HEALTH IN THE ARMY

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A DISSERTATION SUBMITTED FOR THE DIPLOMA
IN PUBLIC HEALTH

INTRODUCTION

The object of this dissertation is to give an account of the Health Service of the British Army at the present time. Much has previously been written about most of the factors concerned; this attempt is now made to correlate these components so as to present under one cover a systematic survey of the whole.

The basic functions of any Health Scheme, Service or civilian, are:

1. Promotion of health.
3. Medical care.

As, however, it would be manifestly impossible in the limited space allowed to treat of every relevant consideration in equal detail, the main emphasis is placed on the promotion of "positive" health with its problems peculiar to the requirements of the Armed Forces. Preventive measures and medical care of the sick, which on the whole differ little from civilian practice, are mentioned briefly for the sake of completeness. Furthermore, special problems of major wars—for example, of accommodation, rations, water, etc.—are not included, as they are considered to be outside the scope of this paper, which is primarily concerned with the Army in the pursuit of its normal peace-time duties.

HISTORICAL

Before 1660 there was no Standing Army; forces were raised and equipped as required. As a rule, although some senior officers had their private medical attendants, there was no machinery for dealing with sick and wounded; they were merely discharged from the Army when unfit to fight, in whatever part of the world they might happen to be. In most cases these unfortunates were not even brought home to England before discharge, but left to their own devices [1]. Arrangements were occasionally made for their transport—Edward III, for example, had the sick and wounded brought back to England in 1346, and in 1563 those from the Siege of Havre were accommodated at the port of disembarkation (Portsmouth) until fit to travel to their homes—but not until 1600 was any regular provision made for their care. In that year military hospitals were authorized.
and established at Dublin and Lough Foyle—from motives, it may be noted, not humanitarian but economical, brought about by the large wastage from sickness of troops sent to Ireland [2]. When the Standing Army was formed in 1660, each Regiment was provided with its own hospital with a Medical Officer, Hospital Serjeant and Hospital Orderlies, but there was no ordered plan for the evacuation of sick and wounded [3]. Nevertheless, this was certainly a most progressive development, particularly when the comparable arrangements, or lack thereof, for the civilian population of England at that time are considered.

No further developments can be recorded for nearly two centuries, when, on the outbreak of the Crimean War in 1854, a Hospital Conveyance Corps was formed. This soon proved a failure because it was recruited from unemployed pensioners who were old and feeble, and in 1855 the first Medical Staff Corps was formed at Chatham, wherein brief training was given for hospital and general duties. This Corps was also unsuccessful, largely because it had no officers of its own, and was followed in 1857 by the Army Hospital Corps, a new feature of which was its subdivision into Medical Staff, consisting of Medical Officers who had no disciplinary powers, and General Staff seconded from regiments [4]. But the administration of the Corps was not entrusted to its own officers, and hence its proper development was retarded until 1873, when the regimental system was abolished.

So far the main efforts of the Army Medical Service had been directed to the third of the functions enumerated above, that is, medical care of the sick. Although all the great military leaders of history, even back to the time of Moses, had realized that losses of men in war from sickness far exceed battle casualties, and many of them had striven hard, and often successfully, to prevent and control such outbreaks, they had been gravely handicapped by the universal lack of scientific knowledge. The Industrial Revolution stimulated the advancement of such knowledge, and the Public Health Act of 1848 provided for the appointment of Medical Officers of Health. The Army soon followed suit by appointing in 1860 Edmund Parkes the first Professor of Hygiene at the newly opened Army Medical School at Chatham. Parkes wrote the first Manual of Military Hygiene. He campaigned for the health education of all who had control of feeding, clothing and housing, and made great efforts for the improvement of the soldier's living conditions, so successfully that when he died in 1876, Baron Mundy, Professor of Military Hygiene at the University of Vienna, said: "All the Armies of the Continent should at parade lower their standards craped, if only for a moment, because the founder and best teacher of military hygiene of our day, the friend and benefactor of every soldier, Edmund Parkes, is no more" [5].

Even so, by the time of the South African War there was still no knowledge of preventive measures by any but medical personnel, and little co-ordination between the medical and combatant branches of the Service. The appalling enteric fever incidence of 100 per 1,000 per annum during the campaign bears witness of this, and the incidence of other preventible diseases was proportionately high, owing to absence of water purification facilities, poor standards of shelter, inadequate field ablution, bathing and laundering arrangements,
unsatisfactory disposal of waste matters, absence of methods of dealing with flies and insects, lack of disinfestation facilities and poor feeding. A Royal Commission on the work of the Medical Services in the South African War was held, as a result of which the young Royal Army Medical Corps, formed in 1898, was charged with the teaching of sanitation and hygiene throughout the Army.

A start was made by publishing in 1905 an Army Manual of Sanitation for non-medical readers, and in the following year a School of Sanitation was founded at Aldershot to train regimental officers and non-commissioned officers in sanitation and water duties. In 1908 sanitation was made a compulsory subject in the examination for promotion to Captain of all regimental officers—a measure which has been reintroduced in 1950, after being in abeyance for many years.

Hence by 1914 the principles of sanitation had been taught to the Regular Army, some equipment for water purification and field sanitation had been developed, and improvements had taken place in accommodation, clothing and diet. During the 1914-18 war all officers were trained in preventive measures, passing on the instruction to their men. Notable advances in preventive medicine were made, of which just one illustration may be mentioned here, namely, the dramatic fall in the incidence of enteric fever following the introduction of mass inoculation and attention to hygienic principles.

After the Great War, when the Army Hygiene Service was completely reorganized, Sir William Horrocks was appointed the first Director of Hygiene in 1919. This organization, substantially unchanged save for the substitution of the title “Army Health” in keeping with modern conceptions, has withstood well the many stresses of the 1939-45 war, and continues today its unceasing task of promoting and maintaining the health of the soldier—the emphasis, be it noted, having shifted once again, this time from mere prevention of disease to the more positive aim of the promotion of health.

No historical survey, however brief, of the development of Army Health could be regarded as in any way complete without reference to the growth of socio-medical facilities for the soldier’s family, which have frequently been in advance of contemporary civilian practice. Thus as far back as 1767 a schoolmaster was appointed by the Queen’s Royal Regiment, and in 1811 every regiment was ordered to start a school for its soldiers’ children [7]. In 1892 Nursery Schools for three-year-olds were provided. Some ten years later systematic school medical inspections were instituted, followed in 1907 by the issue of milk to schoolchildren and shortly afterwards by provision of dental care.

Military families were not officially recognized before 1800, and responsibility for them was not accepted by the Army Medical Service until 1878 [8]. Nevertheless, by 1863 female hospitals had been established at home and in India at the instigation of Florence Nightingale, while in 1873 Married Quarters Rolls were compiled, sanitary inspections of married quarters were being carried out, and instruction was being given to “soldiers’ wives desirous of becoming midwives and qualifying as Army Midwives and Sick Nurses” [9]—the beginning of
a Maternity and Child Welfare Service. Maternity and Child Welfare Schemes, supported by voluntary contribution and effort, were well advanced by 1921, supplementing ante- and post-natal clinics at Military Families' Hospitals. Official sanction was given to them in 1924, together with financial grants and equipment, and at the present day such centres are in operation at all home and overseas military stations where families are quartered.

Promotion of Health

Definition

Positive health has been defined as "attunement to surroundings, combining with vigour, balance and efficiency, and with the adequate co-ordination of mental and physical function to produce a harmonious integration with environment, confidence and satisfaction in work, recreation and leisure, and a capacity for effectiveness of essential relaxation and rest" [10].

The first necessity for the attainment of this object is obviously to select sound, or at least potentially sound, material for the Army from the population at large. The second is to attempt to mould this material to the desired pattern by attention to health education and environmental details. These postulates will now be discussed under the headings of Recruiting Procedure and Personal Hygiene.

Recruiting Procedure

It is an accepted fact that the physical and mental health of an individual are interdependent, and that either or both may be affected for better or for worse by his occupation. His suitability for a particular occupation depends in turn on his physical qualities—general physique, manual dexterity and ability, and mechanical aptitude—and his mental qualities—general intelligence, mental capacity, temperament and educational attainments. The modern Army is a complex organization which employs its men in a great variety of trades or occupations; it is, therefore, important to post each man to a trade suited to his qualities in order to obtain the best results from the individual and hence maximum efficiency of the Service as a whole. It is, perhaps, surprising that not until 1942 was any serious attempt made in the British Army at scientific selection of personnel; true, there was a wide range of medical categories, but these were based only on physical attributes, no account being taken of mental qualities other than gross psychiatric disorder. Since then a quite elaborate procedure for personnel selection has been developed in the attempt to discover individual ability from the physical and psychological aspects.

Having been passed fit for service by a civilian Medical Board, the recruit is in due course called up to a Selection Unit, where he spends fourteen days, devoted to medical classification, personnel selection procedure, issue of kit and a minimum amount of introductory training.

(a) Personnel Selection

Personnel Selection is carried out by specially trained staff. Although non-medical, their work is of considerable medical importance as it is they who assign
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each recruit to his future Army trade. Close co-operation between the medical and personnel selection staffs is essential if successful results are to be obtained; some account of their work will, therefore, be given.

Selection procedure consists of three phases: the application of tests, recording of personal history and an interview. The tests are devised to obtain information about a man's abilities in various directions, and to enable easy and reliable comparisons to be made between different men's capacities. Those used are the Dominoes (replacing the Matrix) Test of general intelligence; the Problems Test of mechanical aptitude; an Arithmetic Test to measure the standard reached in simple mathematics; a Verbal Test of ability to understand and use words; the Instructions Test to determine ability to understand complex instructions and to carry them out rapidly and accurately; and finally the Assembly Test of manual dexterity and ability to see how parts fit together to form a simple mechanism. The results are given in groups which correspond to the proportions of men in the Army as follows:

<table>
<thead>
<tr>
<th>Selection Group 1</th>
<th>Top 10 per cent.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Selection Group 2</td>
<td>Next 20 per cent. below group 1.</td>
</tr>
<tr>
<td>Selection Group 3+</td>
<td>The 20 per cent. just above average.</td>
</tr>
<tr>
<td>Selection Group 3−</td>
<td>The 20 per cent. just below average.</td>
</tr>
<tr>
<td>Selection Group 4</td>
<td>Next 20 per cent. above group 5.</td>
</tr>
<tr>
<td>Selection Group 5</td>
<td>Bottom 10 per cent.</td>
</tr>
</tbody>
</table>

A Summed Selection Group is calculated for each man from the combination of the groups allotted on all except the Assembly Test.

Personal history, including nationality, education, civilian employment record and hobbies, linguistic knowledge, driving experience and service in youth organizations such as the Cadet Forces, is recorded on a four-page Qualification Form by the man at his pre-service medical board. He may also express a preference for a particular Corps. At the Selection Unit the Personnel Selection Officer records on the same form the results of the tests, the man's educational standard in code form, his Combat Temperament, Employment Record, Leadership Potentiality, and whether or not he is a potential officer or non-commissioned officer. His medical classification is also shown on the form.

The man's test results and statement are before the Selection Officer during the interview, which lasts for about twenty minutes. In this time the officer must elicit the answers to six questions [11]—namely:

(i) What are his physical capabilities?
   The answer to this is given in his PULHEEMS assessment.

(ii) What does he know already that is useful to the Army?
   The Qualification Form will provide the details.

(iii) How much and how quickly will he learn?
   The Selection Test results will form a useful guide.

(iv) Has he any special "gifts" which will be useful to the Army?
(v) Is there anything about his personality which will affect his utility in the Army?
(vi) In what is he interested?

After interview, the Selection Officer writes a brief opinion of the man and finally makes three employment recommendations. Three recommendations are made because, owing to differences between supply and demand, the ideal choice obviously cannot be made in every case.

For each employment a series of minimum test levels has been laid down, below which experience shows that a man is unlikely to be successful. It is not claimed that tests will always pick a man for a particular trade, and in any case previous experience must be taken into consideration, but they should serve to eliminate men who will never learn it, or who will learn with such difficulty that it is hardly worth while spending the time and trouble on them.

(b) Medical Classification

On the outbreak of war in 1914 volunteers for the Army were examined for fitness to serve by general practitioners. Naturally enough the results were diverse, as one practitioner's opinion of fitness might vary considerably from another's. In the following year Standing and Travelling Medical Boards were introduced to classify volunteers into four categories of fitness or unfitness for service at home and abroad, and examination by civilian practitioners was abolished. Following the Military Service Act of 1916 the Ministry of National Service took over recruiting for the Army and Air Force; men were placed in one of four numbered grades at medical boards, and transferred to corresponding military categories on joining the Army. This was the basis of the method adopted in 1939-1945. In February, 1940, Army categories were increased and further subdivided for better utilization of manpower, and categories were laid down in detail for the various Arms. This was an improvement, but the great disadvantage remained that no account was taken of emotional and mental make-up and little information was given of the type of man.

The essential requirements of a system of medical classification for occupation are a detailed qualitative estimation of the individual together with a qualitative analysis of employment requirements, expressed in the same terms [12]. A decisive step in this direction was the development of the PULHEMS system by the Canadian Army during the late war. With some alteration of detail this classification was first introduced into the British Army in 1944 under the name PULHEMS. During the change-over period the new and old systems were used side by side until on 1st April, 1948, the old classification was entirely superseded by PULHEMS, which is now applicable, with suitable modifications, to all three Armed Forces.

General Principles of PULHEEMS System [13]

The objects of the system are:

(i) To provide a functional assessment of the individual's capacity for work.
(ii) To assist in expressing the physical and mental attributes appropriate to individual trades and employments within the Service.
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(iii) To assist in posting men to the employment for which they are most suited in the light of physical, intellectual and emotional make-up, and thus to economise in manpower.

(iv) To provide a system which is administratively simple to apply in peace and war.

The name is derived from the first letters of the subdivisions of bodily and mental functions, known as Qualities. These are:

- **P**—**Physical Capacity.** Expressive of general physical characteristics and potential capacity to develop physical stamina with training.

- **U**—**Upper Limbs.** Assesses the functional use of the hands, arms, shoulder girdle and upper spine, and in general shows ability to handle weapons. Pathological conditions of the upper limb having a constitutional basis may also affect the “P” assessment.

- **L**—**Locomotion.** Ability to march. Pathological conditions affecting marching ability which have a constitutional basis also affect the “P” assessment.

- **H**—**Hearing.** Ability to hear; diseases of the ear are recorded separately under “P.”

- **EE**—**Eyesight.** Ability to see with the right and left eyes respectively. Diseases of the eyes are assessed under “P.”

- **M**—**Mental Capacity.** Based on ability to learn Army duties, assessed from the impression made on personal interview, with particular regard to alertness and ability to apply usefully the intelligence possessed, from the record of school and occupational progress, and from selection test results, particularly tests of intelligence and acquired ability.

- **S**—**Emotional Stability.**

It will be noted that the emphasis is on function in all cases, not on anatomical perfection, which represents a further advantage over previous systems.

**Degrees of Assessment.**

The standard of fitness under each quality is assessed in degrees and recorded by figures 1 to 8, though not all of the figures are used in every quality. Thus:

- **P**—Is expressed by 1 to 8.

- **U, L, H**—By 1, 2, 3, 7 and 8.

- **EE.** Visual acuity is expressed by figures 1 to 8 for simplicity in recording, namely:

<table>
<thead>
<tr>
<th>Ratio</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>6/6</td>
<td>1</td>
</tr>
<tr>
<td>6/9</td>
<td>2</td>
</tr>
<tr>
<td>6/12</td>
<td>3</td>
</tr>
<tr>
<td>6/18</td>
<td>4</td>
</tr>
<tr>
<td>6/24</td>
<td>5</td>
</tr>
<tr>
<td>6/36</td>
<td>6</td>
</tr>
<tr>
<td>6/60</td>
<td>7</td>
</tr>
<tr>
<td>Less than 6/60</td>
<td>8</td>
</tr>
</tbody>
</table>
The first E refers to the right eye, the second to the left. Aided vision is recorded when applicable in a similar manner under the figures for unaided vision.

M—By 2, 3, 7 and 8.
S—By 2, 3, 6, 7 and 8.

Any assessment under M or S other than 2 can be allotted only by a psychiatrist.

Colour Perception

Colour Perception is recorded separately in accordance with the following standards:

Standard I—CP 1—Not in use in the Army.
Standard II—CP 2—Normal colour perception.
Standard III—CP 3—Able to distinguish accurately White, Signal Red and Signal Green.
Standard IV—CP 4—Unable to reach Standard III.

Functional Interpretation of Degree of each Quality

This is shown in the table at Appendix I.

Method of Recording

A "Medical Box" on relevant personal documents shows the degree of assessment under each quality, together with the last two figures of the year of birth, the height in inches, Colour Perception, and weight in pounds. Space in the box is also provided for brief notes where the P, U, L or S assessment is below 2.

Application of the System

Since the standards on which PULHEEMS assessments are based are constant throughout all Corps of the Army, except the Women's Corps which have lower standards in P, U and L, and since the functions of the Corps vary, it would clearly be uneconomical to require the same minimum PULHEEMS assessment for combatant, lines of communication and base duties in all Corps. In order to simplify the application of the system the PULHEEMS assessments acceptable to each Corps for each area of operations have been grouped and are expressed in a two-letter code known as the PULHEEMS Employment Standard:

(i) FE (Forward Everywhere). Fit for full combatant duties in any part of the world.
(ii) FT (Forward Temperate). Fit for combatant duties in any area in temperate climates only.
(iii) LE (Lines of Communication Everywhere). Fit for duty in Lines of Communication or Base areas in any part of the world; may be employed in forward areas in any role not primarily fighting.
(iv) LT (Lines of Communication Temperate). As for LE, but in temperate climates only.
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(v) **BE** (Base Everywhere). Fit for Base duties only in any part of the world.

(vi) **BT** (Base Temperate). Fit for Base duties in temperate climates only.

(vii) **HO** (Home Only). Fit for service in United Kingdom only.

The PULHEEMS Employment Standard is obtained from tables which link the PULHEEMS assessments with specific trades and employments for each Arm of the Service. The minimum standards required vary for officers and other ranks, men and women, entry and retention, and Regular and National Service recruits.

A preliminary PULHEEMS assessment is made by the National Service Medical Board (consisting of civilian practitioners) before the man is called to the Colours. This is mainly a determination of anatomical fitness only, but serves to indicate to the Ministry of Labour and National Service and to the Army whether the man is fit to be called up at all, and if so, the type of duties within broad limits which he is likely to be able to perform. In practice such assessments not infrequently prove to be incorrect because, for example, psychiatric disabilities seldom present at this stage, and there is no objective assessment of intelligence or aptitude.

During the first few days at the Selection Unit a so-called Initial Assessment is made by a Service Medical Officer, mainly to help the Personnel Selection Officer to allot a trade. This is still basically anatomical because many disabilities do not come to light until after initial training. During this time also all recruits are dentally inspected, men with visual defects are referred to a Military Ophthalmic Centre for provision of spectacles, while doubtful cases are seen by a Physical Medicine Specialist or Army Psychiatrist as required. The chest is X-rayed of any man who has not been radiographed before enlistment.

The final “Service” PULHEEMS assessment based on physiological function is not made until after twelve weeks’ training, including physical efficiency tests by Physical Training instructors, at the Basic Training Unit. By this time defects and deficiencies have usually become apparent: gross physical and psychiatric disabilities are boarded out of the Army; men with lesser defects are treated and/or allocated to a more suitable trade.

While the PULHEEMS system represents an enlightened advance in methods of medical classification, it is open to the criticism that the degrees of assessment of the \( P \), \( U \), \( L \) and \( S \) qualities are at present determined by more or less arbitrary means. Who, for example, is to say whether the muscular development of a particular limb is average or above average? However, it is hoped that this problem may have been successfully solved before very long, possibly, in the case of the \( P \) quality, by laying down more fixed standards for the different degrees of assessment together with some form of correlation of bodily measurements, or in the case of the \( U \) and \( L \) qualities by a series of standard tests of limb function, using mechanical apparatus and suitably graded in relation to weight, height and age. With regard to Emotional Stability, experiments are in fact proceeding with the object of detecting incipient breakdown under active service.
conditions. If they are successful a further development might well be an objective method of assessing the $S$ quality.

(c) Physically Underdeveloped Recruits

Underweight recruits are examined at the Selection Unit by a Physical Medicine Specialist who recommends their disposal. Ideally, special Physical Training courses of six to eight weeks' duration should be organized for all men suffering from defects remediable in that time, and in fact Physical Development Centres for substandard recruits were opened in 1936 at Aldershot and in Northern Command. Great expansion took place during the war, when their worth was more than proved, until ultimately three centres in this country had dealt with 35,000 men. Unfortunately, due to a combination of circumstances, there are now no Physical Development Centres—manpower is scarce, there are sufficient trades which may be filled satisfactorily by men of poor physique, and it would be uneconomical at present to send National Service men on long courses, as most of them have only eighteen to twenty-four months to serve. Underdeveloped recruits are therefore discharged from the Army if there is small prospect of their improvement in a short time.

Poorly developed recruits with malnourishment or requiring further investigation are admitted to a Convalescent Depot for extra food and general training. Most of them can be graded P3 after six weeks. Underweight recruits with or without postural deformity but capable of rapid improvement to the standard required for their Arm are sent on Conditioning Courses, together with men who break down, without any discernible pathology, during any part of their training. Conditioning Courses, which are intended as a substitute for the old Physical Development Centres, are at present held in three of the Commands in this country. Four to six weeks of graduated physical training, with extra milk and higher ration scale, culminate in a standard test. A measure of the success of these courses is that some 80 per cent. pass the test and are assessed P2, L2, U2. In addition to the improvement in physique, posture and endurance, a significant feature is the raising of morale and self-confidence which is almost always evident.

APPENDIX I

PULHEEMS—Functional Interpretation of Degrees of each Quality (Men) [13]

“P” Quality: Age, Build, Strength and Stamina.

Degree 1. Fit after training for full strain and fatigue on combatant duty. Fit to withstand exposure to all kinds of weather. A front-line fighter in any part of the world.

2. Fit after training for normal work or strain but unable to endure “extreme” degree for long periods. A front-line fighter in any part of the world.

3. Fit for ordinary work. Has not the stamina even after training to endure the strain and fatigue of full combatant duty. Fit for restricted service in any part of the world.
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4. Fit in temperate climates, after training, for full strain and fatigue on combatant duty. A front-line fighter in temperate climates.

5. Fit in temperate climates, after training, for normal work or strain, but unable to endure extreme degrees for long periods. A front-line fighter in temperate climates.

6. Fit for ordinary work. Has not the stamina even after training to endure the strain and fatigue of full combatant duties. Fit for restricted service in temperate climates.

7. Capable of performing useful army duties within limits of his disabilities. Not likely to break down if suitably employed which includes time for regular meals and rest. Service in U.K. only.

8. Medically unfit for any form of service.

"U" Quality: Strength, Range of Movement and General Efficiency of Upper Arm, Shoulder Girdle and Upper Back.

Degree 1. Muscle power above average. Must be able to handle a rifle and do heavy manual work, including digging, pushing, dragging, heaving, lifting and climbing. All tasks carried out with rapidity and efficiency.

Degree 2. Muscle power average. Able to do all a U1 man can do but at a slower pace.

Degree 3. Must be able to use a weapon for defensive purposes and be capable of less severe forms of manual work than U2.

Degree 7. Capable of sedentary and routine work of a lighter type. Includes personnel unable to bear arms on account of physical disability. Service in the base area at home or overseas.

Degree 8. Medically unfit for any form of service.

"L" Quality: Strength, Range of Movement and Efficiency of Feet, Legs, Pelvic Girdle and Lower Back.

Degree 1. Capable of very severe locomotor strain for five or six days. Can undertake forced marches and fight at the end of such marches. Can run, climb, jump, crawl, dig and perform all kinds of labour quickly.

Degree 2. Same as L1, but pace may be slower.

Degree 3. Capable of marching five miles or farther in an emergency. Able to stand for periods of at least two hours. Fit for guard duties.

Degree 7. Able to walk two miles a day at own pace. Can stand for moderate but not prolonged periods. Service in the base area at home or overseas.

Degree 8. Medically unfit for any form of service.

"H" Quality: Acuity of Hearing.

Degree 1. Very good hearing. Ability to hear sufficiently well to perform any duty.

Degree 2. Good hearing. Able to hear sufficiently well to perform any duty.

Degree 3. Able to hear sufficiently well to perform any duty where moderate impairment of hearing does not disqualify.

Degree 7. Able to hear sufficiently well to perform any duty where marked impairment of hearing does not disqualify. Service in the base area at home or overseas.

Degree 8. Medically unfit for any form of service.
"EE" Quality: Visual Acuity.
The degrees entered under EE are simple records of visual acuity, and bear no relationship to the degrees under the remaining qualities. Eye disease may, however, affect the degree entered under "P."

"M" Quality: Mental Capacity.
Degree 2. Ability under army conditions to learn to perform successfully full combatant duties. Includes those who can be trained as tradesmen and specialists.
3. Ability under army conditions to learn to perform simple labouring duties, including fitness to bear arms in self-defence.
7. Because of low mental capacity are unfit to bear arms, but are capable of simple labouring duties under supervision, including a minimum of responsibilities. Service in U.K. only.
8. Medically unfit for any form of service.

Degree 2. Emotionally fit to perform army duties adequately under full combatant conditions in any part of the world.
3. Although having a history of emotional instability are at present well adjusted and fit to serve in any part of the world in a role which is not primarily a fighting one.
6. Whilst having a history of emotional instability are sufficiently well adjusted to serve in temperate climates in a role which is not primarily a fighting one.
7. Emotionally fit to perform army duties adequately under living conditions favourable to the individual, in the U.K.
8. Medically unfit for any form of service.

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[To be continued.]