‘Poor devils without noses and jaws’: facial wounds of the Great War.

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I heard for a second a distant shell whine, then felt a tremendous explosion almost on top of me [...] the floodgates in my neck seemed to burst and the blood poured out in torrents. [...] I could feel something long lying loosely in my left cheek, as though I had a chicken bone in my mouth. It was in reality, half my jaw, which had broken off, teeth and all, and was floating about in my mouth.¹

John Glubb’s description of his wounding in August 1917 creates a vivid image of what it was like to sustain a facial wound during the Great War. Glubb is one of the thousands of Great War soldiers whose lives were affected through severe facial wounds and subsequent disfigurement.

While facial wounds are not unique to the Great War, improved medical treatment available in the field and advances in the transportation of the wounded meant that many soldiers who would have died from such wounds in earlier conflicts were now surviving and
requiring further treatment. My paper tonight examines the nature of facial wounds during the Great War and outlines some of the medical innovations made in the field of reconstructive facial surgery. Not only did such innovation enable facial wound cases to survive their wounds, it also gave them a chance to reconstruct their lives. I will also, in the spirit of Honest History, discuss some recent representations of Great War disfigured veterans that distort the historical accounts and, in some way, go to explaining why people have shied away from undertaking research in this area until now.

There is something of a misconception that the lives of disfigured veterans were inherently tragic. The social stigma surrounding facial disfigurement has long been recognised. Writing in 1818 on disfigured veterans from the Napoleonic Wars, Carl Ferdinand von Graef observed:

We have compassion when we see people on crutches; being crippled does not stop them from being happy and pleasant in society … [But those] who have suffered a deformation of the face, even if it is partially disguised by a mask, create disgust in our imagination.\textsuperscript{ii}

Almost 100 years later, Sir William Arbuthnot Lane, director of the Cambridge Military Hospital at Aldershot, United Kingdom, where facial surgery work - wrote of his interactions with facial wound cases:

It’s the poor devils without noses and jaws, the unfortunates of the trenches who come back without the faces of men that form the most depressing part of the work … people who look like some of these creatures haven’t much of a chance.\textsuperscript{iii}

But through their specialist work, that is what Harold Gillies and the other surgeons at Queen’s Hospital were to provide – a chance for these soldiers, and the societies to which they would return, to cope with the brutal damage wrought upon their faces. The Queen’s Hospital in Sidcup, England, was established in August 1917 for the specific treatment of severe facial wounds. Begun primarily as a British endeavour, the hospital soon attracted surgeons and staff from Australia, New Zealand, Canada, and later, a small unit from the United States. Ear, nose and throat surgeon, Harold Gillies commanded the British section, Major C.W. Waldron and Captain Ernest Fulton Risdon at various times commanded the
Canadian Section, the New Zealand Section was commanded by Major Henry Percy Pickerill, and Lieutenant Colonel Henry Newland, commanded the Australian. The bringing together of such a collection of surgeons was not a matter of chance, or even of simple convenience. Gillies believed that the establishment of a specialised institution for the treatment of severe facial wounds would mean that skills and resources could be most effectively utilised and that techniques could be perfected. Instead of using specialist surgeons to deal with just one part of the face, the aim here was to train and develop well-rounded facial surgeons, who could replace a nose as easily as repair a jaw. Over 5,000 servicemen from the United Kingdom, the Dominions and the United States were treated there, with surgeons performing more than 11,000 operations before its closure in 1925. Through their efforts, the surgeons at Queen’s Hospital set the precedent for the future of reconstructive facial surgery.

While Arbuthnot Lane may have considered them to be ‘poor devils’, the ‘unfortunates of the trenches,’ I would argue that the facial wound cases of the Great War could be considered quite fortunate with regard to the medical advances being made at this time in the field of maxillofacial reconstructive surgery.

Stepping back for a moment to look at the journey to the hospital, the first obstacle for a soldier suffering a facial wound was simply convincing stretcher bearers that they were worth taking to a Casualty Clearing Station. British Private Percy Clare describes the moments after he felt a blow on the right side of his face:

there was no pain whatever, and I hardly felt it. But at the same time a stream of blood spouted like a fountain from my mouth and gushed from my nostrils. A passing solder tried to use his field dressing kit, but his panic not being able to discover the nature of the wound, only a fountain of blood sprouting from my mouth he stuffed the whole packet in just as it was between my teeth – like a biscuit given to a dog!

A soldier sent back as a reserve stretcher-bearer attempted to bring Clare to the attention of stretcher-bearer parties. The first party brought to Clare thought that by the amount of blood caked on his uniform he had a stomach wound and Clare recalls hearing the
corporal in charge of the party say that it wouldn’t be worth taking him to a CCS, as “that sort always dies soon.” Clare writes: “A second party also refused me I was so soaked with blood and looked so sorry a case [...] they probably were justified that their long tramp with so unpromising a burden would be futile. My persevering friend brought up yet a third party and this time when I roused I found them lifting me on to their stretcher.”

Given the nature of their wounds, it was essential that facial wound cases travel upright: many would suffocate if they lay down. Being unaware of this complication in the early months of the war, well-meaning nurses and orderlies would help facial wound cases lay back to rest. Often this resulted in the soldier’s tongue rolling back in his throat, or blood and mucus blocking his airways.

Gillies perhaps best describes the scene of these men travelling to the hospital: “Men without half their faces; men burned and maimed to the condition of animals. Day after day, the tragic grotesque procession […] made its way towards us.”

While each case was, by the nature of the wound itself and other factors, unique, there were certain types of wounds more common than others and treatment procedures that became relatively standard by the war’s end. Gillies claimed that the “ravages of war have enabled a large number of cases to be collected under one team of surgeons. The various methods have been tried and sifted until a satisfactory combination has been developed.”

Work at the Queen’s Hospital was mainly focused on gun-shot and shrapnel wounds (approximately 80 percent of all cases treated at Queen’s Hospital), with most patients arriving from the Western Front rather than other theatres of the war.

Medical staff would then work from artistic records to determine how best to reconstruct a patient’s face, with treatment always planned “from within outwards.” That is, repair of skeletal structure of the face and jaw had to be seen to first and relatively stable before any soft tissue work could begin.
Skin grafts and skin flaps are central to facial reconstruction, and here you can see a wax model used at the hospital to explain the various flaps and procedures to patients – including the innovative technique of the pedicle tube.

Private Alfred House. 7 January 1919; plastic operation to restore lower lip and chin. Images courtesy of the Royal Australasian College of Surgeons (RACS).

Wax model from Queen’s Hospital. Royal College of Surgeons, UK.
Whilst the functional ability of a patient’s face was paramount in the surgeon’s mind, aesthetic considerations were also taken into account and were certainly on the patient’s mind. During the process of reconstruction, a patient might be consulted on various aspects of his repair. Horace Sewell, who while serving with the North Irish Horse in 1914 sustained considerable facial damage (including the loss of the tip of his nose and much of his septum) after being kicked by a horse, recalls the day that he was consulted on the repair to his nose: “[Gillies’] greeting one morning was, ‘Well, Paddy, your big day is here. What sort of nose do you think we ought to give you?’ He made various sketches of me [...] with different shaped noses. ‘I’m not fussy, sir.’ I said, and he decided I should have a Roman nose, as my face was rather round.”

Horace Sewell. Images courtesy of the Gillies Archives.

Some, however, decided to make do with what nature had left them – Glubb, who I mentioned earlier, was shown an album of “photographs of handsome young men and asked to choose the chin I would like to have!” When discovering how long it would take to build this new chin, he decided to “retain his old face, or whatever was left of it.”
Maintaining the men’s strength so they could endure the long process of operations and recuperation was particularly difficult. A facial wound case’s diet was mainly comprised of soups, cocoa, milk and other liquids. Minced meat would only be added to their diet once a patient was able to adequately chew. These liquid meals were fed to Queen’s patients through rubber tubed feeding cups, their mouths and throats then sluiced with water to keep them free from infection. Writing in his diary of his work as an orderly at the Majestic Hotel Hospital in Paris in 1914, Edward Toland described the difficult task of feeding facial wound cases patients:

He [the patient] has to lie face downward and of course cannot take anything but liquid food. [We] put a basin in front of him and a rubber cloth around his neck; then he pushes a rubber tube down his throat and we pour in beef tea, or milk, through a funnel. About every other swallow, it goes down the wrong way and he strangles for two minutes; then nods his head as if to say “all ready again.”

Image courtesy of the U.S. National Library of Medicine. Donated by the family of Roy Sheetz.

Whether it was while feeding them or changing their dressings, staff were instructed to always look their patient’s straight in the face, and were cautioned that the patient was
always looking for some reaction from them as an indication of their appearance. Mirrors were banned in the wards at Queen’s Hospital, though the men’s appearances were still reflected through the reactions of medical and nursing staff. Daisy Spickett, a British civilian nurse with Red Cross Voluntary Aid Detachment, was acutely aware of this role when removing the bandages of a facial wound case, recalling that “as I took [off] bandage after bandage after bandage, I thought to myself ‘There’s going to be no face left here at all, how dreadful it will be.’” Knowing he was watching and waiting for her reaction, rather than exposing her trepidation, she “chatted to him and teased him a little and tried to make him smile.” Indeed, many of the men (and Gillies) recall the strength and humour of both the patients and the nursing staff.

Many nurses at the Queen’s Hospital, however, were painfully affected by the condition of the men treated there. Sister Gertrude Moberly, for example, wrote that, of the 600 men she had seen, there was “not one with a whole face.” After being shown photographs of the men before and after their operations, she was completely overwhelmed:
“my stomach turned sick and I left hurriedly. As soon as I was out of sight of the building I sat by the roadside and cried and cried.”\textsuperscript{xvii} Catherine Black writes with similar poignancy of her interactions with facial cases:

In all my nursing experiences, those months at Aldershot in the ward for facial wounds were, I think, the saddest. Sadder even than the casualty clearing stations to which I went afterwards, for there death was swifter and more merciful, and it is not so hard to see man die as to break the news to him that he will be blind and dumb for the rest of his life.\textsuperscript{xviii}

Ward Muir, an orderly at the facial unit at the 3rd London General, had never felt any embarrassment or awkwardness in dealing with a patient, “however deplorable his state,” until he “came in contact with wounds of the face.”\textsuperscript{xix} He wrote that:

…even these, when still at the stage of needing to be dressed and bandaged, did not repel. When the wound healed, however, and the patient was going about with his wrecked face uncovered, I was sometimes sensible of the embarrassment to which allusion has been made. I feared, when talking to him, to meet his eye. […] I feared that inadvertently I might let the poor victim perceive what I had perceived: namely, the he was hideous.\textsuperscript{xx}

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So how were such ‘hideous’ men received on returning home? A facially disfigured veteran did not fit easily, or comfortably, into the category/mould of the ‘war hero’ or even the ‘glorious war-wounded.’ Representations of wounded soldiers in the press did little to prepare the public for this particularly confronting group of veterans – and you can see some examples here.\textsuperscript{xxi} These were the accepted depictions of a “head” or “facial” wound. Cartoons depicted men with bandages covering their faces – some looking like mummified figures– but these cartoons never portrayed the real medical or aesthetic state of these men.\textsuperscript{xxii} During the war, recruitment and propaganda posters would occasionally depict a soldier with a bandaged forehead or with the bandage strategically positioned over just one eye. These ‘wounded men’ called from the trenches to the men at home to join the fight, but
showed nothing of the actual physical, and horrendous, nature of a facial wound. The square jaw – a physical trait much associated with masculinity and strength – would be undamaged; and at least one good eye would remain visible, pleading with the observer.

Smith’s Weekly, 31 May 1919.

Both in Britain and the Dominions it was acknowledged that there needed to be a uniform basis for the assessment of pensions in respect to facial disfigurement - "having regard to the ex-soldier’s pre-war and present occupation, the effect of such disfigurement on
his earning capacity, and whether his features could be improved or otherwise by surgical operation.” Unlike other disabilities, where assessment was based on physical limitations, the degree of assistance provided to disfigured veterans was determined by a subjective assessment of appearance. In requesting that a description of the extent of disfigurement suffered by a veteran be given on their pension application, however, the term “repulsive” was the only example given, indicating that this was perhaps the expected response.

It was determined that a full military pension would be paid to a very severely disfigured veteran, and a severely disfigured veteran would be paid an eighty percent pension. To give some context to this rate, the full pension was paid to someone who had lost two limbs, and it was over twenty per cent more than that provided to a veteran who had lost one limb or had suffered complete deafness. Such high pension rates indicate that the government realised that while medically repaired, these men would still confront obstacles in gaining employment and required financial aid. It also implies that governments acknowledged the social and emotional ramifications of disfigurement, and consequently, based pension rates on more than just the physical earning capacity of the veteran. It was one thing for government to provide compensation for those veterans who were “maimed” or “disabled” – but how much could financial assistance aid men who, by the Department’s own rhetoric, were “repulsive?”

The use of terms such as “repulsive” leads to a question of whether the rhetoric of repatriation helped or, in some ways, hindered the situation of the disfigured. Who would be willing to apply for a pension on the grounds they were repulsive?

Many disfigured veterans simply chose not to apply to for a pension. James Payne, for example, claimed that a pension “wasn’t worth bothering with really.” In his opinion, “You weren’t dead and that was all that matter. Other men were disabled. I wasn’t disabled, I just couldn’t eat, that’s all.” Indeed, many disfigured veterans who considered themselves physically capable of working regardless of their appearance reasserted their roles as “breadwinners” and heads of households.
Ward Muir, an orderly who had worked in the facial unit at the 3rd London General hospital with Gillies, pondered how complicated home-comings were going to be though:

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

Unlike other war-related disabilities, for which a veteran would generally receive sympathy, the most common responses to disfigurement were (and still are) shock, repulsion or even fear.xxxviii For the men themselves, such reactions may have led to feelings of self-consciousness, isolation, withdrawal, even depression.xxxix But instead of dwelling on such cases (and there are numerous repatriation files that demonstrate the difficulties faced by some of these men), I would like to share some examples of adaptation and resilience.

One man who I think epitomises adaption, is Ivo Howell, who was a school teacher in suburban Melbourne on enlistment with the AIF. When he returned disfigured from war, his greatest concern was that he would no longer be able to stand in front of a classroom of children for fear he would terrify them with his appearance. Instead of giving up on his passion for education, he started one of the first correspondence schools across Victoria.

William Kearsey, had been a 24-year-old coach builder from Inverell when he enlisted. Following a shell explosion in France in October 1917, he sustained a severe wound across his forehead and the bridge of his nose. William was admitted to Sidcup in November 1917 and underwent no less than 29 operations during his 18 months there. When William, who had been engaged to a woman pregnant with his child, returned to Australia, his fiancée called off the engagement and refused to let him see his child. He was also unable to return to his old coach building job. While you could perhaps understand if William had turned to alcohol or remained unemployed, he was able to move on, having benefited greatly from the remarkable medical treatment available.
William Kearsey, c. 1916. AWM P10965.001

William Kearsey, November 1917. Image from Royal Australasian College of Surgeons

William Kearsey, c. 1920. AWM P10965.002
William bought a property just outside of Inverell and became a wool grower and classer. Unlike occupations that were in the public sphere and of a professional nature, rural occupations such as farming and labouring, may have allowed disfigured veterans a degree of solitude, and some freedom from the gaze of others. While William remained a bachelor for most of his life, he was extremely close to his brother’s family. He only married at the age of 59 to a girl twenty years his junior, and together they adopted a young boy in 1960.

Like many returned veterans, those who had been disfigured appear not to have spoken much about their wartime experiences or how they felt about their disfigurement. While William’s niece, Beryl Taylor, knew a little of her uncle’s story, no specific details were spoken of within the family until her uncle’s passing: “We just knew [he] carried the scars from war injury. It was barely mentioned and Uncle Bill never complained.” She simply recalls a man who was gentle, caring, and seemed to carry no bitterness about his experience. I am actually going to meet William’s adoptive son this week, after years of trying to track him down – so I hope to hear more of his story.

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So what does an understanding of these experiences offer us today? In late 2007, Australian Sergeant Michael Lyddiard was deployed with the 3rd Reconstruction Task Force to Afghanistan. While conducting a route clearance task on 2 November, he was seriously wounded when an Improvised Explosive Device (IED) he was attempting to render safe detonated. Along with the loss of the lower right arm, he also suffered severe facial wounds and the loss of his right eye. Lyddiard is just one of many soldiers who have suffered facial disfigurement in recent conflicts such as those in Iraq and Afghanistan.

*Army, February 2008*

Up to 25% of all wounded military personnel form these conflicts presented with facial and neck wounds –almost double the approximate percentage of facial wounds sustained by servicemen during the Great War.xxxi In these recent conflicts, approximately 75% (others estimate as high as 85%) of wounds are caused by improvised explosive devices (IEDs) – the characteristics of which mirror those of the shrapnel wounds of the Great War, with rough, jagged and torn entry and exit points.xxxi The major difference now is an increased frequency of facial burns from the heat of the blast.xxxii The protection afforded by modern body armour has contributed to the survivability of previously fatal wounds, but it
has been suggested that in current conflicts, the unprotected face of a soldier wearing body armour is not only exposed but targeted by the enemy.\textsuperscript{xxxiii}

Medical professionals in the field of maxillofacial surgery today feel that more attention needs to be given to the “symbolic and unique nature of facial disfigurement, and its consequences for social and mental adjustment.”\textsuperscript{xxxiv} While surgical techniques have certainly progressed since the Great War, the social stigma and significant personal challenges of disfigurement remain. It is only through exploring the experiences of disfigured Great War veterans that society can begin to recognise the significance of their stories within medical, military and social history. Instead, I fear, what we may see is the experiences of current disfigured veterans become skewed or (dare I say) forgotten, in the way those of the Great War have been.

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And this is where I become most concerned. Overlooked, but now over-played. In a disturbing use of medical records from Queen’s, in 2007 the videogame \textit{BioShock} was released with zombie-like characters based on Queen’s patients - including the character ‘Toasty’ which is clearly based on the tragic case of Henry Ralph Lumley. Lumley had joined the Royal Flying Corps in April 1916. During a flight from the Central Flying School in Wiltshire, on Salisbury Plain on 14 July that year, Lumley crashed and suffered severe burns. He lost his left eye and could barely see out of the right eye. Despite his wounds, Lumley lived for nearly two more years. In early 1917, he was a patient at King Edward VII Hospital for Officers, on Grosvenor Gardens. The nursing sister caring for Lumley there wrote that ‘he has very little to live for poor boy, but we are doing everything possible.’

Lumley was transferred to Queen’s Hospital on 22 September 1917. The surgical team, led by Gillies, decided to reconstruct Henry’s face using a huge skin graft from his chest. The scar tissue would be removed, and the graft would be stitched into place. Pedicle tubes would be employed to provide further available skin. The operation was performed in stages. The first, on 24 October, outlined the chest graft and created the pedicle tubes at the neck. The second, more major, operation occurred on 15 February 1918. The scar tissue was
excised, effectively removing all traces of Lumley’s ‘old’ face, and the graft was stitched into place. Unfortunately, because of the size of the graft and Lumley’s already weakened state the chest skin was rejected and Henry died of heart failure on 11 March 1918.xxxv

Using medical images in this way raises many ethical questions. These questions have been addressed elsewhere, but what it highlights in relation to this thesis is how these images often stand independent of their historical context.xxxvi There is no attempt on the part of the designers/artists of BioShock to relate the character to the reality of what is being recorded in the medical photographs - other than the questionable choice of the name ‘Toasty’, acknowledging that Lumley was a burns case. There is a sad irony here: the photographs taken at the Queen’s Hospital record the results of weapons that were designed to mutilate and kill. As characters within BioShock, these ‘men’ become targets (and indeed, perpetrators)
of violence once more. The game’s designers write that BioShock ‘forces you to question the lengths to which you will go and how much of your humanity you will sacrifice ... to save your own life’, conveniently neglecting to respect the humanity of the men whose images they have appropriated for their game.

Ultimately, these depictions of disfigured soldiers fail to engage with the complexity of their historical context - using disfigured characters as ciphers for the destruction and tragedy wrought by war, usually without any of the complexities that my research has identified. BioShock takes this destruction and tragedy and turns it back on itself – the ‘characters’ in the game (based so clearly on real patients from Queen’s) are destructive and the ‘tragedy’ of their disfigurement is replaced with a loss of identity that reduces these ‘men’ to monstrous non-humans.

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In a similarly negative depiction of disfigured Great War veterans, the character of Richard Harrow played by Jack Huston in the Home Box Office (HBO) series Boardwalk Empire continues these questions of humanity and identity. While there is a depth to the character that alludes to the emotional complexity of disfigurement, at the heart of it Harrow is a killer. After being a sniper during the Great War, he is now a hitman working for bootleggers in prohibition-era Atlantic City. Physically, his disfigurement is portrayed as someone who – compared to the results seen in the work of Gillies and the surgeons at Queen’s – chose to end his treatment early, leaving his left eye socket as a gaping hole and considerable open scarring to the left side of his mouth.

The mask worn by Harrow to conceal his disfigurement adds to the lack of emotion seen on Harrow’s face. He suffers discrimination and isolation due to his disfigurement, and has an unhealthy obsession with guns and the German sniper’s face shield that he brought back as a trophy of war. At one point, his depressive state becomes so overwhelming that he contemplates suicide and almost does so, only being prevented from pulling the trigger when disturbed by a dog. In the end, he dies in a gunfight with bootleggers –
apparently a fitting conclusion to life he ‘chose’ to lead, but which can be seen in part as being the result of his disfigurement and being unable to adjust to a ‘normal’ life.

Richard Harrow. Images from the HBO series Boardwalk Empire.

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What depictions such as those in BioShock and Boardwalk Empire have done, and continue to do, is distort the history of disfigured Great War soldiers. They separate the image of the disfigured veteran from its historical context. In doing so, they perpetuate the misconception that disfigured veterans were provided with only rudimentary medical treatment and the resulting disfigurement led them to lead tragic and/or maladjusted lives. The range of experiences I have uncovered in my research, including many of resilience and adaption, demonstrate that this is too great a generalisation and more diversity needs to be shown in disfigured characters if the public is to truly understand what disfigured soldiers of the Great War experienced and overcame – to realise that they were far more that ‘poor devils without noses and jaws’.
ENDNOTES – please contact Kerry Neale (kerry.neale@awm.gov.au) for full citations.

iv Gillies, *Plastic Surgery of the Face*, 1920, p. 211
vii Gillies Archives, RACS, LAC CEF records, and Dunedin collection.
ix Black, *King’s Nurse – Beggar’s Nurse*, p. 87.
ixi Pound, *Gillies*, p. 34.
ixii Pound, *Gillies*, p. 34.
ixiv Lyn MacDonald, *The Roses of No-Man’s Land*, p. 149.
ixv Daisy Spickett, IWM interview transcript, IWM 514/08/03, pp. 15-16.
ixvi Daisy Spickett, IWM interview transcript, IWM 514/08/03, pp. 15-16.
ixviii Goodman, *Our War Nurses*, p. 49.
ixix Catherine Black, *King’s Nurse – Beggar’s Nurse*, p. 86.
xii The *Sydney Mail*, September 1915; *The Sydney Mail*, 18 September 1918.
xiii Smith’s Weekly, 30 August 1919; 26 July 1919; 31 May 1919.
xvi James Albert Payne, 9894 [interview], Reel 6, Imperial War Museum.
xix Muir Ward, p.XX, 1918.
xxi Bernstein, *Emotional Care of the Facialy Burned and Disfigured*, pp. 51, 53.


Similar to the process undertaken in the treatment of Vicarage, but more extensive and extreme. His death led to a change in procedure, with future operations of that scale being done more slowly and in smaller steps, with multiple smaller sections of skin being grafted rather than one large piece.


HBO series *Boardwalk Empire*, created by Terence Winter, directed by Martin Scorsese, premiered September 2010. Based on *Boardwalk Empire: The Birth, High Times, and Corruption of Atlantic City* by Nelson Johnson.