, its

lasting legacy. The Great War was a bloody affair that resulted in some 9 million dead, 20 million wounded, and millions permanently disabled. The latter remain largely ignored within popular memory and the historical literature as a whole. As Canadians and citizens of other former combatants participate in commemorative activities, read new accounts, and explore their own personal histories of a conflict that continues to indirectly affect the lives of millions to this very day, it is important that we temper these cultural and intellectual exercises with an intimate understanding of the very grave consequences that industrial conflict bestowed upon those who witnessed it firsthand and survived to return home. Doing so will only enhance our appreciation of war's awesome power, and its frequent futility.

APPENDICES

Appendix I: Methodological Essay

This essay details the methods used to select representative case files utilized throughout the body of this dissertation. In the course of explaining the sampling process, it also describes the nature and scope of these sources as well as the ways in which they have been incorporated into the study. The first section outlines the parameters of the sample group and sampling methodology. It also offers a few key observations on the demographics and service experience of the sample. The second section outlines the historical characteristics of the two principal sets of case files utilized in the body of this dissertation: the Canadian Expeditionary Force's (CEF) service records and the Veterans Affairs Canada (VAC) pension records. This discussion also includes examples of how information was obtained from the records and modified for statistical analysis. Finally, the chapter briefly explores how extracted data was organized and analyzed using statistical software.

In this essay, and at various points throughout this dissertation, a number of key terms are utilized which have a precise meaning in relation to methodology 'Information' is what has been extracted from the case files. When compressed and manipulated statistically it yields 'data.' To put information into a mode where it can be manipulated, it must be 'coded.' Important categories for coding are referred to as 'variables.' The many individual variations within a variable are referred to as 'values.' 'Cases' refer to the incidence of a particular value or variable occurring. This research derived from both sets of case files has been linked together to produce a 'master dataset.'

Throughout this dissertation most of the data appears either as a ‘frequency distribution,’ such as the number of pensions awarded per year, or as a ‘cross-tabulation,’ where, for example, types of pensionable or non-pensionable disabilities are referenced in relation to a variable like the class of a pension. Frequencies and cross tabulations are descriptive statistics. Confirmatory statistics are not used in this study because of the diversity of individual cases and the overall value of the qualitative material from the case files and other conventional primary sources. As such, the sample group should be considered a quantitative exploration into the lives of Canadian veterans rather than a definitive statistical survey.

II. COMPILING AND REFINING THE SAMPLE GROUP

Determining the appropriate sample size posed both logistical and statistical questions. It needed to be large enough to make valid observations with a limited margin of error, but manageable enough to allow for detailed analysis of case files without consuming an excessive amount of time. A well-accepted statistical method for sampling a population in the hundreds of thousands guided the determination of the sample size. It was derived from a statistical sample size generator that utilized the following formula:

$$SS = \frac{Z^2 * (p) * (1-p)}{c^2}$$

Where:

Z = Z value (e.g. 1.96 for 95% confidence level)
p = percentage picking a choice, expressed as decimal
(.5 used for sample size needed)
c = confidence interval, expressed as decimal
(e.g., .04 = ± 4)¹

According to the above formula a sample size of 384 cases would be sufficient to represent the population of the whole CEF (roughly 620,000) at a confidence interval +/- 5 per cent and a confidence level of 95 per cent (19/20).²

After determining the sample size, a random number generator was utilized to select 384 CEF personnel from a master list of military service records.³ The records were accessed through Library and Archives Canada's (LAC) "Soldiers of the First World War: 1914-1918" online database.⁴ The list was compiled manually by the author, and at the time of completion in December 2011, consisted of 6637 individuals, or roughly 1.07 per cent of the total service strength of the CEF. Physical copies of service records for CEF personnel are held at LAC under RG 150 (Overseas Military Forces of Canada) and are organized alphabetically. Early on it was determined impracticable to draw the sample group from this immense collection. Doing so would have required the author to draw the

¹ "Sample Size Formula for our Sample Size Calculator," Creative Research Systems, <<http://www.surveysystem.com/sample-size-formula.htm>> (accessed December 5th, 2011).

² Unless otherwise noted, all calculations of proportionality are derived from a rounded total of 620,000 enlistments. According to statistics compiled after the war by the Department of Militia and Defence and reproduced in G.W.L. Nicholson's official history, the total strength of the Canadian Expeditionary Force for the duration of the war was 619,696. This total includes all enlistments by nursing sisters and men who enlisted outside of Canada. See G.W.L. Nicholson, *Official History of the Canadian Army in the First World War: Canadian Expeditionary Force, 1914-1919* (Ottawa: Queen's Printer, 1962), 535.

³ "Random Integer Generator," *Random.org* <<http://www.random.org/integers/>> (accessed December 5th, 2011).

⁴ The database, which is searchable by first and last name, regimental number(s), letters and sequences of letters, or by browsing through in 50-name intervals, can be visited here: <<http://www.collectionscanada.gc.ca/databases/cef/index-e.html>>

sample from a master list of all known CEF personnel records, then order each box (theoretically, up to 384 or more) containing a soldier's service records. Since LAC restricts the number of boxes an individual researcher can order each day, and the files themselves are extensive, such an approach would have posed significant financial and logistical challenges that would have made the project impracticable.

The use of already digitized files was an expedient, albeit imperfect alternative to this far more costly method of research. For several years LAC has digitized CEF service records through its client request service, allowing interested patrons to order electronic copies of a particular soldier's file. The digitized records are then made available to the public as a PDF document accessible through the "Soldiers of the First World War: 1914-1918" database. Since the digitized files represent an imperfect sample of the broader set of records, a number of considerations were necessary in order to ensure that the personnel files drawn were appropriate for the study but also sufficiently random. Soldiers who died during their wartime service, for example, were automatically excluded because this study is concerned principally with the rehabilitation and reintegration of veterans.⁵ A total of 57 were identified in the original sample, all of which were replaced by selecting the next closest alphabetic entry in the master-list who had survived the war.

⁵ This includes soldiers that were killed in action, died of their injuries prior to 11 November 1918, or died of illness/disease, irrespective of theatre. 51,748 of these were soldiers and nursing sisters killed in action or who died of their wounds, while 7796 died of disease or injury in other circumstances. Canada's Books of Remembrance list the total as 66,755, but these figures take in to account over 7000 soldiers who either died in other services outside the CEF, or passed away between 11 November 1918 and 30 April 1922, regardless of whether their death was deemed attributable to service. Because this study considers soldiers who survived the war to its chronological end, or were discharged prior to its conclusion, I have relied exclusively on Nicholson's statistics when calculating statistics based on surviving members of the CEF. See G.W.L. Nicholson, 535; Tim Cook, *Shock Troops: Canadians Fighting the Great War, 1917-1918* (Toronto: Viking, 2008), 612, 618-19

Deserters and defaulters were ineligible for veterans' benefits after the war and were likewise removed from the original sample (22 cases total) using the same method described above. Most cases involved an individual who had enlisted but did not report for duty; rarely were there cases of desertion overseas or after a period of lengthy service. According to Department of National Defence statistics on the Military Service Act (MSA), there were 24,139 'un-apprehended defaulters' between 29 August 1917 and 11 November 1918 in addition to several thousand deserters, bringing the total to around 28,000.⁶ The total number of desertions for the whole war is unknown.

Further revisions were necessary to maintain the integrity of the sample. As research into the personnel records progressed, a disproportionate number of sample group members (23 in total) were identified as soldiers of No. 2 Construction Battalion, Canada's lone all-black unit in the First World War. The battalion was formed in July 1916 and grew to a total of 603 members before being reorganized into a large labour company of 500 men after arriving in England in April 1917.⁷ Because the presence of these cases would have skewed the composition of the sample, a decision was made to replace all but three soldiers.

In total 79 cases—roughly 20.6 per cent of the original sample—were replaced. Though not purely representative, the final sample was one that offered the most practical means of compiling relevant data and eliminating biases identified within the digitized collection of records.

⁶ Nicholson, 352, 551.

⁷ James W. St.G. Walker, "Race and Recruitment in World War I: Enlistment of Visible Minorities in the Canadian Expeditionary Force," *Canadian Historical Review* 70, no. 1 (1989): 18.

III. MEASURING THE VALIDITY OF THE SAMPLE GROUP

How do we know what constitutes a ‘representative sample’ of CEF personnel? After all, no historian has completed a comprehensive demographic study of the Canadian army in the First World War. The few attempts that have been made, primarily by historians seeking to shed light on provincial and regional patterns of enlistment, rely on data from an ambitious statistical profile of the CEF compiled by the Department of Militia and Defence in 1927.⁸ While a significant statistical achievement for the department’s Historical Section, the profile was not without shortcomings.⁹ Researchers utilized the Hollerith punch card system to tabulate information from 23 categories contained on Canadian attestation records, including age, religion, occupation, birthplace, marital status, and physique from over 600,000 enlistees.¹⁰ One glaring omission was pre-war residence, an essential piece of data missing from attestation papers issued before late 1915. By the time revised attestation papers were introduced, more than 200,000 men had already enlisted.¹¹ A number of other factors also compromised the accuracy of the findings. Date of birth, for example, was notoriously unreliable because it was commonplace for enlistees to lie about their age, while in other cases, many men simply

⁸ An abbreviated version of the study’s findings is reproduced in the appendices of Desmond Morton, *When Your Number’s Up: The Canadian Soldier in the First World War* (Toronto: Random House, 1993).

⁹ Jonathan F. Vance, “Provincial Patterns of Enlistment in the Canadian Expeditionary Force,” *Canadian Military History* 17, no. 2 (Spring 2008): 75-76.

¹⁰ Morton, *When Your Number’s Up*, 277-79.

¹¹ Vance, “Provincial Patterns of Enlistment,” 78.

did not know their actual birth year.¹² Attestation papers, likewise, did not keep track of key identifiers of ethnicity, including race and language spoken. The closest information we have encompasses physical attributes such as hair, eye colour, and ‘complexion,’ but most often recruiting officers would use these to identify visible minorities. As a result, we can only speculate as to the ethnicity of select subjects because, as with most demographic aspects of the CEF, authoritative aggregate data is not available.

Having established just how tenuous this data is, it is of little use to expend great effort examining every characteristic of the enlistees contained in this sample or comparing their records to the findings of the general population. However, since the sample group for this dissertation was drawn from a body of records that only represents a small portion of the CEF, diligence must be taken to identify any significant demographic or experiential anomalies outside of the acceptable margin of error, even if these observations are based on our present, limited understanding of the CEF and those who served in it. In other words, we need to see if the sample has roughly the same traits as the Canadian army in the First World War, and furthermore, identify how any anomalies might affect the outcome of this study and why they exist.

1. Nationality/Ethnicity

The sample group was comprised primarily of male Anglophone enlistees born in the British Isles or Canada, the dominant ethnic and national background of soldiers in

¹² It is important to remember that few official documents beyond a birth certificate or census records would have been available to confirm birth date. Compounding the problem for recruitment officers was that a substantial number of enlistees were born outside of Canada and would not have access to such records.

the CEF.¹³ French Canadians were the second largest group, but proved difficult to identify. Because most attestation papers, personnel files, and any available pension records are written in English, a combination of four variables was used to determine if a soldier could be considered Francophone. The first was geographic location, which was determined by place of birth, pre-war residence, and post-war residence. The second was the language in the personnel files and pension files: if any correspondence was found in French, there was a high probability that the veteran was Francophone. The third took into account the enlistment date and whether or not they were drafted under the Military Service Act. Finally, surnames and given names of the veteran were also examined. Using this method it was determined that roughly 9 per cent of the sample ($n=34$) was likely Francophone.

Since attestation papers do not account for ethnicity or language, there are no readily available statistics on the number of Francophones who served in the CEF. A number of secondary sources suggest that roughly 15,000 volunteers who enlisted between August 1914 and August 1917 were from French Canada, and upwards of half of these men enlisted in places other than Québec. The number conscripted under the MSA may have been as high as 15,000 from all parts of Canada.¹⁴ This would indicate a theoretical total of 30,000, or roughly 5 per cent of the CEF's service strength. Although statistics are available for soldiers who died based on province of birth, there are no

¹³ 2834 nursing sisters also served in the CEF. The sample group contains one nurse.

¹⁴ Estimates are drawn from multiple sources. See "Appendix 1: The Number of French Canadians in the Canadian Expeditionary Forces," in Elizabeth H. Armstrong, *The Crisis of Quebec, 1914-18* (New York: Columbia University Press, 1937), 247-49. Nicholson, 351-52 and Appendix E, "Enlistment in the Canadian Expeditionary Force," Morton, *When Your Number's Up*, 277-79,

reliable figures on the number of French Canadians who died in the war. Consequently, it is impossible to determine how many French Canadians would have survived to become veterans.¹⁵

In addition to the Francophone soldiers, the sample contains a number of recruits born outside of Canada or the British Empire, including the United States, Finland, Austria, Argentina, France, Italy, and Denmark. There were at least 18 American recruits (4.7 per cent) in the sample.¹⁶ A total of five cases were identified as aboriginals. Three black soldiers were also present within the sample. Existing research suggests that approximately 3500 aboriginals and 1200 black soldiers served in the Canadian Expeditionary Force during the war, comprising 0.6 per cent and 0.2 per cent of the CEF's total strength respectively.¹⁷

2. *Wartime Experience*

The more reliable data with which to test the validity of the sample concerns wartime experience. Official statistics on theatre of deployment, conscription, and non-fatal casualties are worth exploring to further assess the sample's representativeness.

The sample for this study contains 300 CEF members (78.1 per cent) who served outside Canada during the war. Of these soldiers, 292 served in Europe, six with the

¹⁵ Christopher A. Sharpe, "Enlistment in the Canadian Expeditionary Force, 1914-1918: A Regional Analysis," *Journal of Canadian Studies* 18, no. 4 (1983-84): 26.

¹⁶ Calculations only take into account enlistees born in the United States. According to the statistical profile of the CEF compiled by Militia and Defence, only 1.0% of the CEF was American-born. See Morton, *When Your Number's Up*, 278

¹⁷ Tim Winegard, *For King and Kanata: Canadian Indians and the First World War* (Winnipeg: University of Manitoba Press, 2012). On aboriginal recruitment see Katharine McGowan, "'In the interest of the Indians': The Department of Indian Affairs, Charles Cooke, and the Recruitment of Native Men in Southern Ontario for the Canadian Expeditionary Force, 1916," *Ontario History* 102 (2010): 109-25. On black enlistments, see Walker, 21, note 66.

Siberian Expeditionary Force (SEF), and two with the Canadian Army Medical Corps (CAMC) contingent in Salonika. According to G.W.L. Nicholson's statistics in the CEF official history, of 619,636 enlistees 424,589 (68.5 per cent) served overseas at some point during the war, while 195,047 (31.5 per cent) served in Canada only.¹⁸ Roughly 345,000 (55.7 per cent) of these men and women served in France or Belgium during the war. The rate for the sample was 65.1 per cent ($n=250$).

This overrepresentation of overseas troops may appear as an anomaly that discredits the sample, but it is crucial to remember that the raw statistics cannot speak for themselves. Even with data obtained from the nominal rolls of combat units and official statistics on casualties (which can be broken down by branch of service), we still have very little definitive information about how many soldiers were experienced actual 'battlefield conditions,' the frequency of this exposure, or the relationship between combat exposure and incidence of illness/injury in comparison to men in units behind front lines or in other theatres. Such questions were simply not a part of the Department of Militia and Defence Historical Section's agenda when official statistics were compiled after the war for A.F. Duguid's ambitious multi-volume official history of the Canadian army or Sir Andrew Macphail's history of the CAMC. It is safe to assume that infantry invariably suffered more battle-related casualties than their counterparts in other branches of the army such as the artillery, forestry corps, or medical corps.¹⁹ However, as Chapter 1 illustrates, service in a non-infantry unit by no means precluded a soldier from being exposed to the unsanitary conditions of a battlefield, stray shellfire, or contact with enemy

¹⁸ Duguid, xv.

¹⁹ Tim Cook, *Shock Troops*, 613.

troops, all of which may have negatively impacted their health. Put simply, without a lengthy, systematic analysis of each soldier's time in a theatre of combat, and a similar body of quantitative data to weigh it against, it is impossible to determine if the overrepresentation of soldiers that served in France/Belgium in this sample group has obscured the results of the study as a whole. Furthermore, one must recognize that service in Canada, England or a non-combat environment was not devoid of risk. Training accidents were common, illnesses from outdoor exposure frequent, and diseases emanating from soldiers' sordid escapades presented a significant drain on military manpower and medical resources. These realities make it difficult for the historian to establish, quantitatively speaking, what the 'norm' of experience was for a soldier any given theatre.

A comparison of volunteers and conscripts can also suggest the representative quality of this sample and its limitation. According to statistics compiled by the Department of Militia and Defence, 124,588 men, or 20.1 per cent of the total strength of the CEF during the war, were conscripted under the Military Service Act.²⁰ In all, 67 individuals (17.4 per cent) in the sample group were found to be conscripts. Between August 1917 and 11 November 1918 some 47,509 conscripts were deployed overseas, with 24,132 taken on strength in France/Belgium.²¹ Of the conscripts in the sample group,

²⁰ Nicholson, Appendix E, 551. Of these 124,588 men taken on strength of the CEF, only 108,288 were available for active service after reporting for duty and proceeding through training. 8637 of these were discharged for various reasons prior to 11 November 1918. All statistics are drawn from figures compiled by the Department of Militia and Defence (differing figures are included in the appendix from the Department of Justice).

²¹ This number is an approximation made by G.W.L. Nicholson based on the regimental numbers issued to conscripts in wartime. Typically, although not always, the regimental numbers of MSA conscripts were in the 3,000,000-4,000,000 series. See Nicholson, 351 and Appendix E.

24 (35.8 per cent) served overseas: 15 in France/Belgium, eight in England, and one in Siberia. There is an overrepresentation in the sample of conscripts who saw service in France compared to Canada or England.

Finally, medical statistics also deserve some comment. In theory, figures on casualties and hospitalizations provide a valuable means of testing the validity of this sample group against the experience of the men in the CEF who were hospitalized during the war. But further investigation into the statistics available in official histories reveals a number of insurmountable barriers to achieving this end. We can easily compare the number of non-fatal casualties (both combat-related and non-combat) to the number of soldiers hospitalized in the sample group as follows:

CEF non-fatal casualties:	30.9% (<i>n</i> =172,950) ²²
SG hospitalizations / treatment received:	66.7% (<i>n</i> =256)

In addition, we can break down the data further and compare casualty rates for combat-related injuries/illnesses between the CEF and the sample group:

CEF non-fatal battlefield casualties:	24.67% (<i>n</i> =138,166)
SG hospitalized for combat-related injury/illness:	33.07% (<i>n</i> =127) ²³

While the first set of figures appear to show a significant disparity between the sample group and the general population of the CEF, when compared against the second set of statistics, it becomes clear that the manner in which official statistics on casualties were rationalized and compiled by the Historical Section poses some problems. Since many

²² Nicholson, Appendix C. Expressed as a percentage of total CEF members who survived the war (560,000 approximately).

²³ Calculated by accounting for injuries or illnesses typically incurred in battlefield conditions, including gassings, GSWs, shell shock/neurasthenia, trench fever/PUO, broken bones, trench feet, and contusions.

soldiers were hospitalized or received treatment for minor illnesses or pre-existing conditions unrelated to combat, it is probable that far more soldiers came in contact with army medical personnel from Canadian and non-Canadian units than the official statistics suggest. For example, in soldiers' personnel records it is fairly common to find marginally-noted admissions to casualty clearing stations, divisional rest areas, or stationary hospitals for a range of conditions including contusions, sprains, digestive issues, myalgia, or other disorders that were not directly related to combat, and in some cases, may have pre-dated enlistment. In other instances, the diagnosis of the injury/illness may be noted, but no record of hospitalization or treatment is present, suggesting that a non-Canadian unit may have administered treatment to the patient. Not all Canadian casualties were treated by the CAMC, nor did the CAMC exclusively treat Canadian casualties.²⁴ Because military medicine was a collaborative effort between allied medical services, it is impossible to calculate how many Canadian soldiers received treatment in wartime and how frequently these interactions occurred. The casualty figures can illustrate at a general level how many soldiers were hospitalized as a result of battle, but the nature of treatment, and the significant anomaly presented by the information gained from the sample group, raises questions about the accuracy of official statistics.

From the data presented in the preceding analysis we have a few metrics with which to measure the validity of this sample. First, we know that there is an overrepresentation of soldiers who served overseas and, based on battle casualty figures

²⁴ In total the CAMC treated 761,635 cases during the war in all theatres. Of 539,690 admissions to overseas hospitals, 144,606 were battle casualties and 395,084 illnesses or disease. The total admissions in Canada were 221,954. See Macphail, 243-46.

and the number of conscripts who saw service in Belgium/France, a minor overrepresentation of soldiers taken on strength in continental Europe as well. This is symptomatic of user-generated online records databases. The sample, for instance, included many individuals who received decorations including two Victoria Cross winners. Moreover, with the increasing public interest in ‘family history’ it is not surprising that relatives of a soldier who served overseas would be more compelled to request service records in comparison to the descendants of a rural conscript or overage volunteer who had never left Canadian soil.

Demographic information revealed that there is also a larger proportion of non-Anglo Canadians in the sample, including Francophone and American-born recruits, than probably existed in the CEF. This may also be a result of a series of client-requests, as was the case with the men of No. 2 Construction Battalion. Finally, it was also discovered that a higher proportion of sample group members were hospitalized as a result of combat, although the severity and long term impact of these injuries or illnesses is difficult to quantify.

Were these sample biases significant enough to impact the trajectory and outcome of this study? Evidence from the preceding analysis, and this dissertation as a whole, suggests likely not. Indeed, the effort to test the reliability of the sample resulted in an unanticipated but vital questioning of the official data and its inherent weaknesses. As should be expected of a sample derived from a user-generated online database, the subjects of this study are not a mirror image of the population of the CEF. Experientially and demographically they are unique. But we cannot automatically assume that there is a

direct correlation between the incidence of post-war disability and exposure to combat conditions. If anything is clear from a comparison of the sample to the generally accepted statistics on Canada's experience in the First World War, it is that there is still much more work that needs to be done to broaden our understanding of the CEF's demographics, and especially, the medical experiences of ordinary soldiers. How can we truly know how many Canadians were hospitalized and the nature of these hospitalizations if our knowledge of Canada's medical experience at war is founded primarily on the "incomplete statistics" presented in Macphail's official history of the CAMC?²⁵ To what extent can raw data on casualties by unit, date, location, and by nature of injury be relied upon? What is needed then, is a robust and penetrating study into every aspect of a soldier's time in service, using service records as the primary means of data collection, in the same fashion as the wartime component of this dissertation. A recent decision by Library and Archives Canada to digitize the entirety of Canada's First World War military service records by the end of 2015 presents a magnificent opportunity for historians seeking to penetrate deeper in to the social and medical history of Canada's Great War.

At a more fundamental level we must also understand that the prevalence of disability in the post-war years was a complex by-product of wartime service, pre-enlistment health, and post-war lifestyle. Canada's lax recruiting standards for much of the war contributed significantly to the number of soldiers claiming that their service had exacerbated pre-existing conditions, while a soldier who had received a significant

²⁵ Cook, *Shock Troops*, 618.

gunshot wound to an extremity but worked in a clerical position may have lived the rest of his life with the injury acting as a mere nuisance rather than a significant handicap.

As this dissertation also illustrates, prevailing medical discourse and time of application affected whether authorities accepted or rejected claims for compensation. Attitudes towards citizenship, masculinity, and class often played a significant role. But, importantly, actual situations in which the disability occurred could clarify matters. Soldiers suffering from shell shock or tuberculosis were less likely to have their disabilities recognized as attributable to service, while victims of gunshot wounds or musculoskeletal injuries were far more likely to obtain a pension, however meagre. A soldier's service records were fundamental in determining whether they received a pension. If no mention was made of an injury or illness that could be tied to a soldier's post-war disability, it was almost universally true that no benefits would be granted. Bureaucracy, ideology, and contingency played an equal if not more significant role in deciding a soldier's pensionability.

IV. THE CASE FILES

The two principal sets of records—the service files of Canadian military personnel held in RG 150 (Overseas Military Force of Canada) and the VAC pension records—require some elaboration in order to explain their function in the study. Each set of records offers a wealth of information on the wartime and post-war lives of Canada's veterans, their kin, the role of medical professionals, and intersection of public and private worlds via state administration. Despite the range of opportunities to explore the social history of war that are offered by military case files, few historians have taken

advantage of them.²⁶ Service files, while rich in content, have been underutilized in most social or medical histories of the First World War in favour of the abundance of official reports, war diaries, and personal writings of participants. Similarly, few historians have utilized First World War pension records in a quantitative fashion, and none in a manner that would allow for a comprehensive study of veterans in the post-war period.²⁷ The dearth of research on these files is surprising given the success that other social historians have demonstrated in studies of crime and criminality, labour, medicine, and the asylum that rely extensively on case files as their source base.²⁸

The absence of case file research on the First World War in the Canadian context is explained by two factors. Neither collection of records was accessible until the 1990s. Pension records are still subject to the provisions of the Access to Privacy and Information Acts (ATIP). Broader historiographical factors have also played a role. As outlined in the introduction of this dissertation, most recent historians of war and medicine have been preoccupied with exploring the public discourse surrounding health and the male body or the long-term socio-cultural ramifications of war disability. In doing

²⁶ See Mark Osborne Humphries, "The Treatment of Evacuated War Neuroses Casualties in the Canadian Expeditionary Force, 1914-1919" (MA Thesis, Wilfrid Laurier University, 2005); Humphries with Kellen Kurschinski, "Rest, Relax, and Get Well: A Reconceptualisation of Great War Shell Shock Treatment," *War & Society (Australia)* 27, no. 2 (October 2008): 89-110.

²⁷ Studies that incorporate First World War pension files in a qualitative capacity include Marina Larsson, *Shattered Anzacs: Living with the Scars of War* (Sydney: University of New South Wales Press, 2009). For a quantitative study of psychological trauma using pension files see Edgar Jones, Ian Palmer and Simon Wessely, "War Pensions (1900-1945): Changing Models of Psychological Understanding," *British Journal of Psychiatry* 180, no. 4 (2002): 374-79. Research by Jones, Palmer and Wessely only utilizes statistics available on pension records from the British National Archives and does not examine any of the files in detail.

²⁸ On the role of case files in the history of crime and criminality, see John Weaver, *Crimes, Constables, and Courts: Order and Transgression in a Canadian City, 1816-1970* (Montréal and Kingston: McGill-Queen's University Press, 1995). The most comprehensive Canadian account of historical case file research is Wendy Mitchinson and Franca Iacovetta, eds., *On the Case: Explorations in Social History* (Toronto: University of Toronto Press, 1998).

so, historians have added a valuable dimension to our understanding of the Great War, but ‘representation’ has taken precedence over uncovering hard quantitative and qualitative evidence on events that unfolded on the ground, both on and off of the battlefield. A central objective of this dissertation is to remedy this gap in our understanding of war and health, and as such, the case files have taken a leading role.

In order to gain a better understanding of how the war impacted a veteran’s health, it was essential to first examine their personnel records for information on wartime service. Typically ranging between 50 and 60 pages, these files provide a detailed account of a soldier’s life in uniform from enlistment to discharge. They include attestation and discharge papers, medical examinations, accounts of movements to and from units and theatres of operation, pay sheets, and, if applicable, hospital records, citations for meritorious actions, and disciplinary proceedings. The records, unfortunately, are poorly organized, and in some cases may only include minor details on hospitalizations or treatment. A single line on a hospital card or medical history sheet is common, even for severe injuries. In some cases, medical boards also failed to provide a prognosis for soldiers discharged from the CEF as ‘medically unfit.’ Although such contextual details are often missing, the files are still a valuable source of information on the wartime experiences of Canada’s veterans.

The lesser-known and more sophisticated case files are the First World War pension records managed by Veterans Affairs Canada. These extraordinary documents are unlike any other available to historians today. The most detailed provide insight on the life paths of Canadian servicemen and their families from youth until death, a span of

up to 70 years. A multitude of perspectives are contained within them, including those of pension authorities, physicians, voluntary organizations, family members, co-workers, fellow veterans, members of their community, and, of course, the veterans themselves. The vast majority reveal a great deal about the complexity of the private lives of these men and their families, and their evolving relationships between the state and civil society. Some files are purely administrative and often document a soldier's brief interaction with veterans' authorities (such as a failed pension application), however, a majority of the files utilized for this study were at least 200 pages in length, and some as long as a thousand.

Only three significant studies have utilized these files: a BA thesis written by Michael Wert and corresponding article in the journal *Canadian Military History*, and most recently, a 2009 MA thesis written by Chelsea Clark.²⁹ This limited use is due both to the relative obscurity of the records, and the strict protocols in place to protect veterans' personal information. It is for this express reason that pseudonyms have been utilized throughout this study and effort has been taken to ensure that no veteran's surviving kin could be identified. The one exception is the case of William Harry Jennings, a soldier whose letters are available through the Canadian Letters and Images Project website (www.canadianletters.ca), who died in 1925.

²⁹ See Michael Wert, "From Enlistment to the Grave: A Case Study of the 34th Battalion's Experience with the Great War" (BA Thesis: Wilfrid Laurier University, 1990) and "From Enlistment to the Grave: The Impact of the First World War on 52 Canadian Soldiers," *Canadian Military History* 9, no. 2 (Spring 2000): 43-58. Also see Chelsea Clark, "Not Attributable to Service: First World War Veterans' 'Second Battle' with the Canadian Pension System" (MA Thesis: University of Calgary, 2009).

In all, 189 pension records were obtained for members of the sample group—a return rate of 49.2 per cent. Several other files were collected for their intrigue and are incorporated throughout the study in qualitative fashion. Each ‘pension record’ typically consists of two separate sets of files. The first are the Head Office (HO) files, which include pension rulings and appeals, benefit and program inquiries, correspondence between veterans’ authorities, department investigations, and death records. These files are currently held at the head records office in Charlottetown, PEI. The second set of records are the Regional Office (RO) files, which contain similar material to the HO files, but also include detailed treatment records, correspondence between the veteran (or a party on their behalf) and the regional office, retraining files, as well as War Veterans Allowance (WVA) investigations and reports. The RO files are scattered across Canada and housed in various repositories under the jurisdiction of regional VAC branches.

There is no ‘standard’ pension record, but experience working with the files has shown that they tend to fall into one of four categories.³⁰ The first are short HO/RO files, usually spanning no more than 10 pages, which most often contain a failed application for a pension or retraining made shortly after discharge. The original copies of these files have mostly been destroyed with only a microform copy remaining. The second category are longer microform files, which sometimes correspond to an additional set of paper records, but more commonly represent a ‘bare bones’ account of a veteran’s interactions with the state. Most commonly these are HO files that deal exclusively with pension

³⁰ Not every client record contains both RO and HO files. For instance, no regional files exist for veterans living outside of Canada. In some cases a veteran may only have a HO file or RO file depending on the nature of the case and if the records were retained after their death.

proceedings, rulings, and appeals. They also frequently include War Veterans Allowance reports and death records as well.

The third variety is the most complex and most enlightening for the purpose of this study. Nearly a third of the records obtained for the sample group were a combination of substantial RO and HO files, which on average span several hundred pages, but in a few instances reached over a thousand in length. They contain all of the standard medical and pension application forms, correspondence, detailed home investigations by department staff, treatment records, and in certain cases, lengthy appeal proceedings from a pension tribunal or other appeal body. The size of these files is relative to how long the veteran or his dependents lived and maintained a relationship with the state. This is especially true of veterans who survived well in to the post-1945 period, a time when bureaucracy of the Department of Veterans Affairs grew considerably.

The fourth variety is the troubling ‘incomplete files.’ Principally, this category encompasses cases where portions of or an entire RO or HO file (or both) has gone missing or was purposefully destroyed by the department. In some cases remnants of a HO file (including microform copies) will still be intact, but the more detailed RO file will be missing or destroyed. More problematic are instances where a soldier *should* have had pension records based on available medical data and discharge medical board proceedings retained in his CEF service record. As many as 14 soldiers in the sample group were discharged with a substantial disability but had no corresponding pension record. While it is possible that these soldiers did not pursue a pension (though this is highly unlikely) one would expect their treatment records to still be intact if the files had

not been tampered with. Unfortunately, it is impossible to determine just how many records have been lost.³¹

V. COLLECTING THE DATA

1. The Service Records

In order to link post-war health and wartime service, each soldier's personnel file was systematically analyzed and specific variables were extracted to begin the process of assembling the dataset. For the purpose of this chapter only the most important variables that help shed light on the post-war health of veterans are explained in detail. The two most significant are 'Instances of Hospitalization' and 'Disabilities at Discharge.' The former takes into account all recorded hospital visits noted in a soldier's service records, while the latter represents the final diagnosis given by an army medical board before a soldier was discharged from the CEF. A general overview of all major variables for which data was extracted is available in Appendix III, though not all have been used in this study.

It is first important to note that data in the Instances of Hospitalization category cannot account for all injuries or illnesses soldiers experienced. As explained in Chapter 1, during the war it was commonplace for soldiers with minor ailments to be treated without records being kept, particularly in mass casualty scenarios and near the front lines. Nevertheless, most personnel records allow a researcher to document a soldier's health and medical history in rough chronological order by simply following medical case

³¹ The British National Archives have preserved a 2 per cent sample of their own records, which amounts to 22,756 case files. Further information on the extent of the British records can be found here: <http://www.nationalarchives.gov.uk/records/research-guides/first-world-war-pensions.htm>.

sheets, hospital cards, or casualty forms. Determining exactly when, where, and how long a soldier was hospitalized, however, is a different matter. Although an injury/illness may have been noted in the records, it was not always possible to discern where it originated, nor are treatment details always available. Consequently, exact dates of hospitalization have not been tabulated for this study. Treatment methods, including surgeries, prophylactics, bed rest, physical therapy, and drug therapy, etc. were also omitted.

Identifying the true nature of a soldier's injury or illness also proved challenging. During the Great War military physicians tended to use standardized or interchangeable terms that did not precisely describe the nature of the patient's hospitalization. For instance, 'GSW' (gunshot wound) was often used interchangeably with 'SW' (shrapnel wound), making it difficult to discern whether a soldier was hospitalized as a result of a bullet, shell fragment, or shrapnel wound.³² Other conditions such as anklyosis, rheumatism or myalgia could be used as a common label for the same functional condition, but may be used inconsistently throughout a soldier's medical case sheets and medical board forms. War neuroses and associated 'nervous disorders' posed similar problems for standardization. Again, this was in part a result of interchangeable terminology, but also reflective of the dynamism of symptoms over a short period of time

³² It is important to note difference between shell fragments and shrapnel, the former being pieces of a shell casing and the latter the lead balls commonly contained within an artillery shell. While shrapnel injuries from shell bursts were much more common, shell fragments could be much more devastating because of their size and contorted shape.

and the professional viewpoint of the attending physician.³³ The ‘language of trauma’ presents a formidable diagnostic challenge. Take for instance two somatic illnesses like disordered action of the heart (DAH) and valvular disease of the heart (VDH). During the Great War both were used interchangeably, and additionally, were convenient somatic labels for ‘nervous’ casualties. In some cases, DAH or VDH would genuinely manifest itself as a chronic heart condition (most often arteriosclerotic heart disease) after the war, but due to each disorder’s association with ‘shell shock,’ neurasthenia, and other euphemisms for war trauma in the medical discourse of the period, a correct diagnosis cannot be fully known based on the service records alone. We must therefore treat the diagnosis as it was understood at the time and retain the original label. In sum, we cannot ‘second guess’ or attempt to correct labels where the medical etymology is of such significance.

To simplify the data collection process and eliminate confusion when coding for the database (explained later in this essay), a list of standardized, final diagnoses from medical board case sheets or other hospital records were used wherever possible. For instance, if a soldier was hospitalized for multiple shrapnel wounds to a leg and it was labelled ‘GSW left thigh, calf, and foot,’ the injury was modified to ‘GSW left leg.’ In a case where a soldier was first diagnosed ‘Pyrexia Unknown Origin’ (PUO) or ‘Pyrexia NYD (Not Yet Diagnosed)’ and later changed to ‘Trench Fever,’ the latter appears as the

³³ On the diagnosis and subjectivity of war neuroses in the First World War see Peter Leese, *Shell Shock: Traumatic Neurosis and the British Soldiers of the First World War* (New York: Palgrave Macmillan, 2002); Paul Lerner, *Hysterical Men: War, Psychiatry, and the Politics of Trauma in Germany, 1890-1930* (Ithaca: Cornell University Press, 2003), and Humphries with Kurschinski, 89-110. Some of the diagnostic complications were the result of General Sir Douglas Haig’s 1916 order that ‘Shell Shock’ be removed from all army medical terminology.

entry in the database. In more complex scenarios where a soldier contracted a related or unrelated illness/injury—influenza or a form of venereal disease being the two most common while under treatment—an additional entry was made under the same hospitalization variable. This process of compression allows each illness or injury—especially those affecting an isolated area of the body—to be treated as a single value that can be measured across multiple variables. As an example, the modified diagnosis for the multiple GSW to ‘GSW left leg’ allows the data to be measured by both a broad variable for all GSWs, or a more targeted one for all leg injuries both GSW and non-GSW. In another example, instances of influenza or pneumonia which were later changed to chronic bronchitis during the same period of hospitalization allow the data to be collapsed into respiratory disorders as opposed to immune disorders, where the two former illnesses would be placed. Such an approach offers maximum flexibility when examining the frequency distribution of different classes of injury or illness.

Other coding decisions require clarification too, especially decisions about the compression of values for the four variables that describe a soldier’s medical condition at discharge: Reason for Final Discharge, Disabilities at Discharge, Relationship of Disability to Service, and Prognosis of Disability. Prior to discharge, a member of the forces would appear before a medical board at least once if he served in Canada, and twice—once in England, and once in Canada—if he saw overseas service. It was at these medical boards where military physicians assessed a soldier’s overall physical condition, ranked them according to the rating scale (found in Appendix IV), and made final recommendations for discharge. Rather than using the A-E scale of classification, most

discharge papers indicate that a soldier was struck off the strength of the forces due to one of ‘Demobilization,’ ‘Medically/Physically Unfit,’ ‘Undesirable,’ ‘Overage,’ or ‘Underage.’³⁴ In rare cases, soldiers were also discharged after transferring to another arm of the Imperial Forces or the Royal Flying Corps. All information on a soldier’s condition at discharge has been compressed to fit these basic categories.

If a soldier was discharged ‘Medically Unfit,’ his disability would normally be indicated in a separate medical board report produced after his return to Canada.³⁵ Like hospitalizations, disabilities required manipulation for the purpose of compression and improve the flexibility of the data when coding and categorizing. Unlike injuries noted for each instance of hospitalization, medical boards would commonly indicate the nature of the disability—i.e. the functional implications of the injury—rather than the principal cause on a soldier’s final medical report. So, for instance, a CEF member who received a ‘GSW left leg’ could have his disability at discharge labelled ‘Weakness of left knee’ or ‘Partial loss of function of left leg.’ The functional disability, in each case, is ostensibly the same, but the description is different. More complicated cases, such as a soldier who suffered from chronic bronchitis from a gassing, or one who was discharged with ‘Debility’ as the result of trench fever or nephritis may not have the direct cause noted. In order to track both the nature of the disability and its physical or mental consequences, two separate pieces of data were kept: the functional disability (if applicable), and if

³⁴ ‘Undesirable’ was also used interchangeably with ‘Not Likely to Become Efficient,’ a euphemism for soldiers who could not pass the physical or mental rigors of their basic training following enlistment.

³⁵ Desmond Morton, “‘Kicking and Complaining’: Demobilization Riots in the Canadian Expeditionary Force, 1918-1919,” *Canadian Historical Review* 61, no. 3 (1980): 334-60. Some soldiers that grew impatient with the process of demobilization chose to waive their free passage to Canada and apply for discharge in England. For these soldiers only one set of medical board files exists.

known, the cause inserted in brackets. Where no information was available, or if the soldier was not previously hospitalized for an injury/illness connected to the disability, the condition at discharge is all that is noted—i.e. ‘GSW left leg,’ ‘Neurasthenia,’ or ‘Myalgia.’ In addition, the attributability and prognosis of each disability is also accounted for under separate variables if the information was available.

2. The Pension Files

The most onerous research task for this dissertation was sifting through the thousands of pages of pension records, determining the appropriate variables to define, and extracting pieces of information that could best contribute to our understanding of veterans’ health between 1915 and 1944. After perusing the files a decision was made to establish six categories of variables for analysis: retraining, post-war employment history, hospitalizations, pension awards, War Veterans Allowance awards, and circumstances surrounding death. The final category goes beyond the chronological scope of the study and includes any death information available from a veteran’s pension file, CEF service record, or in a few rare cases, newspaper obituaries.³⁶ After examining official statistics and factoring in how certain cases (such as TB patients) might affect the overall shape of the data, hospitalizations were omitted from the study. Employment also proved to be a challenge since veterans’ authorities were not obliged to track the employment status of a veteran and many incomplete files led to incomplete information, particularly surrounding the dates during which a particular occupation was held.

³⁶ A significant number of CEF service records include an official DVA death notification or otherwise have the soldier’s date of death marked indicated in red ink within the first few pages of each file.

Pensions variables required the most care in order to establish rules and methods of compression that would allow a veteran's award status and health to be tracked over the span of several decades. One of the first data collection challenges to consider was how to best capture and quantify the physical extent and material impact of a disability. Canadian pension regulations for veterans of the Great War were established by order-in-council in 1914 and awarded based on a four-class scale ranging from 25 per cent (or less) to 100 per cent (see Appendix IV), then increased to a five-class scale separated by increments of 20 per cent in 1915. In 1917 pension regulations were revised once more and a new, more comprehensive twenty-class pension rating system was introduced. Under the new scale, awards were based on five per cent increments with a one-time gratuity available for any disability totalling less than five per cent. Between 1914 and 1944, pension rates and supplements for dependents increased several times, with multiple revisions to the Pension Act (1919) impacting eligibility criteria and level of compensation.³⁷ Because of the evolving and complex character of Canada's pension system, as well as the fluidity of compensation based on a pensioner's familial circumstances and overall health, a decision was made early in the data collection process to omit the monetary value of pension awards. Incorporating such data would have required that other complicating factors such as dependents' allowances, suspensions while under treatment in hospital or after failing to submit documentation on time, overpayments, adjustments for retroactive awards, and so forth be accounted for. A more

³⁷ For a concise history of Canada's pension system and the evolution of the Board of Pension Commissioners see Desmond Morton, "Resisting the Pension Evil: Bureaucracy, Democracy, and the Board of Pension Commissioners, 1916-33," *Canadian Historical Review* 68, no. 2 (1987): 200-24.

streamlined approach was thus adopted to keep track of pension awards using these following core variables (see Appendix III for all pension variables):

- **Disability Pension Application:** the disabilities for which the original pension application was made.
- **Pensionable Disabilities:** disabilities for which the original application was awarded.
- **Non-Pensionable Disabilities:** includes disabilities rejected upon initial application and, if the award was successful, all rejected disabilities during the tenure of the award.
- **Pension Decision Effective:** the date the original pension award became active or, if unavailable/rejected, the applicable BPC/CPC ruling date.
- **Extent of Disability:** The assessed rate of disability expressed as a percentage, if given.³⁸
- **Extent of Pensionable Disability:** the attributable rate of disability expressed as a percentage, if given.
- **Rate Change Date:** date of changes to pension award or assessment of extent of disablement by BPC/CPC medical examiners.
- **New Disabilities Upon Reassessment:** additional disabilities that were added to the pension award.
- **Extent of Disability Upon Reassessment:** includes any increase or decrease in disability assessment, expressed as a percentage.
- **Extent of Pensionable Disability Upon Reassessment:** includes any increase or decrease in pension rate, expressed as a percentage.
- **Pension Termination Date:** date pension award was terminated (does not include instances where pension was terminated and then re-activated with retroactive compensation).

³⁸ In cases where no disability was found, or the disability was not attributable/aggravated by service, pension medical examiners would often neglect to assess the degree of impairment or inaccurately express it as 'nil.'

- **Reason for Pension Termination:** cause of pension termination, includes death, gratuity in lieu of pension, disability no longer present/otherwise ineligible

To identify and standardize the myriad of disabilities for which ex-servicemen sought compensation, the same approach for medical diagnoses in the service records was utilized for pension medical data. For instance, a soldier who applied to receive a pension for a gunshot wound to the left leg would have the entry in the database labelled ‘Partial loss of function of left leg (GSW)’ if the description of the functional disability was originally given on his pension medical examination. Likewise, a case of Chronic Bronchitis that resulted from a gassing would be labelled ‘Chronic Bronchitis (Gas).’ Where the cause of the disability was unknown, or if it was a pre-existing condition that was exacerbated by service, no causal relationship was noted. If no functional disability was provided, the final diagnosis on the pension medical examination was used.

Identifying the trajectory and nature of pension applications was the most difficult aspect of the research process. Under Canada’s pension regulations any soldier who was honourably discharged from the CEF was eligible for a disability pension provided that he could prove, through medical evidence, that his affliction was directly attributable or aggravated by service in any theatre. A significant number of veterans applied for a pension at least once. If unsuccessful, an applicant could appeal the decision of the Board of Pension Commissioners/Canadian Pension Commission (BPC/CPC), most commonly through a review by the Pension Tribunal, or if unsuccessful there, through an appearance before the Federal Appeal Board/Pension Appeal Court.³⁹ Successful applications may

³⁹ In 1933 the Pension Tribunal was disbanded.

have been awarded upon first application, after review initiated by one of the above authorities, or upon medical review at a later date. In the latter two cases, pensions would typically be awarded retroactively, either from the date that the disability was first diagnosed, or up to six months prior to the initial application. Cases where a veteran applied for a pension, received an award, and had few complications in the administration of their pension benefits were rare after 1919.

To eliminate confusion and compress the data so that rejected and accepted applications could be tracked chronologically, a few simple rules were used to determine dates and the status of a pension application. First, if an application was successful, and the veteran received identifiable monetary compensation, all pension variables were tabulated for this specific pension award under the broad label ‘Pension Ruling 1’ until the time that the award was terminated. If a veteran received an award increase/decrease, or if a new disability was discovered that affected his pension rate, the date was noted and the new rate tabulated. As a result, the author was able to chart pension award rates for individual cases and the entire sample over the course of several decades (see for example Figure 2.6 in Appendix II: Statistical Appendix).

For rejected pension applications, only the first available BPC/CPC ruling date is used. This applies even if the veteran made subsequent applications or appeals for the same disability. The appeal process, which included multiple stages over a lengthy period of time (sometimes years), was simply too complex to quantify. If a veteran was successful in an appeal to the Pension Tribunal or the Federal Appeal Board/Pension Appeal Court, however, the decision date or date that a retroactive award became

effective was indicated as the beginning of the pension award and the original rejection date negated. In these rare scenarios the same data collection rules apply as in other successful applications. Likewise, if the appeal was denied, the original BCP/CPC ruling date (i.e. when the application was first rejected) was retained. In instances where a veteran applied for a new pension for a disability that had not previously been accepted for a pension award, a new string of variables under ‘Pension Ruling #2’ (or in some cases #3) was begun.

A key variable, Relation of Disability to Service (its ‘attributability’), was typically expressed in four ways in the pension records: No Disability, Not Attributable/Aggravated by Service, Aggravated by Service, and Attributable to Service. While in most cases it was possible to identify these rulings in an original pension application, it was much more challenging to find the relevant information on BPC/CPC rulings for disabilities subsequently added to the pension award. ‘New’ disabilities discovered during a routine examination would be forwarded to the commissioners for a decision, the ruling for which would later be noted on a soldier’s pension award case sheets. Most commonly these rulings appear as either “(Disability name), I.D.S.” for a successful award, or “(Disability name), not granted.” I.D.S.—sometimes also expressed as ‘I.O.A.S.’—stands for ‘Incurred During Service.’⁴⁰ In either case the specifics of attributability are not discernible, and consequently, it was decided to omit this data for disabilities added to the pension award.

⁴⁰ The latter stands for ‘Incurred on Active Service.’

Pensions that were awarded retroactively either due to error during a medical assessment or ruling, commutation, or a discontinuation (the latter two being the most common) presented another compression challenge. Would it benefit the dissertation to indicate when and why a pension was discontinued? How would this impact the coherence of the data when trying to examine the trajectory of pension awards over the course of several years? If a pension was cancelled and then reinstated it was probable that the veteran had continued to suffer from a disability despite receiving no compensation. Retroactive awards, though rare, were generally granted for the entire period between the date that a veteran's pension was cancelled and then reinstated. To chart the course of the sample group's post-war health, the entire period that a veteran was considered 'pensionable' needed to be considered. Therefore, when a veteran's pension was awarded, cancelled, and reinstated, the original award date was kept in the database. In rare situations where a pension was awarded, cancelled, and retroactive benefits were granted beginning on a date different from the cancellation date the BPC/CPC ruling date or, if available, the date the retroactive pension award became effective was noted in the database. For the purpose of organization these rare cases were treated as a separate Pension Ruling with a new string of variables, even though the disability may have been the same.

These variables—especially pension rates and pensioned disabilities—allow one to assess the shifting course of a veteran's health and wellbeing over the span of his post-war life. Moreover, since pension compensation rates remained relatively stable after 1920 with only minor increases, it is also possible to use this data to calculate the base

pension for a soldier at any given date. These rates can then be combined with employment history and weighted against consumer price indexes and cost of living to make general observations about living conditions and quality of life. Statistics on the number of pensioners, hospitalizations, WVA applications, pension appeals, and more can also be compared against statistics found in annual government reports and elsewhere.

V. CODING AND USING THE DATA

The data contained in the sample group is intended to supplement and expand our understanding of current research on Canada's re-establishment efforts and veterans' programs in the post-war period. This study employs a 'bottom-up' approach that connects soldiers' wartime experiences to their post-war lives by linking the two sets of case files. In order to compile and manipulate the information referred to throughout this chapter, statistical software was needed, principally a Microsoft Excel master database to store the information and a corresponding SPSS dataset manipulate and analyze the data. In order to achieve this a complex coding system needed to be rationalized and organized from scratch for use with IBM's SPSS statistical analysis program. The first phase involved identifying the most useful variables that were extracted from the case files, while the second involved standardizing and labelling each attribute (value) or piece of non-numerical data that would fall under these variables. As previously noted, injuries or illness incurred during the war were standardized to best reflect the nature of the injury, and in the case of disabilities at discharge or on a pension application, the origins of the disability and functional implications.

This process of compression was necessary to retain as much information about the disability as possible while streamlining the coding process for SPSS. In practice, ‘Partial loss of function of right leg (GSW)’ was coded exactly the same as ‘GSW right leg.’ Similarly, ‘Debility from VDH’ and ‘VDH’ were coded identically. In effect, the functional description and the cause of the disability/disorder were combined. Once again, at the outset a decision had to be made about the level of detail to include and what would need to be sacrificed during compression. It was decided that it would be more useful to quantify the medical condition as a whole rather than the described symptoms.

Coding was extended to all information that was not numerical in its original form. The majority of the research carried out for in this portion of the study required some manipulation and compression in order to make the coding process feasible and ensure that a single piece of data such as an injury, location, or occupation could be easily expressed as a value for a particular variable. Using this method we can determine, for example, how many conscripts received favourable pension rulings, the distribution of pension awards based on province or city veterans settled in after the war, or the relationship between length of service and rate of pension applications.

VI. CONCLUSION

Open-access digital archives present an opportunity to gather, categorize, and analyze a wealth of data on countless historical subjects. LAC’s service files database for soldiers of the Great War made the approach taken in this study feasible, but it also imposed a number of methodological complications that required intervention and manipulation. Compression and coding for the purpose of statistical analysis, as just

discussed, involved modifying the raw historical information obtained from the CEF service records and veterans' pension files into something that could be easily quantified and examined. At times, this process required a priori judgements about what historical information would be important. In other words, the historical inquiry was not one that fell into place through pure empiricism: the chips had to be sorted rather than letting them fall freely. The sample group can reveal much about the certain aspects of the veterans' experience in the post-war years but it cannot stand on its own. Official statistics and representative qualitative examples are thus used throughout the dissertation to further elaborate on the findings derived from the sample. Stories of veterans, their hardships, successes, and day-to-day experiences living with the physical and mental legacies of their service, have been incorporated wherever possible. These narratives drawn from the case files add a complex human dimension to official reports, statistics, government publications, periodicals and other traditional sources that also inform this study. This unique combination of qualitative and quantitative research has enhanced our understanding of the Great War, the state, medicine, and the lives of individuals.

Appendix II: Statistical Appendix

OVERVIEW

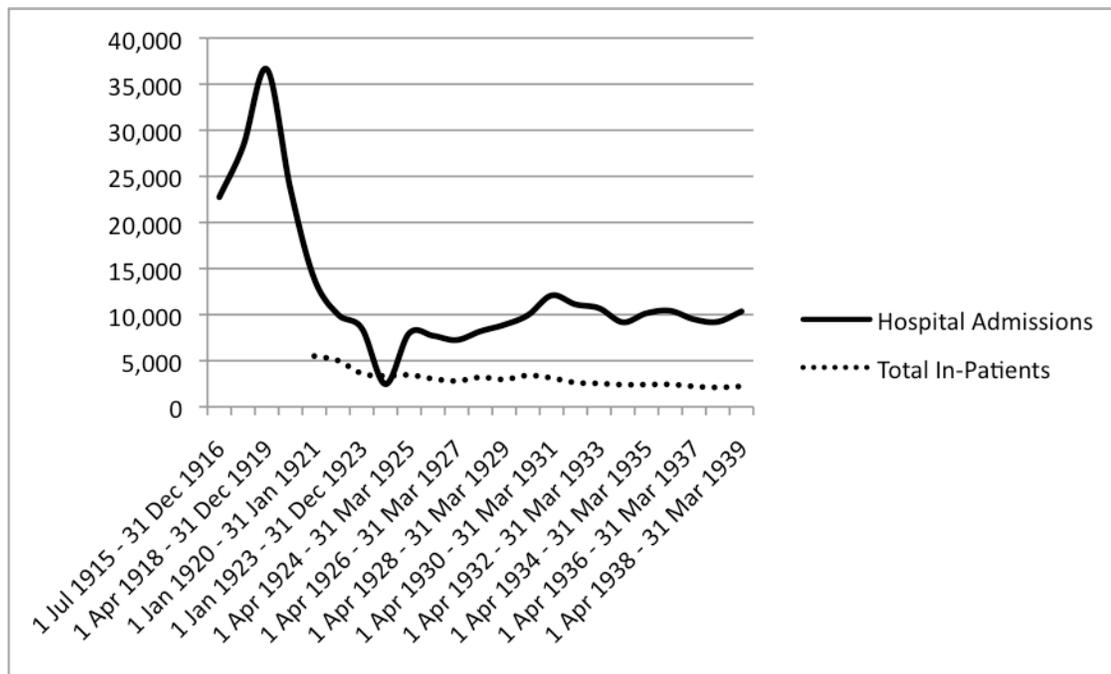
The tables and figures presented in the following appendix offer a partial statistical summary of the activities of Canadian medical, rehabilitation, and pension authorities from 1915 to 1944. The majority of the data contained herein has been derived from various tables and statistical returns printed in parliamentary committee reports, and especially the annual reports of the Board of Pension Commissioners and Canadian Pension Commission. General citations are provided below each table.

Many tables and figures contain information that has been calculated or extrapolated from published statistics. Every effort has been made to ensure that these calculations are accurate to the best of the author's ability. A close observation of the records, however, shows that occasional inconsistencies in official figures occur due to human error. Slight alterations in the scope and meaning of particular categories of enumeration such as disability classification may also affect the representativeness of some statistics. Accordingly, the tables and figures compiled in this appendix—and corresponding statistics cited in this dissertation—should be viewed as a work of scholarly synthesis rather than an exact reproduction of the historical record.

For ease of reference, the appendix is organized into three sections. Section 1 covers medical statistics collected by military and civilian authorities during and after the war. Section 2 presents a summary of activities related to pensioning from 1915 to 1944. Section 3 pertains to vocational retraining and the training outcomes of members of the sample group.

Section I: Medical Statistics (Tables and Figures)

FIGURE 1.1 – ANNUAL HOSPITAL ADMISSIONS AND IN-PATIENTS TREATED, 1 JULY 1915 – 31 MARCH 1939



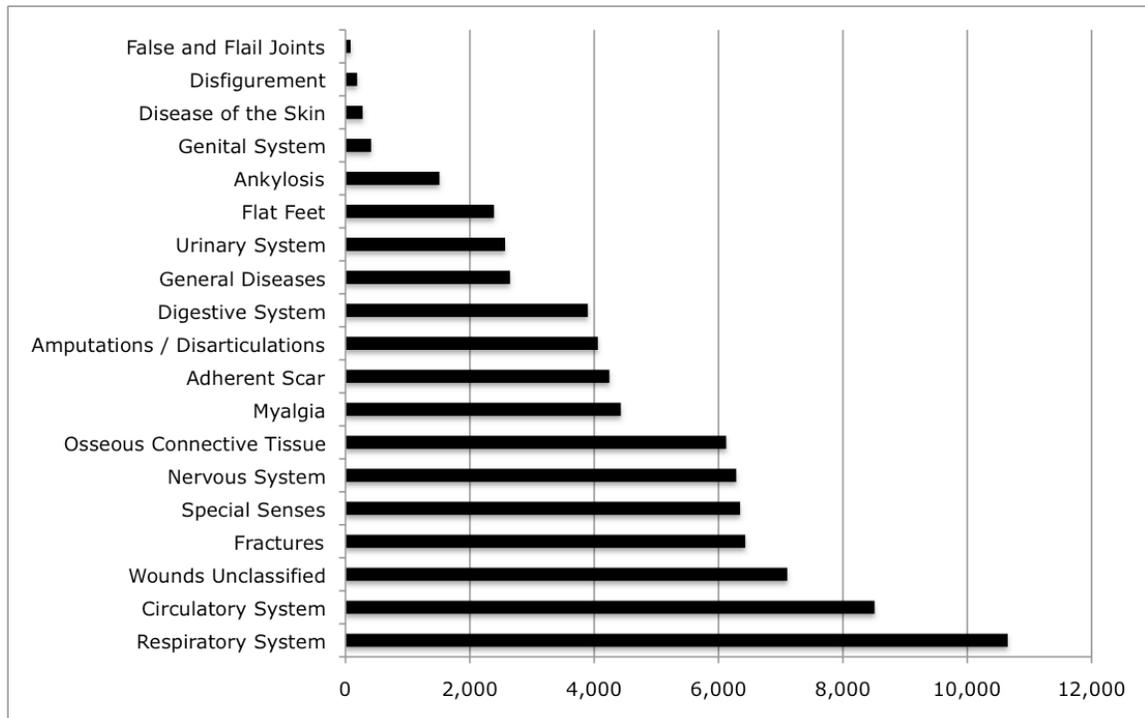
Source: *Annual Reports of the Department of Soldiers' Civil Re-establishment Department of Pensions and National Health, 1919-39.*

Note: In 1925 the Medical Branch of the Department of Soldiers' Civil Re-establishment began tabulating hospital admissions and patient strength based on the fiscal rather than calendar year. The steep downward curve in the line, based on the general trend, would likely reflect a decline in 800-1000 patients at most. Statistics on the total number of patients treated, rather than admissions, is not easily identifiable in the years prior to 1921.

Section II: Pension and Benefits Statistics (Tables and Figures)

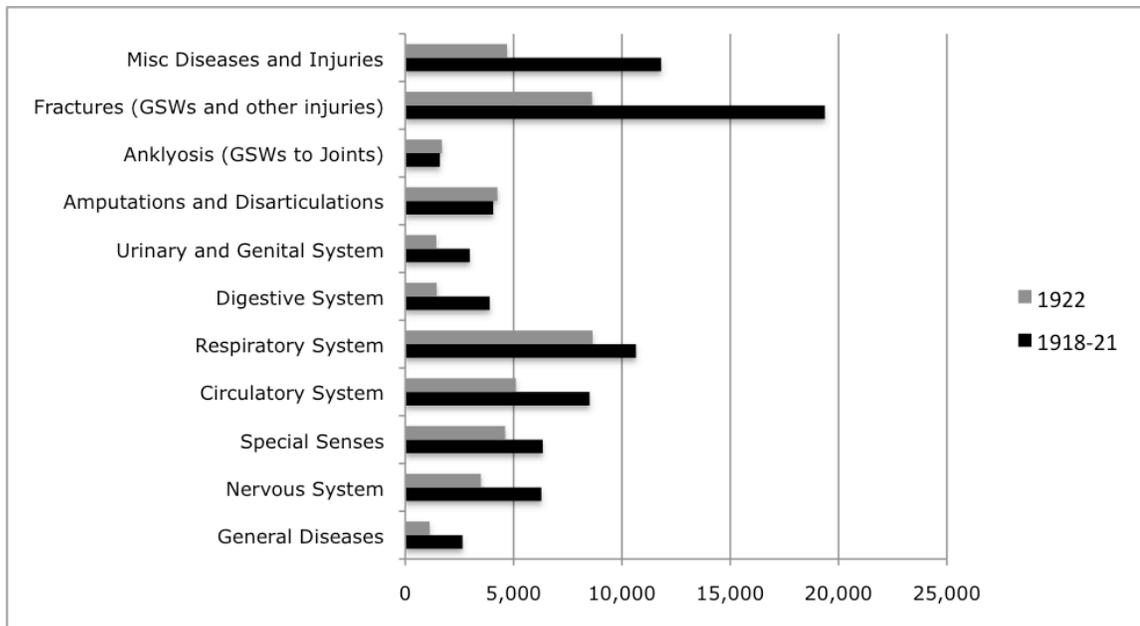
I. FIGURES

FIGURE 2.1 – DISABILITY PENSIONS AWARDED BASED ON OFFICIAL NOMENCLATURE UP TO 31 MARCH 1921



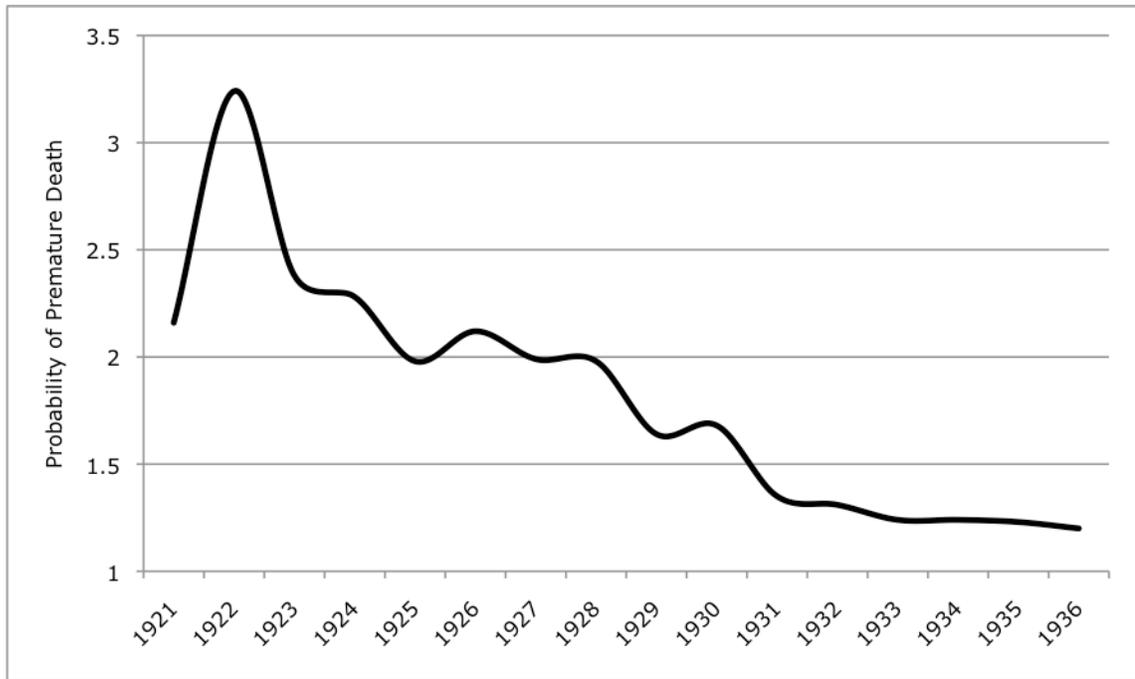
Source: Report of the Work of the Board of Pension Commissioners (Ottawa: King's Printer, 1921). Hereafter cited as BPC Report.

FIGURE 2.2 – DECLINE IN PENSIONED DISABILITIES BY CATEGORY, 1918-22



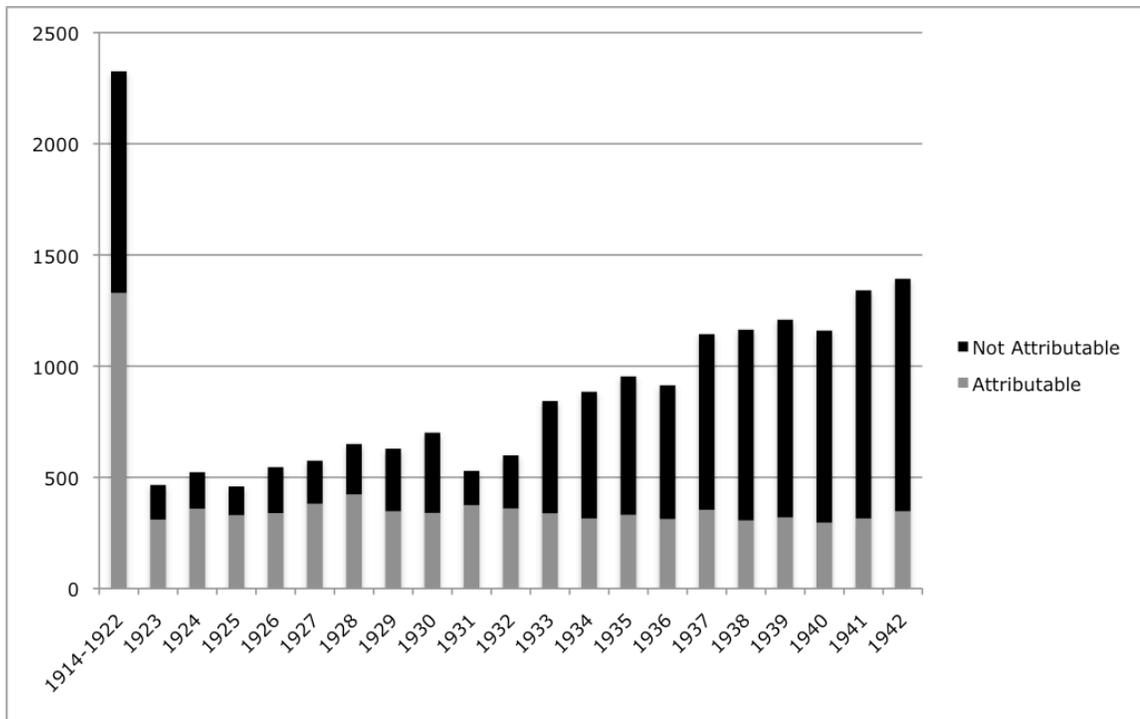
Source: BPC Reports, 1921-22.

FIGURE 2.3 – PROBABILITY OF PREMATURE DEATH AMONGST PENSIONER POPULATION
BASED ON CANADIAN LIFE TABLES, 1921-36



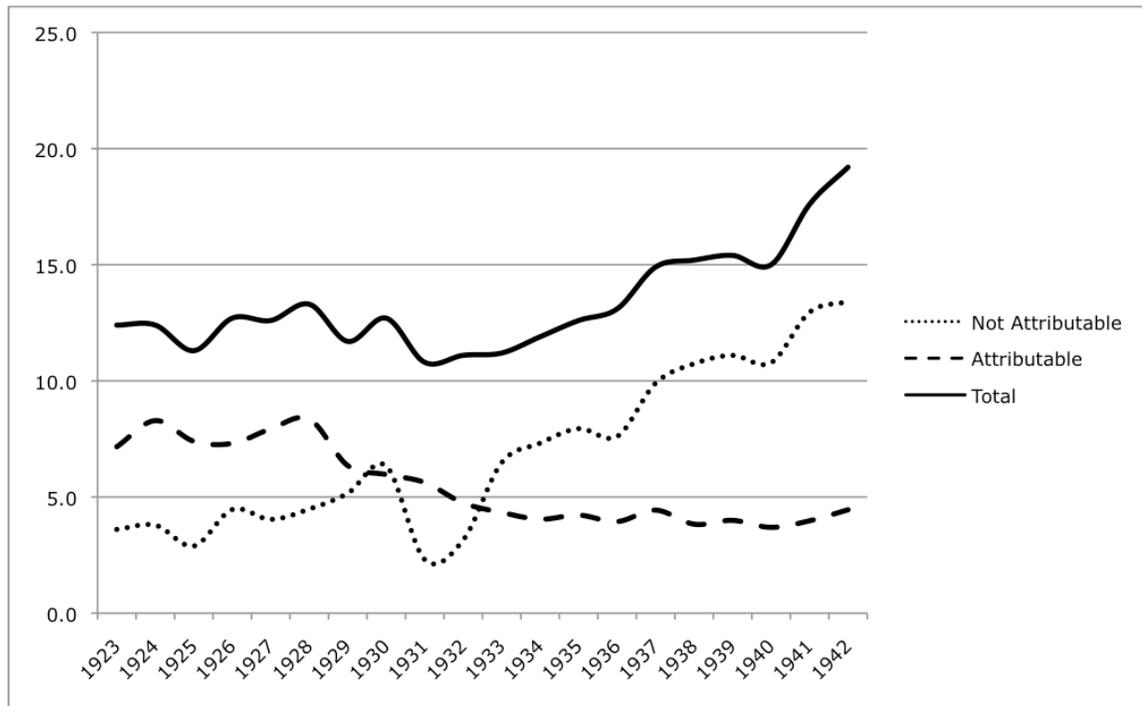
Source: F.S. Burke, "Death Among War Pensioners," *Canadian Medical Association Journal* 29, no. 11 (November 1939): 457-465.

FIGURE 2.4 – PENSIONER DEATHS BY ATTRIBUTABILITY, 1914-42



Source: BPC and DPNH Reports, 1921-1942.

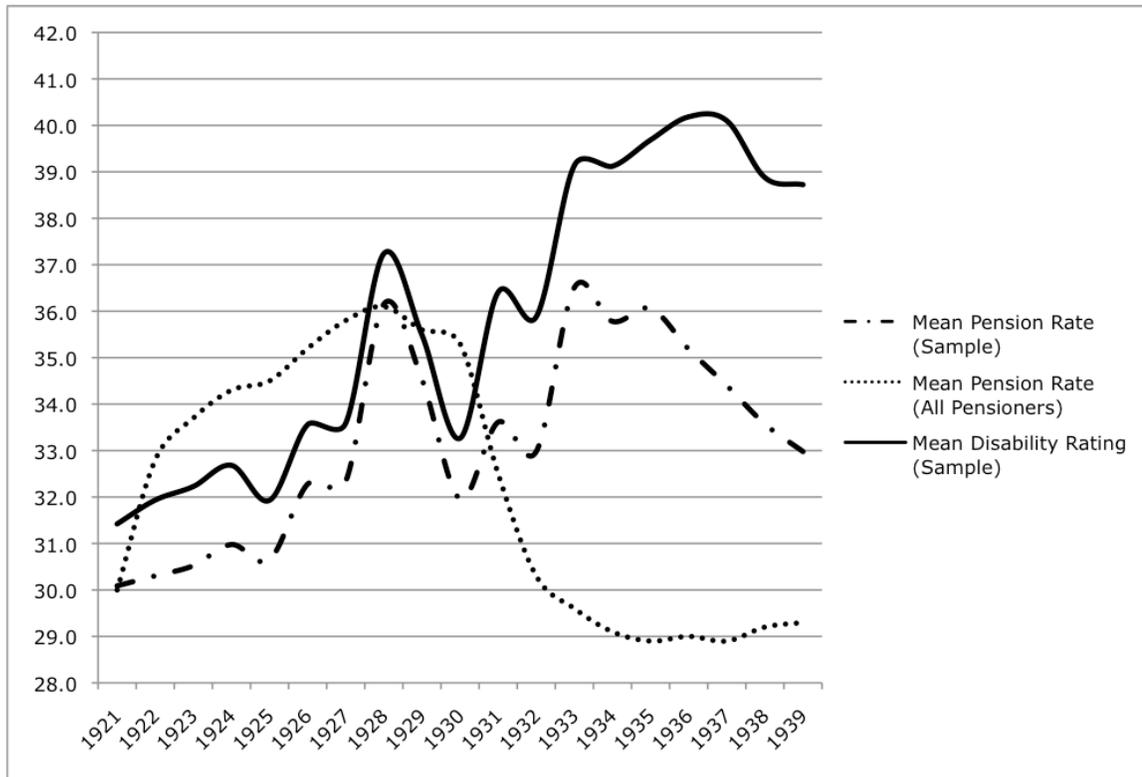
FIGURE 2.5 – MORTALITY PER THOUSAND PENSIONERS, 1923-42



Source: BPC and DPNH Reports, 1923-42

Note: 1923 is the first year where official statistics allow for the measurement of the ratio of deaths amongst active pensioners. The sudden decline of deaths ruled 'not attributable' between 1930 and 1933 reflects legislative changes which took place in 1930 that contributed to a backlog in rulings. Several hundred outstanding cases were resolved in the years that followed. The total does not necessarily reflect the exact number of pensioners that died each year, but rather the number of cases submitted to pension authorities for consideration. Over this period an average of 62 cases remained unresolved at the end of each fiscal year (31 March).

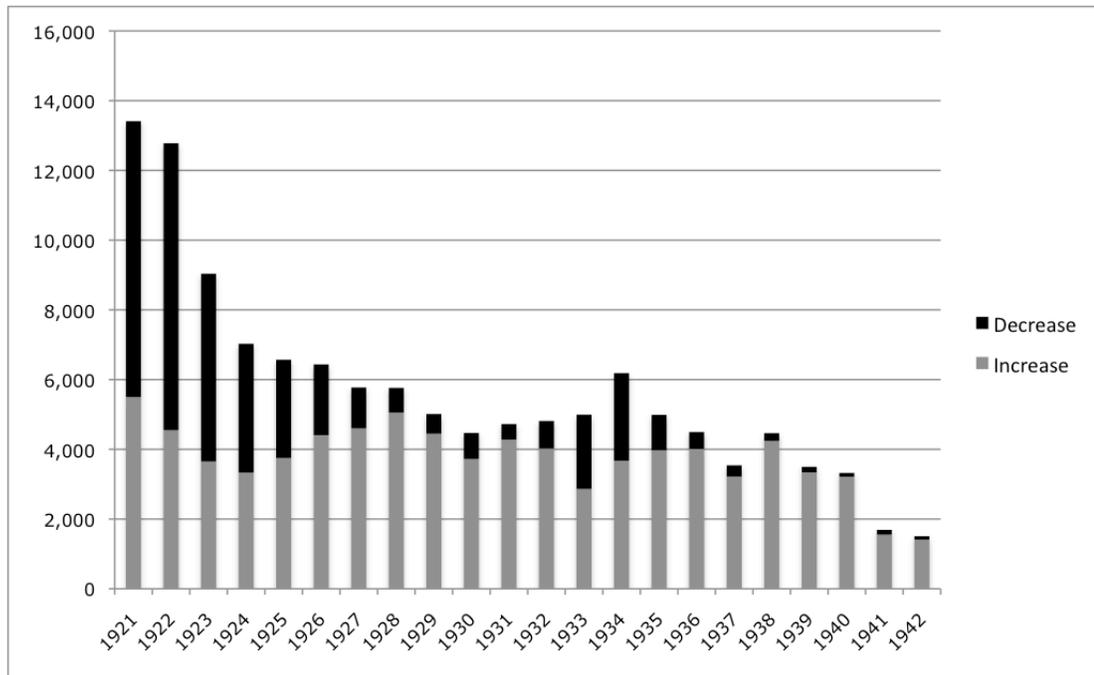
FIGURE 2.6 – MEAN DISABILITY PENSION AWARDS HELD BY SAMPLE GROUP AND ALL PENSIONERS, 1921-39



Source: BPC and DPNH Reports, 1921-39, and dissertation sample group.

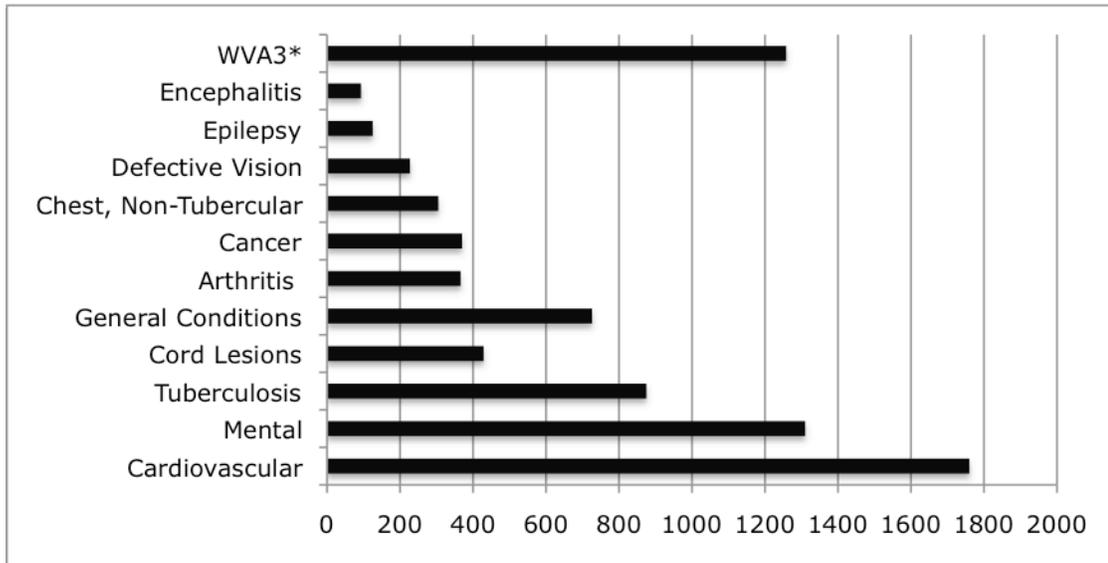
Note: The 'Mean Disability Rating' is the assessed rate of disability upon medical examination, rather than the actual class of pension award a veteran held.

FIGURE 2.7 – PENSION AWARD INCREASES AND DECREASES, 1921-42



Source: BPC and DPNH Reports, 1921-42.

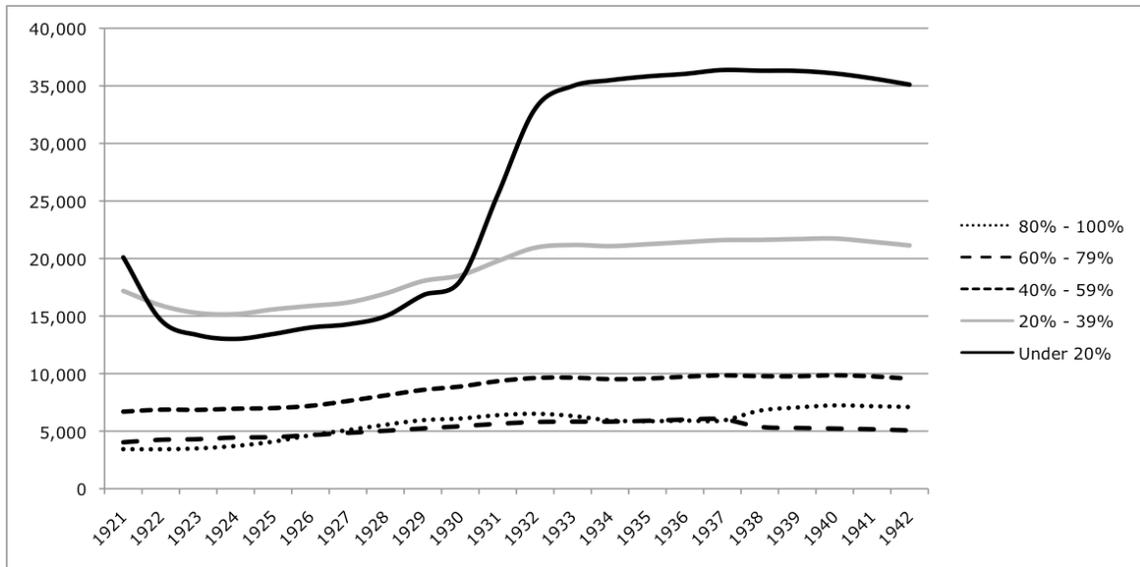
FIGURE 2.8 – MEDICAL CLASSIFICATION OF WAR VETERANS ALLOWANCE RECIPIENTS UNDER 60 YEARS OF AGE, TO 31 MARCH 1938



Source: DPNH Report (1938), 86.

Note: The “WVA3” category included in this table is based on the 1936 legislation, rather than the 1938 amendment’s definition.

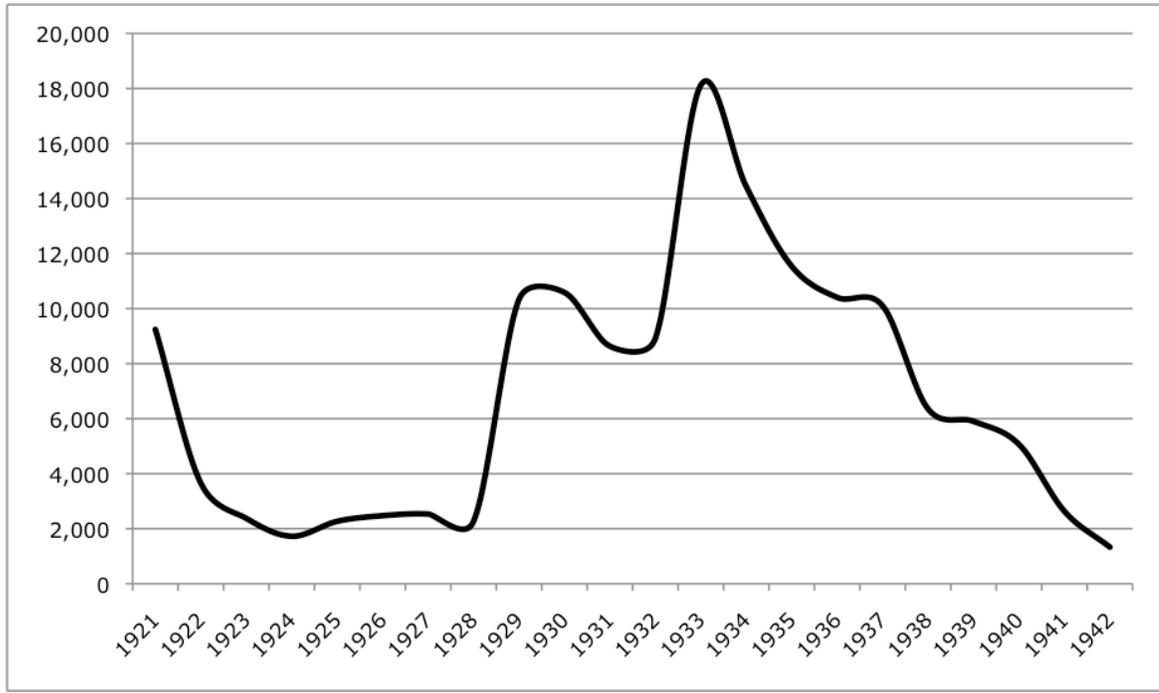
FIGURE 2.9 – DISABILITY PENSION RATE FLUCTUATION FOR WHOLE PENSIONER POPULATION, 1921-42



Source: BPC and DPNH Reports, 1921-42.

Note: The steep rise in awards under 20 per cent is due to the 1930 amendments to the Pension Act, which led to the reinstatement of several thousand pensions that had been commuted for a gratuity. The gradual rise in pensions of 80 per cent or more and corresponding decline of those between 60 and 79 per cent is in large part due to legislative changes that increased pensions for amputees by at least 5 per cent.

FIGURE 2.10 – TOTAL PENSION APPLICATIONS, 1921-42



Source: BPC and DPNH Reports, 1921-42.

Note: Steady increase includes re-applications/re-assessments of previously commuted disability pensions.

II. TABLES

TABLE 2.1 – DECLINE IN PENSIONED DISABILITIES BY CATEGORY, 1918-22

DISABILITY CLASSIFICATION	TOTAL PENSIONS AWARDED 1918 - 1921	AWARDS IN FORCE 1922
General Diseases	2647	1126
Nervous System	6285	3490
Special Senses	6347	4611
Circulatory System	8510	5105
Respiratory System	10,651	8646
Digestive System	3898	1451
Urinary and Genital System	2979	1431
Amputations and Disarticulations	4060	4255
Anklyosis (GSWs to Joints)	1594	1693
Fractures (GSWs and other injuries)	19,371	8624
Misc Diseases and Injuries	11,814	4701
Total	78,156	45,133

Source: BPC Reports, 1921-22.

TABLE 2.2 – ANNUAL PENSION APPLICATION RULINGS (EXCLUDING RE-INSTATEMENTS AND DISCONTINUATIONS), 1921-42

YEAR	REFUSALS	NEW AWARDS	TOTAL APPLICATIONS	SUCCESS RATE (%)
1921	3432	5811	9243	62.9%
1922	1761	1894	3655	51.8%
1923	1097	1278	2375	53.8%
1924	587	1140	1727	66.0%
1925	595	1673	2268	73.8%
1926	799	1674	2473	67.7%
1927	1090	1441	2531	56.9%
1928	440	1828	2268	80.6%
1929	7776	2557	10,333	24.7%
1930	8811	1774	10,585	16.8%
1931	5911	2722	8633	31.5%
1932	5823	3091	8914	34.7%
1933	16209	1912	18,121	10.6%
1934	13377	1058	14,435	7.3%
1935	10367	1170	11,537	10.1%
1936	9172	1233	10,405	11.9%
1937	8824	1273	10,097	12.6%
1938	5403	952	6355	15.0%
1939	4884	1018	5902	17.2%
1940	4140	924	5064	18.2%
1941	2276	357	2633	13.6%
1942	1115	215	1330	16.2%

Source: BPC and DPNH Reports, 1921-42.

TABLE 2.3 – ACTIVE DISABILITY AND DEPENDENT PENSION AWARDS, 1918 – 1942

YEAR	DEPENDENTS	DISABILITY	TOTAL	DEPENDENTS	DISABILITY	TOTAL
1918	10,488	15,335	25,823	\$4,168,602	\$3,105,126	\$7,273,728
1919	16,753	42,932	59,685	\$9,953,056	\$7,470,729	\$17,063,785
1920	17,823	69,203	87,026	\$10,841,170	\$14,335,118	\$25,176,288
1921	19,209	51,452	70,661	\$12,954,141	\$18,230,697	\$31,184,838
1922	19,606	45,133	64,739	\$12,687,237	\$17,991,535	\$30,678,772
1923	19,794	43,263	63,057	\$12,279,621	\$18,142,145	\$30,421,766
1924	19,971	43,300	63,271	\$12,037,843	\$18,787,206	\$30,825,049
1925	20,015	44,598	64,613	\$11,804,825	\$19,816,380	\$31,621,205
1926	20,005	46,385	66,390	\$11,608,530	\$21,456,941	\$33,065,471
1927	19,999	48,027	68,026	\$11,419,276	\$22,811,373	\$34,230,649
1928	19,975	50,635	70,610	\$11,209,351	\$24,374,502	\$35,583,853
1929	20,002	54,620	74,622	\$11,090,158	\$26,095,150	\$37,185,308
1930	19,644	56,996	76,640	\$10,742,518	\$27,059,992	\$37,802,510
1931	19,676	66,669	86,345	\$10,985,518	\$29,226,208	\$40,211,726
1932	19,308	75,878	95,186	\$10,859,806	\$30,998,571	\$41,858,377
1933	18,745	77,967	96,712	\$10,624,775	\$31,124,543	\$41,749,318
1934	18,236	77,855	96,091	\$10,339,971	\$30,453,454	\$40,793,425
1935	18,241	78,404	96,645	\$10,372,607	\$30,406,411	\$40,779,021
1936	18,175	79,124	97,299	\$10,381,121	\$30,473,353	\$40,854,474
1937	18,186	79,789	97,975	\$10,417,158	\$30,365,865	\$40,783,023
1938	18,105	79,876	97,981	\$10,411,095	\$30,270,960	\$40,682,055
1939	17,896	80,104	98,000	\$10,318,775	\$30,094,890	\$40,413,665
1940	18,177	80,133	98,310	\$10,610,292	\$29,845,959	\$40,456,252
1941	17,941	79,204	97,145	\$10,539,876	\$29,058,304	\$39,598,180
1942	17,730	77,971	95,701	\$10,484,192	\$28,194,697	\$38,697,159

Source: BPC and DPNH Reports, 1921-42.

TABLE 2.4 – ACTIVE DISABILITY PENSIONS BY CLASS, 1921-42

CLASS	1921	1922	1923	1924	1925	1926	1927	1928	1929	1930
Class 1 (100%)	2693	2435	2380	2488	2736	3089	3472	3813	4062	4159
Class 2 (95%)	15	18	15	16	27	33	37	39	43	45
Class 3 (90%)	118	155	197	208	221	277	284	320	374	365
Class 4 (85%)	52	92	94	104	113	143	173	183	190	199
Class 5 (80%)	559	729	819	901	990	1100	1128	1202	1288	1331
Class 6 (75%)	1177	1171	1074	1018	924	958	1296	1309	1372	1391
Class 7 (70%)	665	714	752	809	964	1533	1271	1319	1345	1385
Class 8 (65%)	800	848	847	845	823	516	521	524	529	540
Class 9 (60%)	1394	1516	1634	1775	1773	1648	1760	1881	1993	2111
Class 10 (55%)	178	190	226	220	211	228	242	268	299	319
Class 11 (50%)	2738	2738	2622	2559	2587	2954	3199	3441	3687	3834
Class 12 (45%)	534	539	555	573	579	600	642	676	710	761
Class 13 (40%)	3247	3401	3451	3600	3631	3421	3539	3718	3886	3964
Class 14 (35%)	1103	1047	1023	1077	1154	1210	1300	1443	1564	1597
Class 15 (30%)	2818	2883	3161	3352	3554	3724	3850	4002	4230	4358
Class 16 (25%)	4525	4249	3953	3839	3930	4055	4131	4335	4569	4695
Class 17 (20%)	8738	7750	7121	6900	6941	6891	6898	7177	7674	7882
Class 18 (15%)	9344	8010	7434	7201	7156	7195	7244	7409	8004	8393
Class 19 (10%)	7656	4719	4325	4255	4511	4854	4965	5215	5871	6372
Class 20 (5%)	3098	1929	1580	1560	1773	1956	2075	2361	2930	3295
Total	51,452	45,133	43,263	43,300	44,598	46,385	48,027	50,635	54,620	56,996

TABLE 2.4 (CONTINUED)

1931	1932	1933	1934	1935	1936	1937	1938	1939	1940	1941	1942
4382	4433	4165	3797	3765	3821	3856	3925	3972	4018	3900	3802
43	44	46	48	46	45	41	69	65	61	67	73
385	397	380	360	394	366	354	394	392	394	389	383
211	226	234	253	256	286	290	354	370	383	381	375
1370	1415	1500	1482	1403	1403	1385	2043	2263	2384	2434	2469
1408	1421	1422	1396	1379	1370	1364	916	810	756	757	744
1430	1467	1491	1504	1496	1495	1521	1599	1583	1546	1527	1506
566	600	607	609	637	683	705	463	450	444	432	430
2232	2308	2310	2322	2394	2456	2448	2397	2435	2480	2450	2382
340	365	391	404	418	434	458	473	480	486	474	457
4030	4167	4222	4154	4135	4202	4207	4104	4102	4385	4403	4362
809	840	868	859	894	965	1012	1019	1004	766	716	667
4163	4248	4171	4102	4124	4131	4169	4181	4184	4216	4166	4077
1705	1805	1846	1845	1900	1953	2013	2039	2055	2086	2075	2035
4559	4823	4911	4937	4970	5039	5096	5119	5141	5135	5041	4974
5021	5303	5303	5274	5286	5288	5309	5310	5318	5297	5231	5157
8489	9008	9114	9022	9086	9145	9182	9151	9176	9216	9109	8969
9145	9747	9908	9875	9844	9731	9704	9591	9497	9351	9213	9057
10,868	15,244	16,374	16,529	16,636	16,765	16,918	16,877	16,926	16,862	16,687	16,452
5513	8017	8704	9083	9341	9546	9757	9852	9881	9867	9752	9600
66,669	75,878	77,967	77,855	78,404	79,124	79,789	79,876	80,104	80,133	79,204	77,971

Source: BPC and DPNH Reports, 1921-42.

TABLE 2.5 – DISABILITY PENSIONS AWARDED ACCORDING TO OFFICIAL MEDICAL NOMENCLATURE, 1918-42

DISABILITY	1918 TO 1921	1922	1923	1924	1925	1926	1927	1928	1929	1930
General Diseases	2647	1126	765	624	656	640	645	672	688	3834
Nervous System	6285	3490	3384	3400	3600	3825	4036	4392	4810	2765
Special Senses	6347	4611	4517	4534	4704	4910	5031	5225	5476	4977
Circulatory System	8510	5105	4911	5090	5249	5462	5657	5998	6542	6574
Respiratory System	10,651	8646	8814	8934	9176	9452	9721	10,142	10,877	10,558
Digestive System	3898	1451	1298	1303	1373	1524	1623	1807	2115	1959
Urinary and Genital System	2979	1431	1334	1301	1292	1299	1324	1397	1480	1388
Amputations and Disarticulations	4060	4255	4224	4232	4119	4260	4310	4308	4336	3411
Anklyosis (GSWs to Joints)	1594	1693	1740	1723	1725	1702	1688	1676	1657	4028
Fractures (GSWs and other injuries)	19,371	8624	8363	8513	9012	9544	10,081	10,692	11,509	15,806
Misc Diseases and Injuries	11,814	4701	3833	3646	3692	3767	3911	4326	5130	1551
Venereal Diseases	0	0	0	0	0	0	0	0	0	145
Total	78,156	45,133	43,183	43,300	44,598	46,385	48,027	50,635	54,620	56,996

TABLE 2.5 (CONTINUED)

DISABILITY	1931	1932	1933	1934	1935	1936	1937	1938	1939	1940	1941	1942
General Diseases	4995	6086	6414	6476	6601	6714	6794	6841	6865	6870	6744	6599
Nervous System	3343	3912	4176	4223	4313	4401	4472	4485	4486	4471	4415	4346
Special Senses	5601	6197	6293	6227	6279	6330	6403	6403	6398	6401	6333	6216
Circulatory System	7542	8595	8785	8633	8717	8767	8808	8720	8683	8607	8456	8276
Respiratory System	11,502	12,491	12,696	12,657	12,652	12,699	12,708	12,625	12,533	12,450	12,234	11,987
Digestive System	2420	2922	3068	3066	3088	3117	3176	3197	3228	3260	3229	3177
Urinary and Genital System	1567	1809	1816	1775	1753	1755	1766	1756	1750	1737	1716	1677
Amputations and Disarticulations	3205	3197	2904	2770	2709	2652	2596	1827	1716	1639	1613	1588
Anklyosis (GSWs to Joints)	4957	5789	5976	5962	5959	6007	6070	6117	6174	6224	6179	6121
Fractures (GSWs and other injuries)	19,219	21,929	22,776	23,006	23,207	23,462	23,699	24,562	24,905	25,106	24,947	24,707
Misc Diseases and Injuries	2153	2762	2863	2844	2912	3013	3097	3148	3177	3190	3169	3119
Venereal Diseases	165	189	200	216	214	207	200	195	189	178	169	158
Total	66,669	75,878	77,967	77,855	78,404	79,124	79,789	79,876	80,104	80,133	79,204	77,971

Source: BPC and DPNH Reports, 1921-42

Note: The categories in the above table are a synthesis of broad medical categories utilized by pension officials throughout the inter-war years. Changing diagnostic criteria makes it difficult to utilize the exact categories.

TABLE 2.6 – WVA APPLICATIONS BY AWARD TYPE, 1930-44

YEAR	WVA1 AWARDS	WVA1 REJECTIONS	WVA1 APPLICATIONS	WVA1 SUCCESS RATE
1930-32	2,360	1,123	3,483	67.8%
1932-33	908	452	1,360	66.8%
1933-34	1,065	401	1,466	72.6%
1934-35	1,129	348	1,477	76.4%
1935-36	1,208	246	1,454	83.1%
1936-37	1,340	325	1,665	80.5%
1937-38	1,189	253	1,442	82.5%
1938-39	1,482	344	1,826	81.2%
1939-40	972	281	1,253	77.6%
1940-41	683	151	834	81.9%
1941-42	497	115	612	81.2%
Total	12,833	4,039	16,872	76.1%

TABLE 2.6 (CONTINUED)

YEAR	WVA2 AWARDS	WVA2 REJECTIONS	TOTAL APPLICATIONS	WVA2 SUCCESS RATE	TOTAL APPLICATIONS	OVERALL SUCCESS RATE
1930-32	1,930	4,163	6,093	31.7%	9,576	44.8%
1932-33	622	1,349	1,971	31.6%	3,331	45.9%
1933-34	517	1,098	1,615	32.0%	3,081	51.3%
1934-35	724	1,233	1,957	37.0%	3,434	54.0%
1935-36	899	1,478	2,377	37.8%	3,831	55.0%
1936-37	1,684	3,433	5,117	32.9%	6,782	44.6%
1937-38	1,479	2,270	3,749	39.5%	5,191	51.4%
1938-39	6,018	5,644	11,662	51.6%	13,488	55.6%
1939-40	3,207	4,485	7,692	41.7%	8,945	46.7%
1940-41	1,330	1,768	3,098	42.9%	3,932	51.2%
1941-42	1,015	879	1,894	53.6%	2,506	60.3%
Total	19,425	27,800	47,225	41.1%	64,097	50.3%

Source: DPNH Reports, 1932-44.

Note: Period 1930-32 spans from 1 September 1930 to 31 March 1932 (19 months). Awards do not include those granted to dependents.

TABLE 2.7 – BENEFICIARIES UNDER THE PENSION ACT (GREAT WAR ONLY), 1921-42

YEAR	DISABILITY BENEFICIARIES	DEPENDENT BENEFICIARIES	TOTAL BENEFICIARIES
1921	115,529	36,064	151,593
1922	110,412	36,456	146,868
1923	111,469	34,433	145,902
1924	115,603	34,146	149,749
1925	124,544	33,273	157,817
1926	134,209	32,345	166,554
1927	141,982	31,392	173,374
1928	151,502	30,220	181,722
1929	165,506	29,298	194,804
1930	174,732	27,691	202,423
1931	203,176	27,162	230,338
1932	232,303	26,086	258,389
1933	239,599	24,845	264,444
1934	237,794	23,812	261,606
1935	236,474	23,777	260,251
1936	233,205	23,541	256,746
1937	227,594	23,368	250,962
1938	219,323	22,922	242,245
1939	210,793	22,306	233,099
1940	201,391	22,494	223,885
1941	189,734	21,712	211,446
1942	178,058	21,030	199,088

Source: BPC and DPNH Reports, 1921-42.

TABLE 2.8 – WAR VETERANS ALLOWANCE AWARDS GRANTED, 1930-44

AWARDS YEAR	OVER 60	UNDER 60	TOTAL/YEAR	TOTAL/ACTIVE	WVA3
1930-32	2,360	1,930	4,290	3,825	n/a
1932-33	908	622	1,530	4,867	n/a
1933-34	1,065	517	1,582	5,837	n/a
1934-35	1,129	724	1,853	7,186	n/a
1935-36	1,208	899	2,107	8,820	n/a
1936-37	1,340	1,684	3,024	11,306	n/a
1937-38	1,189	1,479	2,668	13,244	n/a
1938-39	1,482	6,018	7,500	20,010	5,245
1939-40	972	3,207	4,179	23,211	2580
1940-41	683	1,330	2,013	24,024	937
1941-42	497	1,015	1,512	24,360	656
1942-43	n/a	n/a	n/a	24,192	380
1943-44	n/a	n/a	n/a	23,848	351

Source: DPNH Reports, 1932-44.

TABLE 2.9 – WAR VETERANS ALLOWANCE APPLICATION OUTCOMES, 1930-44

YEAR	WVA1 CATEGORY				WVA2 CATEGORY				ALL APPLICATIONS	
	AWARDS	REJECTED	TOTAL	SUCCESS RATE	AWARDS	REJECTED	TOTAL	SUCCESS RATE	TOTAL	SUCCESS RATE
1930-32	2,360	1,123	3,483	67.8%	1,930	4,163	6,093	31.7%	9,576	44.8%
1933	908	452	1,360	66.8%	622	1,349	1,971	31.6%	3,331	45.9%
1934	1,065	401	1,466	72.6%	517	1,098	1,615	32.0%	3,081	51.3%
1935	1,129	348	1,477	76.4%	724	1,233	1,957	37.0%	3,434	54.0%
1936	1,208	246	1,454	83.1%	899	1,478	2,377	37.8%	3,831	55.0%
1937	1,340	325	1,665	80.5%	1,684	3,433	5,117	32.9%	6,782	44.6%
1938	1,189	253	1,442	82.5%	1,479	2,270	3,749	39.5%	5,191	51.4%
1939	1,482	344	1,826	81.2%	6,018	5,644	11,662	51.6%	13,488	55.6%
1940	972	281	1,253	77.6%	3,207	4,485	7,692	41.7%	8,945	46.7%
1941	683	151	834	81.9%	1,330	1,768	3,098	42.9%	3,932	51.2%
1942	497	115	612	81.2%	1,015	879	1,894	53.6%	2,506	60.3%
Total	12,833	4,039	16,872	76.1%	19,425	27,800	47,225	41.1%	64,097	50.3%

Source: DPNH Reports, 1930-42.

Section III: Retraining (Tables and Figures)

TABLE 3.1 – SAMPLE GROUP VOCATIONAL STUDENTS’ DISABILITIES, RETRAINING COURSES, AND OUTCOME, 1916-21

PRE-WAR OCCUPATION	DISABILITIES AT TIME OF RETRAINING	COURSE TAKEN	POST-RETRAINING OCCUPATION(S)
Rancher	Partial Loss of Function – Right Arm, Right Leg; Defective Vision	Poultry Farming	Unknown
Shoemaker	Myalgia	Shoe-repair	Shoemaker
Farmer	Haemorrhoids	Gas Tractor Operation	Unknown
Carpenter	(GSW) Partial Loss of Function – Right Hand	Architectural Drawing	Carpenter
Horse Driver	Flat Feet	Barbering	Barber
Labourer	Myalgia, Kyphosis	Shoe-repair	Labourer; Farm Labourer
Sailor	(GSW) Partial Loss of Function – Left Leg	Welding	Garage Mechanic
Civil Engineer	Debility (Trench Fever)	Motor Mechanics	Surveyor; Engineer
Teamster	Head Injury; Abdominal Injury; VDH	Shoe-repair	Shoemaker
Clerk	Partial Loss of Function – Left Leg	Poultry Farming	Unknown
Baker/Apprentice	Defective Vision; Debility (Nephritis)	Steam Engineering	Steam Engineer; Construction Superintendent
Trapper	Debility (Nephritis)	Shoe-repair	Farmer
Farmer	Chronic Appendicitis; Otitis Media	Bandsaw Filing/Fitting	Saw Filer
Mason	Amputation – Left Leg	Commercial/Civil Service Course	Mud Surveyor
Plasterer	Debility; Dyspnoea	Commercial/Civil Service Course	Unknown
Driver	Pulmonary Tuberculosis	Hardware Sales	Hardware Clerk; Letter Carrier
Horse Trainer	Myalgia	Bench Carpentry	Unknown
Mechanic	(GSW) Partial Loss of Function – Both Legs	Tailoring	Tailor; Bus Driver
Farm Labourer	Nervous Debility	Insurance Sales	Book Agent; Farm Labourer; Clerk
Locomotive Mechanic	(GSW) Loss of Left Eye	Commercial/Civil Service Course	Clerk

Appendix III: Dataset Variables Compiled from CEF Personnel Files and Pension Files

The following list provides an overview of the variables collected for use in this dissertation. Each piece of numbered information is a variable. Where necessary, bulleted text describes how the data is expressed in the dataset. Variables without descriptions are either self-explanatory, or encompass too many individuals values (Hospitalizations for instance) to account for in this reference appendix. Several variables, including birthplace, pre-war / post-war occupation, or information pertaining to post-war hospitalizations were not incorporated quantitatively into the body of this dissertation, but still assisted greatly in charting the trajectory of a veteran's life.

I. PERSONNEL FILE VARIABLES

1. Name
2. Date of Birth
3. Rank at Discharge
4. Regimental Number(s)
5. Birthplace
6. Pre-war Residence
7. Pre-war Occupation
8. Marital Status
9. Conscript (Yes / No)
10. Enlistment Date(s)
11. Discharge Date(s)
12. Reason for Final Discharge
13. Theatre of Service
14. Instance of Hospitalization(s): Final Diagnosis
15. Disability at Discharge
16. Relation of Disability to Service
17. Prognosis of Disability
 - Length expressed in months if not permanent
18. Post-war Residence
 - Obtained from discharge certificates or any post-discharge correspondence

II. PENSION FILE VARIABLES

1. Retraining (Yes / No)
2. Retraining Occupation or Course
3. Training Length
 - Length expressed in months if known
4. Training Location
5. Occupation
6. Occupation Location
7. Occupation Length
8. Hospitalization: Final Diagnosis
9. Hospital Where Treatment Received
10. Hospitalization Length
 - Length expressed by date of admission and discharge for duration longer than two weeks
11. Total Hospitalizations
 - Total visits of in-patient treatment lasting 1 day or more
12. Disability Pension Application(s)
13. Marital Status upon Application
14. Number of Dependent Children upon Application
15. Pension Decision Effective
 - Date when pension ruling comes in to effect, including retroactive awards
16. Pensionable Disabilities
 - Disability for which original pension is awarded
17. Non-pensionable Disabilities
 - Disabilities rejected upon first application, or if successful, for duration pension award is held
18. Relation of Disability to Service
19. Rank when Disability Incurred
20. Extent of Disability
 - If rated, expressed in % based on pension commissioners' ruling
21. Extent of Pensionable Disability
 - If rated, expressed in % based on pension scale in force at date of award or reassessment
22. Rate Change Date

23. New Disabilities upon Reassessment (attributable only)
24. Extent of Disability upon Reassessment
 - Expressed in % based on pension commissioners' ruling
25. Extent of Pensionable Disability upon Reassessment
 - Expressed in % based on pension scale in force at time of reassessment
26. Pension Termination Date
27. Reason for Pension Termination
27. War Veterans Allowance (WVA) Application Ruling
28. War Veterans Allowance Ruling Date
29. WVA Amount (\$ per month)
30. WVA Rate Change(s)
31. WVA Rate Change Date
32. WVA Termination Date
33. Reason for WVA Termination
34. Date of Death
35. Age at Death
36. Cause of Death
37. Relationship Between Death and CEF Service
38. Chronic Medical Conditions at Time of Death
39. Hospital or Residence where Death Occurred
40. Location of Hospital or Residence