Making good : World War I, disability, and the senses in American rehabilitation

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Making Good: World War I, Disability, and the Senses in American Rehabilitation

by

Evan P. Sullivan

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Preface

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# Table of Contents

Acknowledgements .............................................................................................................. ii  
Preface .................................................................................................................................... iv  
Table of Contents ..................................................................................................................... vii  
Abstract ................................................................................................................................. ix  
Introduction ............................................................................................................................. 1  

Chapter I: “A Better Citizen Than He Was”: Citizenship and Rehabilitation in the Section of Defects of Hearing and Speech ................................................................. 14  
   I: Deaf and Speech Education in the United States before 1917 ........................................ 17  
   II: Language and Citizenship in Wartime America .............................................................. 23  
   III: “A Blessing to the Deafened Soldier:” War Wounds, Lip Reading, and Rehabilitation .. 29  
   IV: War Wounds and the Impulse for Speech Correction ..................................................... 39  
   V: Conclusion ....................................................................................................................... 45  

Chapter II: Devices of Adjustment: Managing Disabled Bodies through Touch and Physicality 49  
   I: Regulating the Touch Organ: Healing Peripheral Nerves and Silencing Pain.................. 51  
   II: Educating the Senses: Touch, Vocational Training, and Economic Independence ........ 59  
   III: Morality of Touch: Feeling, Sexuality, and Manhood .................................................. 64  
   IV: Conclusion ..................................................................................................................... 86  

Chapter III: Gustatory Healing: Taste, Ingestion, and Power in Rehabilitation .................... 88  
   I: Food, Voluntarism, and the American War Effort ............................................................ 89  
   II: Sensory Problems and Curative Environments ............................................................. 97  
   III: Greasy Forks, Squeaky Carts, and the Experience of Ingestion ................................... 102  
   IV: “A Nuisance to the Country”: Patients and Alcohol Consumption ............................. 111  
   V: Conclusion ..................................................................................................................... 120  

Chapter IV: Seeing Blinded Veterans: Sight and Culture in War and Healing ..................... 122
<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Oh Boy, That’s Sure Worth Working For!: Visual Aids in War and Rehabilitation</td>
<td>124</td>
</tr>
<tr>
<td>II</td>
<td>Affliction’s Heaviest Cross: Constructing the Blinded Veteran Image</td>
<td>131</td>
</tr>
<tr>
<td>III</td>
<td>New Eyes for the Old that War Closed: The Politics of Sanitizing Wounds</td>
<td>137</td>
</tr>
<tr>
<td>IV</td>
<td>Conclusion: Garlands, Hymns, and Praise</td>
<td>147</td>
</tr>
<tr>
<td>V</td>
<td>Chapter V: Seeing Wounds: The Problem of Invisible Wounds and the Promise of Making Wounds Invisible</td>
<td>149</td>
</tr>
<tr>
<td>I</td>
<td>I: Left to His Own Desires: Confronting the Problem of Invisible Wounds</td>
<td>150</td>
</tr>
<tr>
<td>II</td>
<td>II: Just As Good As… Before the War: The Promises of Making Facial Wounds Invisible</td>
<td>160</td>
</tr>
<tr>
<td>III</td>
<td>III: Conclusion: They Ache Just The Same</td>
<td>173</td>
</tr>
<tr>
<td></td>
<td>Conclusion</td>
<td>175</td>
</tr>
<tr>
<td></td>
<td>Bibliography</td>
<td>180</td>
</tr>
</tbody>
</table>
Abstract

This study looks at how disabled American soldier-patients and the US Army used the senses as tools of rehabilitation after the Great War. Contemporaries argued that, when the hundreds of thousands of American soldiers came home wounded or sick after the Great War, the men needed to make good. The phrase “making good” meant that sacrifice in the war was not enough, and veterans had to become socially and economically independent, and return to heterosexual relationships. In an effort to return to normalcy, the US Army relied on rehabilitation, which aimed to medically and socially re-integrate the men into society.

Wounded and sick soldiers entered hospital wards and mess halls, operating rooms and vocational training while using their senses to make sense of their wounds, their disabilities, and their places within a rapidly demobilizing America. What did it mean to be disabled after the war? How did ideas about manhood or morality shape the rehabilitation experience? By looking at rehabilitation through the lens of sensory history, this study argues that the senses were political tools for both the individual and the state. The US Army politicized hearing, for example, when they did not allow deaf and hard-of-hearing veterans to learn American Sign Language, and instead appealed to the more popular lip reading movement, an easier form of communication for aural society more broadly. The sense of taste was a way for soldiers to take control over the healing experience and hold the state to higher standards of care. And the sense of touch had many vocational functions, but also served to re-integrate men into gendered and sexualized relationships.

Looking at rehabilitation through sensory experiences also offers important themes in appealing to society’s needs after the war. While most blinded veterans returned with complex
physical and neurological wounds, the many stories published about them ignored the complexities, displayed bodily whole and uncomplicated wounds for public consumption, and focused on their success as a way to motivate other disabled veterans. The image of facially wounded veterans was also sanitized for public viewing, as stories often focused on the promises of modern surgery to fix broken faces. Contemporary depictions of sanitized and successfully rehabilitated veterans appealed to the public’s vision of morally positive veterans, but obscured the true costs of war on the human body and mind, and subverted important and necessary conversations about war and trauma. The senses were, therefore, tools for coming to terms with, or averting attention from, the human costs of war in the modern era.
Introduction: A War of the Senses

Harry Keefrider turned 25 years old a month prior to being wounded at Verdun on September 28, 1918. Shrapnel struck the Pennsylvanian and former newspaper salesman in the face and left arm, destroyed his left eye, and passed through his nasal cavity before it emerged from his right cheek. Keefrider arrived at US Army General Hospital No. 2 at Fort McHenry in Baltimore five months later, in February 1919. He had already gone through one operation prior to his arrival that cleared out what remained of his left eye socket and nasal cavity. But it was clear to surgeons that his wound still needed further treatment. He entered the operating room again in June 1919, where surgeons removed scar tissue and pus, and cleared the partially blocked nasal cavity.¹ Keefrider’s journey continued at US Army General Hospital No. 7 in Baltimore, a special rehabilitation center for blinded veterans of the war, where he used his senses to navigate the institution’s halls and complete vocational training. Keefrider made good, or re-integrated back into society according to American society’s gendered standards of work and family, as he married his fiancé Priscilla, opened an insurance agency, and helped raise their six children.²

This dissertation is a study of the interconnectedness of ideas about gender, disability, the senses, the state, and power in the years of the Great War. It will investigate competing narratives about how soldier-patients came to understand their disabilities, how the state and society contributed to disabled veteran narratives, and how the senses allowed soldiers power within the massive state-driven rehabilitation experiment. The senses were often political. They were tools of state power. But they also enabled a soldier to act independently within a top-down

¹ Harry E. Keefrider, RG 112, Series NM 31 (K), Box 185, Folder: Untitled, US National Archives; biographical information provided by Harry Keefrider’s grandson, Chris M. Keefrider.
² Information provided by Harry Keefrider’s grandson, Chris M. Keefrider.
system that tried to impose a sense of normality onto men returning from war, even if their bodies and senses were damaged or destroyed. Senses allowed a soldier to control his surroundings in an almost uncontrollable atmosphere. And they were tools for coming to terms with, or diverting attention from, the human costs of modern war, and ultimately making good. Examining the politics of wounds and the senses helps illuminate broader ideas about disability and normality in the modern United States. Placing the senses at the center of the healing narrative allows for a focused and fruitful investigation of the hospitals and the social conditions soldiers endured in the postwar years.

Harry Keefrider was one of the many soldiers of the First World War who suffered a wound or illness that damaged or destroyed their senses. While existing scholarship has rightfully focused on pervasive and culturally salient wounds such as amputated limbs and shell shock, sensory wounds were significant in number and impact. And sensory wounds, as well as the Army’s use of the patients’ senses to stimulate healing after the war, point to important themes in postwar rehabilitation, such as how central the senses were as tools of healing, the power negotiations between soldiers and the state, and how gender, sexuality, and productivity factored into mainstream ideas of successful rehabilitation. But, as Keefrider’s experiences indicate, the war itself was, quite literally, a war of the senses. Sights, sounds, and smells permeated fighting and healing with great intensity. Keefrider’s sensory experiences in wounding and healing were typical for wounded men in First World War rehabilitation, and highlight important trends in the postwar experiences of disabled veterans such as what it meant to be a disabled man, and which wounds provoked, or did not provoke, criticism of war itself.

But the soldiers were not simply passive victims of war trauma. Instead, the comprehensive US Army rehabilitation program during and after the war mobilized the senses in the service of soldier-patient healing. Officials argued, for example, that men who were blinded in war should use their sense of touch to navigate their new world. The state politicized language, as deaf veterans entered a complex power system meant to “normalize” their communication through lip reading and speech training. Patients took power into their own hands, in many cases, as they used their sense of taste to hold the state to higher standards of care in food production. The sense of sight was important as well to society’s efforts to return to normalcy. Postwar commentators carefully constructed the imagery of blinded veterans and maxillofacial patients to motivate other veterans to “make good” – a phrase that signified successful social and economic re-integration after war – or to tout the promises of modern medicine to heal the wounds of war. The senses exposed critical debates, such as why it was

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4 Photograph courtesy of the US National Archives. Harry E. Keefrider, RG 112, Series NM 31 (K), Box 185, Folder: Untitled, US National Archives.
5 Photograph courtesy of Harry Keefrider’s grandson, Chris M. Keefrider.
important to displace the visual scars of facial wounds and instead highlight the promises of surgery in fixing them, which help one understand the nature of healing and the role of the state and the individual in coming to terms with the human costs of war.

The Great War was not the first time Americans confronted war-related disability on a large scale. The American Civil War introduced Americans to mass death and disability in an arguably more widespread manner, as soldiers of the northern and southern United States engaged in extensive fighting that, in ways similar to the Great War, engaged the senses. The Civil War shaped modern conceptions about disability and normality after hundreds of thousands of veterans returned to society with visible and invisible wounds or illnesses, and in need of care or material assistance. The creation of the National Home for Disabled Volunteer Soldiers, a system of shelter and medical care for Union veterans, signaled the growth of the federal government in giving direct assistance through pensions and institutional care, while at a progressively growing cost to society.

The rise of the Progressive movement, aimed at efficiency and social reform, provided the context for many activists to consider alternatives to pensions and institutional care. Middle-class social reformers embarked on moral crusades meant to influence society, as they sought to

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address, among other issues, poverty and venereal disease. One of the many Progressive Era goals was to reduce the costs borne by the state by limiting social welfare on the local and national levels. Progressives achieved this through mechanisms such as means testing for benefits and the use of the poorhouse to deter the working class from seeking relief.

Progressive Era efforts to clean up public morality often overlapped with eugenic goals to clean up the human genetics of disabled people. Care mechanisms for people with disabilities in the United States had been home and community based prior to the 19th century, when many people with disabilities were increasingly secluded in institutions, where newly fashionable medical and moral therapies could be applied. With the spread of eugenics, ideas abounded in the US and abroad that argued individual character traits such as criminality, as well as disability, could be prevented. Eugenics permeated much of Progressive discourse and policy. For example, American immigration policy around the turn of the century hinged largely, but not exclusively, on the exclusion of people with disabilities, who were deemed a threat to the nation because they were considered possible public charges. Around the same time, cities across the

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nation put in place “ugly laws” that aimed to identify, discipline, and ultimately get rid of “unsightly” individuals on city streets.\textsuperscript{15}

Eugenic efforts to classify and control disabled populations were seen at nearly all levels of society. It was prevalent in a high profile 1927 Supreme Court case, where Justice Oliver Wendell Holmes upheld the state of Virginia’s ability to forcibly sterilize “mental defectives” such as Carrie Buck because, according to Holmes, “three generations of imbeciles are enough.”\textsuperscript{16} The eugenic crusade also contributed to efforts to institutionalize deaf Americans and impose oralism (lip-reading) by classifying deaf users of American Sign Language as “outsiders.”\textsuperscript{17} The years of the Great War, therefore, coincided with progressively intrusive attempts to reform the social body by controlling individual bodies.

Disability policy throughout the United States imposed ideas of uniformity and genetic “purity” that also converged with interpretations about what it meant to be an American. Impulses to “Americanize” or classify and control populations took on increased importance during the years of the Great War. During the war American nativism and civic nationalism contributed to widespread coercive voluntarism. Americans felt pressure to contribute to the war effort for the good of the nation and, in turn, strengthen singular ideas about citizenship.\textsuperscript{18} These efforts extended to the xenophobic policing of German-American cultural and social life, widespread pressure to serve in the armed forces or to conserve food and other materials, as well

\footnotesize
\textsuperscript{16} Paul A. Lombardo, \textit{Three Generations, No Imbeciles: Eugenics, the Supreme Court, and Buck v. Bell} (Baltimore: Johns Hopkins University Press, 2008), ix.  
as enforcement of middle-class morality by preventing alcohol consumption and venereal disease among soldiers who were training for war.19

As Progressive Era efforts to shape society during the war years intensified, reformers looked to veterans’ pensions as yet another avenue for potential change. Progressives saw the Revolutionary War and Civil War pensions of the past as inefficient and corrupt, and argued that vocational training was a way to reduce or erase cash payments for veterans.20 Reformers argued that, through rehabilitation, the American government could “rebuild” disabled veterans to economic self-sufficiency as masculine wage earners and thereby save money.21 War-related disability, the argument went, was merely a temporary setback that could be erased.22

The modern system of veteran health care took shape in the postwar years in a patchwork of bureaucratic agencies. Lawmakers who were worried about the growing cost of veterans’ pensions designed the War Risk Insurance Act (WRIA) of 1917. The WRIA based compensation on the extent to which war disability reduced the capacity of a veteran to earn income through wage labor, and added additional compensation based on the number of dependents the individual had. The legislation “affirmed a traditional middle-class vision of family and gender

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The Vocational Rehabilitation Act of 1918 placed vocational training under the supervision of the Federal Board for Vocational Education, and provided tuition, medical care, prosthetics, and monthly compensation. The system of veterans’ benefits was broad but inefficient. “Ex-soldiers had their disabilities medically certified by the army, received compensation from the Bureau of War Risk Insurance in the Treasury Department, and turned to the U.S. Public Health Service for medical care.” Congress responded to the policy inefficiencies, and the lobbying of groups such as the American Legion, by creating the Veterans’ Bureau in August 1921. With an annual budget of $450 million, the Veterans’ Bureau provided an institutional home within the federal government for veterans to apply for compensation, medical care, or air grievances.

Wounded and disabled veterans encountered not only policy changes, but also an increasingly powerful medical-bureaucratic alignment that exerted far more control over the veterans’ wounded bodies and minds. Physicians often found opportunities in the war to exert their own status and authority, and prove their worth to the state. Modern medicine’s expanding influence during the war years, while important to our understandings of veteran care, often

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24 Kinder, Paying with Their Bodies, 124.
25 Rose, No Right to Be Idle, 195-196.
27 Kinder, Paying with Their Bodies, 106.
overshadows individual soldier experiences. Ana Carden-Coyne and Beth Linker argue that wounded soldiers were not mere victims but were also agents in the military medical establishments by, for example, producing stories about brutal doctors or nurses or writing letters to family about the poor sanitation in hospitals.\(^{29}\) Yet, despite modern medicine’s elevated power and efficiency, not all war wounds were cured. And postwar rehabilitation relied in part on covering up or hiding war wounds, or the “problem” of the disabled veteran.\(^{30}\) A visible wound could be both “unsightly” and also a constant reminder of war.\(^{31}\)

Americans experienced and understood the war years through sensory observation. The war itself was a sensory experience.\(^{32}\) On the home front, the federal government reached civilians through appeals to their sense of taste as a way to compel them to not waste food, or to eat substitutes for some staples.\(^{33}\) On the Western Front, American soldiers encountered a multi-sensory hell, some through devastating and disorienting wounds, and others through the quotidian assault of horrific sights, deafening explosions, the stench of slaughter and decay, the bitter taste of poor food and polluted air, and the feel of damp uniforms, sucking mud, freezing temperatures, and more in the trenches.\(^{34}\) Away from the front, pain was politicized in hospitals where physicians preferred silence and equated vocal restraint with early twentieth century

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\(^{31}\) Schweik, *The Ugly Laws*; Kinder, *Paying with Their Bodies*.


notions of masculinity, forcing men to suppress their responses to continued assaults upon their senses. The senses are, therefore, critical to understanding values, moral assumptions, identities, power structures, and decisions during the First World War.

Exploring the sensory experiences of wounded and disabled soldiers in hospitals, and the ways the military, state, society, and veterans used the senses as tools for social and medical re-integration, reveals contested visions of what it meant to be disabled, what it meant to be a man with a war wound, and how those who returned from war were supposed to conduct themselves. Nicholas J. Saunders and Paul Cornish write, “Any human body in any conflict (and its aftermath) is an arena where a multitude of physical, psychological, cultural, spiritual and emotional issues are played out, often in unpredictable ways, and with kaleidoscopic complexity.” Exploring this complexity, in the sensory wounded world, allows for a fuller picture of disability and disabled veteran identity after the First World War. “Making good,” a simple and short phrase, carried enormous cultural significance, and understanding what contemporaries meant by it opens windows onto many aspects of early-twentieth-century American culture and society.

This study will address four of the five senses in its investigation of wounded, ill, and disabled veterans of the Great War: sight, hearing, taste, and touch. (The major omission is smell, but that is because institutional, cultural, and personal accounts of hospitals and the aftermath of the war contain little, if any, major evidence of debates related to the sense of smell among soldier-patients, the military medical establishment, and society.) Each chapter addresses a sense and contested visions of its meaning before, during, and after the war. Chapter one, “A Better Citizen Than He Was,” focuses on soldiers at the US Army Section of Defects of Hearing

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36 Cornish and Saunders, Bodies in Conflict, xvi.
and Speech in Cape May, New Jersey. The US Army segregated soldiers who were deaf from wounds, or deemed in need of speech therapy. The soldiers there joined ongoing conversations about deafness and ideas about what society considered proper aural speech patterns. Their experiences occurred within the context of heightened debates about what it meant to be an American citizen. The Section was a training ground for oralist education, a means of teaching lip reading to deaf individuals. The politics of oralism were intensified by the socio-political importance of its veteran clientele. Communication standards were just as important to the economic, social, and medical goals of rehabilitation as learning a trade or using a prosthesis.

As veterans and the state used hearing and speech to navigate broader conceptions of citizenship and inclusion, other patients deployed the sense of touch to find a new place for their wounded bodies in postwar society. Chapter two, “Devices of Adjustment” explores the social and cultural meanings of touch within the walls of American hospitals. Blinded veterans, for example, used the sense for technical and navigational purposes. But the sense of touch also had broader social and cultural meanings, as tactile boundaries also signified re-integration into gendered and sexualized roles, and conveyed ideas of bodily autonomy in the face of state power.

Chapter three, “Gustatory Healing,” shows that taste and ingestion were important to rehabilitation and disabled veteran experiences in the United States after the Great War. Not only were food, taste, and ingestion crucial for nutritional value, but they also signified to the individual soldier the care that the state took when healing the wounded or ill. When the state did not live up to gustatory expectations, soldiers protested, and held hospitals to higher standards. Additionally, patients often used ingestion as a way to define their own involvement in rehabilitation. Many patients and medical detachment men, for example, defied regulations and
the state-promoted ideal of the moral veteran when they found ways to obtain and drink alcohol in cities near the hospitals.

Sight was important in state-prescribed ideals of successful rehabilitation as well. Chapter four, “Seeing Blinded Veterans,” reveals that despite their often-complex physical and neurological wounds, stories published about blinded veterans portrayed them with singular and uncomplicated wounds. State and non-state publications painted blindness as among the worst wounds one could endure. But instead of coming to terms with the realities of war wounds, and the role of the state-sponsored violence of war in damaging citizens’ bodies, the stories emphasized the successful postwar lives of the blinded men. The sanitized narratives of war wounds met the need of the public to accept the violence of war and support postwar rehabilitation efforts. These narratives portrayed men as cheerfully overcoming their sightlessness—the kinds of stories about disability that persist today—to inspire other disabled veterans. The message of these narratives was, if these men can do it, so can you.

Sight played a role in other narratives of postwar healing as well. Chapter five, “Seeing Wounds,” examines two ways visibility and invisibility shaped conversations about wounds, treatment, and rehabilitation. First, despite official rhetoric seeking to give equal support to veterans with visible and non-visible wounds or illnesses, the state failed to provide adequate services for certain categories of patients with invisible wounds or war-related illnesses, such as diabetic and arthritic patients that did not fit within rehabilitation’s promise to “cure” war disabilities. Second, widely publicized stories of veterans with horrific facial wounds overshadowed the war wound stories and emphasized the promise of making these wounds invisible through modern plastic surgery. The sense of sight was, therefore, important to defining what it meant to have a war wound, and what it meant to heal from war wounds. These
conversations lay bare important ideas about medical power and society—who had the power to construct the narratives—and they avoided more difficult conversations about the costs of war itself.

Each soldier of the American Expeditionary Forces who went through US Army General Hospitals experienced healing through the senses. Yet, neither the senses nor the patients were passive recipients of care. Instead, they were actors imbued with the social and cultural values and assumptions that permeated wider society. Exploring sensual experiences and expectations allows for more vibrant histories of life, treatment, and healing within the walls of Great War hospitals, and the expectations the state and society had of wounded men. Understanding these experiences helps reveal what it meant in the early twentieth century to be American, to be wounded, to be disabled, and to be a veteran, a man, and a citizen, or to be deemed none of the above. And these experiences help us understand larger questions about war, violence, culture, and the human body, as important today at the beginning of the twenty-first century as they were at the beginning of the twentieth.
Chapter I: “A Better Citizen Than He Was”: Citizenship and Rehabilitation in the Section of Defects of Hearing and Speech

Private Isadore Warshoevsky was the first soldier of the American Expeditionary Forces to return deaf and take rehabilitation classes in the Section of Defects of Hearing and Speech at US Army General Hospital No. 11 in Cape May, New Jersey. A Jewish immigrant who escaped the 1905 pogroms in Kiev, Warshoevsky’s service in the Great War ended with his inability to hear, and upon arrival at Cape May he sought desperately to communicate with his wife, whom he married prior to the war. There he learned to read and write English, learned lip reading, and finally began communicating with his spouse, which was his highest priority. After his rehabilitation it seemed that he would soon return to his career in shoe repair. “His progress in speech reading” according to a column in the rehabilitation magazine *Carry On* “has been most satisfactory.” Warshoevsky would return within months “a better citizen than he was when his country called him to war.”

Isadore Warshoevsky’s experiences highlight important trends in the broader history of postwar rehabilitation. His story emphasized “re-gaining” manhood through postwar re-education in efforts to make good. In Warshoevsky’s case, education in lip reading allowed him to re-unite with his wife, a theme common to many post-war “success” stories. And much like other returning veterans, the men at the Section faced a policy and social atmosphere that dictated their service was not enough and that they must re-integrate into social and economic life in order to fulfill completely the obligations of citizenship. Like thousands of other veterans,

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37 “Seeing is Hearing: The Army is Educating its First Deaf Soldier by the Newest Methods” *Carry On: A Magazine on the Reconstruction of Disabled Soldiers and Sailors* 1, no. 3 (September 1918), 15-16; “Seeing is Hearing: The Army is Educating its First Deaf Soldier by the Newest Methods” *The Journal of the Missouri State Medical Association* 15, no. 11 (November 1918), 411-412; Must Write Wife: Deaf Soldier Quickly Taught” *The Daily Panhandle*, November 1, 1918, 4; “Must Write Wife; Deaf Soldier Quickly Taught” *The Evansville Indiana Press*, November 11, 1918, 4; “Removing War’s Handicaps” *The Princeton Union*, October 24, 1918, 1; “Deaf Soldier Writes Wife After Learning in Army Overseas” *The Walnut Valley Times*, October 30, 1918, 3.
Warshoevsky entered one of many rehabilitation institutions that sought to transform disabled veterans into productive workers and hide their disabilities as much as possible.

Yet Warshoevsky’s experiences are also shaped in ways specific to his condition. Deaf and hard of hearing veterans joined ongoing social and cultural debates about deaf education and citizenship stemming from the foundation of American deaf schools in the nineteenth century. Deaf schools began in the early nineteenth century as inclusive educational spaces for sign language. By the late-nineteenth century, lip reading education and an increasingly medicalized view of deafness positioned Deaf Americans as patients who needed a “cure,” and who were not quite at the evolutionary level as aural speakers. Many in hearing society thus imagined deaf

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38 “Seeing is Hearing,” Carry On, 16. Open source.
people could not fully exercise their citizenship.\textsuperscript{39} While the Deaf community staked its claims to citizenship on various degrees of war service and work, it made fewer efforts to connect with disabled veterans in the Section, which left the veterans isolated from other deaf individuals.\textsuperscript{40}

Despite their relative isolation from the broader Deaf community, veterans at the Section engaged with sensory adaptation, learned normative speech, and joined a larger wartime social atmosphere that prioritized clear speaking. Warshoevsky’s ability as a deaf man to communicate clearly in English through the use of lip reading qualified him to be counted among citizens of the nation, while exclusionary eugenic policies barred many disabled immigrants from entering the country and Deaf leaders distanced the community from people with disabilities to fit within the nation’s ideas of normality.\textsuperscript{41} Language and the sense of hearing, therefore, were socially contingent and powerful indicators of worthiness in American society. The experiences of men treated in the Section show how they negotiated medical and disability norms in American society, and demonstrate the extent to which the sense of hearing, as well as language more generally shaped conceptions of citizenship in the war years. Efforts to correct speech defects and teach lip reading to deaf veterans represent one of many sensory-connected attempts to help disabled veterans “make good” by returning to normative conceptions of productive and sociable lives.


\textsuperscript{40} Many scholars define “Deaf” as a community of deaf people sharing the same language, cultural values, history and social life, and “deaf” as “simply those who do not hear.” “Deaf” therefore connotes a community situated cultural and socially around a shared language. These definitions help conceptualize deafness as an identity as well as a biological fact. See: Davis, \textit{Enforcing Normalcy}, 100; Nicholas Mirzoeff, “Paper, Picture, Sign: Conversations between the Deaf, the Hard of Hearing, and Others,” in Helen Deutsch and Felicity Nussbaum, eds., \textit{“Defects”: Engendering the Modern Body} (Ann Arbor): The University of Michigan Press, 2000), 78-79.

Deaf and Speech Education in the United States before 1917

Deaf and hard of hearing, as well as speech “defective” individuals were at the center of American debates about hearing, speech, and social inclusion long before the First World War. Americans paid little attention to deaf people before 1817 when Reverend Thomas Gallaudet and French deaf educator Laurent Clerc established the American School for the Deaf in Hartford, Connecticut.\(^{42}\) After the first institutions were built, American newspapers and journals began covering with interest the growth of schools, poems by deaf authors, and the thriving Deaf communities in the 1840s and 50s.\(^{43}\)

In the years before the American Civil War advocates for deaf education largely embraced “the language of signs” in the schools for the deaf.\(^{44}\) Educators saw the instruction as a means of providing accessibility to scripture and allowing deaf individuals to be better integrated into the Christian community.\(^{45}\) By late in the nineteenth century the concept of community changed from Christian to American, and the impulses of the Progressive Era influenced deaf education as reformers sought to create a more uniform and normative conception of the individual fitting into American society. However, this meant that the growing efforts of lip reading instruction superseded the language of signs, since lip reading supposedly promised to incorporate deaf individuals into mainstream society and the workforce.\(^{46}\)

Deaf education was widely publicized between the American Civil War and the First World War, and the growing eugenics movement had much to do with the evolving views about

\(^{45}\) Baynton, *Forbidden Signs*, 15.
\(^{46}\) Baynton, *Forbidden Signs*, 9.
sign language. After the birth of eugenics, scientists looked more acutely at hereditary characteristics and social problems and science exited the lab and absorbed the culture it aimed to conquer.\textsuperscript{47} Social institutions targeted a variety of groups, including the “feebleminded,” who were considered “morally degenerate” and a drain on society.\textsuperscript{48} Public health reformers and state actors simultaneously marked bodies not worth reproducing or even living, leading to exclusionary immigration policies, institutionalization, and sterilization.\textsuperscript{49} People who did not fit turn-of-the-century ideas about “normalcy,” situated in ideas of bodily and mentally wholeness, were thus cast aside. As a result, leaders in the Deaf community in part sought to distance themselves from people with physical and mental disabilities and associations between deafness and “feeblemindedness.” For example President George Veditz of the National Association of the Deaf called on membership to form a committee on eugenics to prevent deaf individuals from being classified as defective.\textsuperscript{50}

Americans with nationalistic and eugenic ideas infused deafness and educational standards with civilizationist rhetoric that positioned sign language as something nearly foreign and evolutionarily primitive. They argued that sign language prevented deaf integration into society and a productive industrialized economy.\textsuperscript{51} Deaf Americans were a linguistic minority, much like large groups of immigrants who did not speak English, and thus considered

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\textsuperscript{50} Robinson “‘We Are of a Different Class,’” 14.
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“foreigners among their own countrymen.” To remedy the isolation, oralists – or those who sought to promote communication through the use of lip reading instead of sign language – in the final years of the nineteenth century rallied behind Alexander Graham Bell’s crusade to proliferate oralism into schools and rid most programs of sign language. One method oralist schools used was to hire only hearing teachers in order to limit contact between deaf students and sign-literate educators, and eliminate signing altogether. Paradoxically, however, it was within strict educational confines of oralism that deaf students defined themselves socially as members of a distinct community with shared experiences.

Deaf education was still somewhat contested between 1914 and 1918. Most schools by the first decades of the century taught “oralism” or speech reading, or were “combined” schools that used both oral methods and signs. The rapid growth of oralism served as partial “justification” for its continued use as a method of teaching communication. Robert Patterson, the Principal of the Ohio State School for the Deaf, referred in grim terms of the divisiveness surrounding deaf education. “It is no secret” he writes “that there is a dark shadow over our hearts, caused by the smoke rising out of the battle of methods which is going on in our schools for domination… Strange it is that at this time, while our country is fighting in the world war in the cause of justice, liberty and humanity, there is still a struggle in our land of the Stars and Stripes for equality of opportunity and of justice in the education for the deaf.”

Patterson spoke of the “ruthless destruction” of sign language in deaf schools by the oralists, and he was not the only one who voiced his concerns. The Convention of the National

52 Davis, Enforcing Normalcy, 78 and 229.
53 Baynton, Forbidden Signs, 30.
54 Baynton, Forbidden Signs, 81.
55 Buchanan, Illusions of Equality, xiii.
56 Miles Sweeney, “The Jersey Corner” The Silent Worker 30, no. 3 (December 1917), 51.
57 “The Education of the Deaf From the Viewpoint of the Educated Deaf” The Silent Worker 30 no. 2 (November 1917), 17-18.
Association of the Deaf held a conference in the summer of 1917 and endorsed the combined system of teaching but, like Patterson, it protested the indiscriminate elimination of sign language, and argued that oralism should be the first choice and “those who fail” would be transferred to the sign classes. The position, considered to be moderate, set a precedent that superior students would learn through the oral method, further marginalizing the language of signs and its users.

The moderate position also reflected decisions elsewhere in the Deaf community. The League for the Hard of Hearing, an organization of deaf or hard of hearing individuals founded in 1910, positioned its members as “normal” citizens. The organization partnered with otologists and crafted a medicalized discourse that positioned the deaf as people who spoke English, and deafness as something that could be prevented through medical intervention. “Passing as ‘normal,’” writes historian Jaipreet Virdi, “enabled d/Deaf people to separate themselves from other disabled people… and generally avoid the stigma of disability for themselves.”

The battle over sign language therefore was not simply an external one, but comprised of personal identity negotiations among the deaf and hard of hearing as well.

Speech therapy was not new to the stage of public debate either. Speech education can be traced to the mid-1800s, though most modern clinics and education programs appeared between 1895 and 1921. The first speech correction classes began in Boston in 1895, followed by New York, Chicago, and other major cities between 1908 and 1910. The first director of the Speech Clinic at the University of Wisconsin, Smiley Blanton, along with his wife and speech teacher trainer Margaret Blanton, spearheaded educational standards in the field around the turn of the

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58 “The Sign Language” *The Silent Worker* 30, no. 3 (December 1917), 40.
century. In their books and articles on the subject, the Blantons emphasized the emotional health of stutterers in their treatment.⁶¹

Social reformers often tied speech defects not only to emotions but also to broader public health concerns. Opened in May 1917, the New York Clinic for Speech Defects treated around five hundred patients by October 1918, providing comprehensive medical, psychiatric, dental, and lip reading services to civilians.⁶² The director, James Greene, joined a plethora of voices seeking to highlight the importance of vocal inflections and speech patterns. He argued, however, that with the relatively recent professionalization of the field, speech disorders had been largely left to “semi-professional empirics” and “self-styled doctors.”⁶³

⁶¹ Duchan, “The Early Years of Language, Speech, and Hearing Services in U.S. Schools,” 156-159.
⁶³ Greene, “Releasing the Tongues of Men,” 65.
While it treated some cases as having stemmed from physical problems, the clinic had particular moral assumptions about the manifestations of speech disorders as well. According to Greene, most patients at the clinic were ‘highly strung or sensitively organized,” emotional and easily influenced. He argued that without speech correction a person would go from a “weak, good-natured individual” to “one with tendencies toward criminality.” An advertisement for the clinic depicts an individual hampered by his deficient speech, which brings along with it misery and poverty, identified as two witch-like creatures. Only through speech training could the

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individual rise up to a “world of opportunity.” Ideas about deficient morality informed medical approaches to treating speech disorders. And rhetoric about deafness and speech disorders indicated an increasingly medicalized framework in the years leading up to American involvement in the war. These broader debates about deafness, disability, and citizenship set the context for the War Department’s adoption of lip reading for deaf and speech defective veterans of the Great War.

Language and Citizenship in Wartime America

Turn-of-the-century debates about communication show how deaf, hard-of-hearing, and speech defective individuals occupied an uncertain place in broader conversations about citizenship in the war years. Before American military involvement, individuals from these groups worked to establish their patriotism in a coercive wartime environment where public policies and civilian organizations challenged individual, group, and national dedication to war efforts. After decades of oralist advancement into deaf schools and positioning deaf Americans as “others,” many in the Deaf community used the war, much like other minority populations, as a means of putting on display their full citizenship. Deaf journals published articles on the question of deaf service in the armed forces and the contributions of children of deaf adults, highlighting how the Deaf community unequivocally professed its dedication to the American ideal, despite the wider society attempting to mold deaf identity to social conformity or cast deaf individuals as outsiders.

Deaf youth were active in military training before 1917, especially within institutions of higher education. The 1862 Morrill Act compelled land-grant universities to incorporate military

66 Greene, “Releasing the Tongues of Men,” 65.
training into their instruction. Revealing of the efforts of some deaf individuals in military training was Edward Ragna, who studied at Connecticut State Agricultural College in the years leading up American involvement in the war. Though his training was not compulsory at first due to his deafness, by his senior year he trained with his hearing counterparts. “I could not hear orders,” Ragna writes, “but I was placed in the second line of the company, and I always watched and did exactly what the man in front of me did.” Ragna hoped his experience would prove that deaf men could be proficient in the military. Within the context of men such as Ragna who sought to prove themselves, Captain Robert Rees, an instructor at the officer’s training school at Fort Snelling in Minnesota during the war years, was “greatly impressed” with the deaf cadets who trained there.

If deaf military cadet training was not enough to include them fully in the national community, service overseas could be. John Cloud served as an ambulance driver in France. Cloud studied at Gallaudet College as a hearing student in the fall of 1916. After applying for membership in the Harvard ambulance corps, he appealed to the Deaf community through the Deaf-Mutes Journal to sponsor an ambulance for him to drive. The appeal was a hit, as readers of the journal allegedly sent money in faster than any Liberty Bond sale. Cloud’s knowledge of American Sign Language, according to the Journal, would make him an asset “with those who can no longer speak or who can speak only in a foreign tongue.” “The deaf,” Cloud concluded, “want to be in this war. They are among the most patriotic citizens everywhere in this country.”

The most notable example of the Deaf community professing Americanism during the war was the regular column in The Silent Worker dedicated to children of deaf adults in service.

69 Edward E. Ragna, “A Deaf Cadet at Fort H.G. Wright” The Silent Worker 29, no. 9 (June 1917), 149.
70 J. Frederick Meagher, “Nadfratities” The Silent Worker 30, no. 5 (November 1917), 31.
in the armed forces. One such article asked, “Do the children of deaf parents make good?” They did, it argued, more so in many cases than children of parents with all five senses, as evidenced by Dr. Robert Patterson, son of a deaf principal who made good through his war service on the Italian front. The journal sought to print stories about “as many sons of deaf parents who are fighting for Uncle Sam as possible,” and in most cases featured at least six men per issue. One editorial, for example, highlighted four brothers who joined the war: Elwyn, James, Sidney, and Arthur Smith. Elwyn and James found their sign language to be “of great help” in understanding foreigners, and all of them “are real patriots and have no kick coming against the life of a soldier.”

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72 “He Is Assuredly Making Good” The Silent Worker 33, no. 2 (November 1920), 69.
73 “Sons of Deaf in the War” The Silent Worker 30, no. 2 (November 1917), 23.
Finally, the journal challenged children in the Deaf community to take part in wartime service. Alexander Pach of *The Silent Worker* wrote of a common existence of hearing children who were ashamed of their parents’ deafness. According to Pach, Sergeant George Lounsbury’s service near Verdun served as proof that he respected the wishes of his deaf parents by serving the United States in the war. Deaf individuals clearly believed that their citizenship and patriotism were in question among the hearing, and so deaf individuals sought ways to make plain their dedication to the country through wartime service. Debates about citizenship were increasingly relevant with the return of newly deafened soldiers, as deafness became infused

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75 “Some Sons of Deaf Parents in the War Service,” *The Silent Worker* 30, no. 5 (February 1918), 87. Open source.
with the societal ideal of the independent and industrious American veteran, as seen through the exposé on Isadore Warshoevsky that argued his newfound language skills made him a better citizen than before the war.

The social pressures of war influenced ideas about speech as well, though in less direct ways. The American war effort led particularly to mobilizing positive speech. Ideas like “100 percent Americanism” pressured immigrants against hyphenating their nationality or speaking foreign languages such as German, adding additional context for the Deaf community to conform to oral English. In New York, for example, the American Defense Society (ADS) – a wartime quasi-vigilante group spurred by xenophobia – pressured schools to “drop the Hun tongue” by getting rid of German language programs. 77 Public speaking professionals critiqued American language patterns well into the postwar years. While for many individuals, foreign languages among recent immigrants was a source of anxiety, to others it offered hope for Americans. Susan Davis, Speech Professor at Kent State College, argued in her 1921 talk, “Better Speech for Better Americans,” that the half a million speech defective Americans were “lip-lazy,” and that voice revealed a person’s inner nature. 78 Though Davis differed from the xenophobic ADS in that she credited immigrants with having vibrant linguistic traditions in contrast to Americans, her lecture highlights the centrality of positive aural speech to ideas of nationality.

Society mobilized public speaking for the war effort as well. Liberty Loan drives relied on orators to relay messages about patriotism to hearing crowds, making the messages inaccessible for many deaf and hard of hearing individuals. The Four Minute Men organization gave brief patriotic speeches to the public, including thirty-five thousand speakers who gave

Woodrow Wilson’s Fourth of July message in 1918. Additionally, local branches of the Four Minute Men organized around the country. The ideal organization consisted of a moving picture manager, a four-minute man speaker, and a teacher of speech to hear all potential speakers and make sure they were effective enough to speak to large audiences. While the ideal was only realized in a few places, the nationalization of the Four Minute Men more broadly gave the state a large force of proficient public speakers for the war effort. The success of the Four Minute Men was so widespread that proponents of positive speech not only likened the service to efforts to correct veteran speech defects, but many also proposed their activities continue into post-war “Liberty Forums” to discuss civic ideas that would serve as memorials to soldiers of the Great War. Public speakers therefore featured prominently in national and local displays of citizenship and Americanism.

The US Army also emphasized positive speech. Men were often barred from officer commissions due to speech disorders. One man at the Plattsburgh training camp in New York wrote to *The Survey* that he “stammered very badly” all his life, and because of it he was refused enlistment in the army. Aside from “stammering” or “stuttering,” the Army singled out unclear speech as a problem. General Henry McCain, the great-great uncle of Vietnam War Veteran and Senator John McCain, reported in 1918 that many failures of securing commission in the Officers’ Training Camps were due to “lack of clearness in enunciation, and inability to give the commands with sufficient volume of voice to be heard a reasonable distance.”

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decisions are all practical safety concerns, policies barring speech disorders show that the military was not isolated from civilian concerns. Clear speech mattered in war.

By the time American soldiers arrived to the US Army Section of Defects of Hearing and Speech at Cape May, American social attitudes toward the spoken, and heard, word positioned their war wounds or illnesses as particular problems. Social reformers and physicians had already positioned deafness and speech disorders as medical problems to be fixed. Groups within and outside the Deaf community labored to show they could be counted as dedicated Americans in the wartime United States. And social pressures as well as other barriers made attempts to prove citizenship through military service particularly difficult for people with speech disorders. When soldiers returned to the United States as wounded or ill patients with speech or hearing disabilities, the pressures of war and coercive nationalism turned into the pressures of crafting the ideal citizen who could communicate with the wider American community in a productive capacity.

“A Blessing to the Deafened Soldier:” War Wounds, Lip Reading, and Rehabilitation

Conditions of warfare between 1914 and 1918 left many men vulnerable to wounds that caused deafness, hearing loss, or damage to the capacity for speech. Near constant bombardment strained hearing and bred neurological side-effects. The lower half of the human head, uncovered by a helmet, was also particularly vulnerable to shrapnel and bullet wounds. Private Ray for example suffered a gunshot wound to the ear, which precipitated surgical re-adjustment with a prosthetic left ear while at Cape May. Other patients, such as Charles Recoy, had impaired hearing of “nerve origin,” likely from artillery, as writers such as psychiatrist John MacCurdy

84 Photograph of Private Ray, RG 112, Series NM 31 (K), Box 226, Folder: 730 (Oto-laryngology), US National Archives.
often argued that shell shock contributed to deafness.\textsuperscript{85} And after shrapnel broke his jaw Wallace Becker of the 106\textsuperscript{th} Infantry joined other veterans who had trouble speaking.\textsuperscript{86} The Section provided surgical and educational rehabilitation for these men.

The Surgeon General’s Office established the Section of Defects of Hearing and Speech at US Army General Hospital No. 11 at Cape May, New Jersey on July 23, 1918 under the direction of prominent Otolaryngologist Charles W. Richardson. Organized in the large eight-story Hotel Cape May, General Hospital No. 11 specialized more broadly in treating head wounds. Richardson addressed hospital staff and newly arrived veterans on July 22\textsuperscript{nd}, the evening before the Section opened. Veterans sat in rows in front of Richardson “eagerly leaning forward, trying to understand some word that was being said.”\textsuperscript{87} Authorities saw this moment as an example of the importance of correcting hearing through modern lip reading techniques, while some in the Deaf community continued in its at least partial support of Sign Language.\textsuperscript{88}

At the outset the numbers of men sent to Cape May for these services were relatively small. In total by the summer of 1918, the Cape May hospital treated between 50 and 125 soldier-patients a day, the majority of whom were deaf or hard of hearing.\textsuperscript{89} Of the veterans the Army deemed in need of immediate speech reading training, 43 were classified as “in line of duty” and twenty were “not in line of duty.” Most were from battlefield wounds like shell

\textsuperscript{85} Chief of Medical Service to Commanding Officer, “Concerning disposition of convalescent cases on medical service at Base Hospital No. 11” July 14, 1918, RG 112, Series NM 31 (K), Box 957, US National Archives; John T. MacCurdy, \textit{War Neuroses}, Reprinted from “Psychiatric Bulletin” (July 1917), 86.
\textsuperscript{86} “Becker Almost Shot To Pieces: Former Kingston Boy Torn In Score of Pieces By Shrapnel and Bullets, Being Rebuilt By Most Skillful Surgeons” \textit{The Kingston Daily Freeman}, February 3, 1919, p. 4.
\textsuperscript{88} At the February 1918 convention of the National Association of the Deaf, leading advocates re-affirmed support for Sign Language. Henry B. Young, “The Sign Language As the Universal Language,” \textit{Proceedings of the Twelfth Convention of the National Association of the Deaf} 3, no. 1 (February 1918), 9-11.
\textsuperscript{89} “History of U.S. Army General Hospital No. 11, Cape May, New Jersey” RG 112, Series NM 31 (K), Box 223, Folder: 314.7-2, US National Archives.
explosions, though some had non-wound medical conditions like otitis, or inflammation of the inner ear, along with other illnesses. While the hospital closed in July 1919, the numbers of veterans who utilized speech and hearing services through the Federal Board for Vocational Education (FBVE) continued well into the 1920s. By June 1920 the FBVE had 262 deaf and 95 speech defective veterans registered for services. A year later the numbers rose to 506 deaf and 279 speech defective men. And the overall numbers more than doubled between 1920 and 1922. The small initial numbers at the Section therefore do not reflect the longer-term neuropsychiatric and physical symptoms of trauma that manifested in the interwar years.

The smaller numbers also do not reflect the importance of this program to the military-medical apparatus. The Surgeon General, for example requested the numbers of deaf and speech defective soldiers from every major military hospital in 1919 with a plan to send them all to Cape May. Not all types of potentially economically limiting injuries or illnesses were treated with the same urgency. For example, while it established limited services at a hospital in Lakewood, New Jersey for arthritis and diabetic cases, the Army failed to make any concerted effort to survey and send patients there from other hospitals as it did with deaf and speech defective patients, despite their numbers being proportionately larger.

93 C.R. Darnall to the Commanding Officers, “Report as to the complete or near deaf and speech defects in your hospital” November 19, 1918, RG 112, Series NM 29, Box 433, Folder: 741.-1 (Hearing and Vision, Deaf and Deafness, Blind and Blindness, Age, Height, Weight, etc.), US National Archives.
94 The section for arthritis, located within the orthopedic division at Lakewood, continuously lacked adequate staff and wrote repeatedly to the Surgeon General seeking more cases to study. And the official stance of the Surgeon General
The Surgeon General emphasized the importance of these veterans in postwar society, specifying that Section graduates should continue practicing their speech and should remain under continual observation according to how well they communicated with others, their earning capacity, and how well they “mingled with their fellow men.” The importance to the state of rehabilitation of hearing and speech therefore was evident, and there existed at least a general plan to monitor and shape the long-term socialization standards between deaf, hard of hearing, and speech defective veterans in wider society.

Mrs. George Sanders praised the initial work of the Section of Defects of Hearing and Speech in her June 1919 exposé on the Cape May hospital for deaf readers of The Silent Worker. Speech reading education there was “a foregone conclusion” and the wounded learned so quickly “it might be ‘Speech-reading taught while you wait! Satisfaction guaranteed!'” The soldiers – 90 percent of whom had served overseas – allegedly learned lip reading efficiently in just six weeks, leading to Sanders’s claim that “the ability to read the lips, it matters not what the degree, will be a blessing to the deafened soldier. The world owes more than one debt to Dr. Bell!” Oralist supporters like Sanders praised the work of speech reading, and the Cape May hospital with its heroic soldier constituents proved an effective platform for the justification of oralism in American society.

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95 The Chief of the Oto-Laryngological Service to the American Red Cross at U.S.A. General Hospital No. 11, “Present Status of patients discharged from Section of Defects of Hearing” May 2, 1919, RG 112, Series UD-8, Box 958, Folder: 705 Oto Laryngological Patients, US National Archives.
96 Mrs. George T. Sanders, “Hospital No. 11, Cape May, N.J.” The Silent Worker 31, no. 9 (June 1919), 161-162.
Military hospitals did consider the use of “manual methods” in the process of rehabilitating deaf veterans. Shortly after the war, however, representatives of the Surgeon General’s Office convinced authorities that Colonel Richardson’s original order for lip reading instead of the manual method of sign language “gets results” and “was being executed with unexpected satisfaction and that manual methods were not needed.” The debates over its use in the military context were certainly not isolated from the broader social debates about sign language versus lip reading. If it helped the soldiers re-integrate into a society dependent on aural language, they reasoned, surely it was a worthy cause.

Teaching Lip Reading

Rehabilitation hospitals reflected wider society’s emphasis on hearing and aversion to sign language, and Cape May’s Section therefore cannot be detached from broader conceptions of communication. Commanding Officers integrated idealized speech within most US Army hospitals that necessitated an ability to hear in order to benefit from the messages they brought. The most prominent examples of this were the many talks of industrial, political, and religious speakers at Walter Reed, Lakewood, New Jersey, and Fort McPherson. One was John Hays Hammond, a mining engineer who spoke on May 23, 1919 and emphasized hard work, spending

98 Samuel Hopkins Adams, “The Record of a Rescue,” Carry On 1 no. 6 (March 1919), 9.
time outdoors, and the idea that one could be successful with one’s disability. He cited a disabled engineer M.H. Burnham who, “despite the use of an artificial leg” had “made good.” Hospitals brought in Burnham and others and made use of positive speech that relayed character ideas for how disabled men should act – including being industrious, persistent, and ruggedly individualistic – and relied aural communication to transmit messages predicated on the idea that disability was something to overcome and, if possible, hide.

In organizing the Section’s services the military took this medicalized approach, which mirrored civilian efforts that simultaneously sought to highlight and hide the disability. Soldiers who arrived to the United States for services, whether at Cape May or through the United States Veterans’ Bureau, first had to be measured and then instructed in communication. Audiograms created a graphic rendering of their deafness, and made the disability visible for physicians to assess. Then the patients or veterans went through two to three months of lip reading to keep their disability hidden. Referencing the use of sign language, physicians saw deaf veterans’ failure in rehabilitation as “a visual sign of medical failure.” Success was a referendum on American medical and social reconstruction.

Ultimately, over 500 hearing impaired veterans took lip reading training through the FBVE in institutions throughout the country, in addition to the over 100 who trained at Cape May immediately after the war. The FBVE suggested corrective services for anyone who could not understand a conversation “at a greater distance than five or six feet.” They utilized testing as a way to judge who was fit for lip reading courses, which included audiogram

99 “The Address of John Hays Hammond at Walter Reed Hospital” May 23, 1919, RG 112, Series UD 8, Box 1298, Folder: 000.76 Come Back, Walter Reed, US National Archives.
measurements. Then an officer within the Medical Department administered a test, “speaking to the man with the mouth covered,” and then wrote a prognosis for recovery.١٠٣ Courses usually lasted three to six months, with two to three lessons per day in schools close to their homes. Irregular attendance or lack of effort would result in being reported to the district offices of the Board. One goal in particular after 1919 was to re-integrate the individual seamlessly into normative audible social discourse. No stone was left unturned. Reflecting on the difficulties that some veterans may have had in everyday communication, the official report read, “Most lip-readers find the speech of men difficult to understand, due, largely, to the fact that many men wear mustaches and speak with very little lip movement. The excellent lip-reader can follow not only conversations, but lecture [sic]. The average lip-reader can not do this.”١٠٤ The goal was to produce excellent lip readers, and it was very much up to the deaf veteran to conform to social standards rather than society to attempt to conform to diverse biological realities.

The official embrace of lip reading came with the stringent policing of its use. Veteran Alfred Pemberton lost his hearing after he contracted spinal meningitis while stationed at Camp Newton Baker in Texas in February 1918. Following his discharge the FBVE instructed him to begin lip reading and voice training at the State School for the Deaf in Columbus, Ohio where he took classes every day. Pemberton excelled and wanted to learn from other instructors and “get a variety of lips to read.” But Pemberton also writes, “The use of the manual alphabet and signs is strictly tabooed except as a means of communication with the other pupils. Even then we use speech as much as possible.”١٠٥ Thus the relative leniency of civilian schools that used the

combined method of oralism and manualism did not translate as easily to men like Pemberton. Their status as veterans – a politically appealing constituency who had served their country – heightened the importance to portray a successful lip reading system. In the process, however, veterans remained outside the mainstream Deaf cultural community that often continued using sign language.

Oralists continued using veteran success as justification for the superiority of the methods they championed. *The Volta Review*, a publication from the Volta Bureau, an organization funded partially by Alexander Graham Bell and devoted to advancing lip reading over sign language, published a plethora of stories about soldiers who were seemingly better off having learned the former instead of the latter. Indeed, Pemberton himself wrote, “To use a bit of army slang, a deaf person without a knowledge of lip-reading is ‘out of luck.’ There is no use in a deaf person staying ‘out of luck’ when with a little effort he can acquire lip-reading and so be ‘in luck.’”

Thomas Baker was another veteran *The Volta Review* profiled. Baker lost most of his hearing from the constant sound of artillery bombardment while serving in the Saint-Mihiel and the Meuse-Argonne offensives. After returning home, “he would not listen to the government agent who kept urging him to take lessons in lip-reading.” The agent called on Baker and his wife and at last “made him see the advantage of ‘hearing with his eyes.’”

The state sought to utilize the persuasive power of duty to the family to enforce normalcy. Lip reading programs ultimately served as a self-justifying endeavor for the Federal Government and oralists to shape disabled veteran sociability without the threat of being blamed for any potential failures. John Breazeale’s experience in being made to see the benefits of lip

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106 Pemberton, “First Impressions of a Deaf Soldier,” 40.
108 This is reference to Lennard Davis who argues that mainstream society enforced normalcy onto the deaf population through the use of oralism. Lennard J. Davis, *Enforcing Normalcy: Disability, Deafness, and the Body* (New York: Verso, 1995).
reading is the best example of this. Deaf from meningitis, Breazeale “shrank from contact with his associates” until he began training in lip reading and became more sociable. “But of course” the article continues, “Lessons in lip-reading alone did not make the change in this man. It was the tremendous grit in John B. Breazeale.”¹⁰⁹ The implied obverse of this statement was that men who, unlike this veteran, did not learn lip-reading and “make good” lacked the requisite “grit” and were responsible for their own failure. Individual effort was the primary factor in the success or failure of re-integration among deaf veterans, while the state came in for praise for providing the opportunity for success.

Hedging success stories on individual effort or responsibility was not unique to veteran experiences, but reflected the experiences of the broader Deaf community. For example, when the League for the Hard of Hearing aligned with otologists in the first decades of the twentieth century, they simultaneously embraced medical intervention and oral methods of instruction to differentiate deaf individuals from other disabled people. By focusing on public awareness and prevention campaigns that emphasized hearing tests and otology examinations, League members stigmatized and medicalized the condition. Implicit in the strategies was the idea that since there were medical avenues to pursue, it was the hearing-impaired person’s individual responsibility to pursue them and “cure” their disability.¹¹⁰ Like his civilian counterparts, it was the soldier’s individual responsibility to take the state’s training services and conform to the hearing world.

Officials also saw in lip reading a powerful tool of social mobility, though this view was mired in racial assumptions for hearing-impaired black veterans. Hearing society had long “othered” deaf individuals of all races, and had considered sign language as primitive, especially

¹¹⁰ Virdi, “Prevention & Conservation,” 533 and 542
in the context of Native American sign language use.\textsuperscript{111} Deaf African Americans had far fewer opportunities and schools than their white counterparts as institutions within the Deaf community re-created the social divisions of hearing society, including racial segregation.\textsuperscript{112} And deaf African Americans were arguably more vulnerable to institutionalization due to the intersections of power in race and disability. One example of this trend is Junius Wilson. Wilson was a student at the North Carolina School for the Colored Blind and Deaf in Raleigh, North Carolina before being falsely accused of rape in 1925, falsely found insane at a lunacy hearing, and surgically castrated and committed to a hospital criminal ward until the 1990s. He was incarcerated, argues historians Susan Burch and Hannah Joyner, “merely because he was deaf and black; bureaucratic inertia and staff paternalism helped keep him there for sixty-five years.”\textsuperscript{113} Deaf black veterans entered Cape May with few institutional supports to help them thrive, and lip reading further marginalized them from a Deaf-Black community that was sparse to begin with and hampered by paternalist and racist sentiments.

The Section had initially found illiteracy among naturalized foreign born and “most of the native negroes” to be a serious impediment. However lip reading teachers proved somewhat successful in helping illiterate men finish their training.\textsuperscript{114} Alabama native Charles Morris trained at Cape May and gained knowledge of reading and writing while training in lip reading after entering “deaf, dumb, hopeless in expression… and almost a human wreckage in the sea of adversity.” Morris’s report boasts that upon completion of his course he went up for discharge

“with an intelligent enthusiasm bred by contact” with the “energy of the Aides.” FBVE beneficiary Frank Solomon also learned the benefits of “hearing with his eyes.” Solomon especially captivated the Bureau. A black veteran and illiterate, he was able to communicate through lip reading and, “Most remarkable of all, his own wife did not know he was deaf for several days.”

Officials who trained deaf veterans assumed a dual inferiority of blackness and deafness in men like Morris and Solomon, imbuing in lip reading a means of social mobility and family stability that could in some cases transcend assumptions of racial inferiority. More broadly for the Section veterans, officials and veterans alike conceptualized lip reading as the path from a life of destitute isolation to one of re-integration and happiness. However, if a white veteran succeeded it was because of his individual effort. If a black veteran succeeded it was because of the system or the enthusiasm of his peers. The Veterans’ Bureau, the Federal Board for Vocational Education, and the various entities involved in the rehabilitation of deaf and speech-defective veterans therefore de-coupled program success from the availability of services, placing sole responsibility for success or failure of rehabilitation on the individual. If the man did not succeed, it was a failure of the man, not the state. While the most coercive aspects of citizenship criteria of the war years receded somewhat after the Armistice, veteran speech and hearing training in the postwar years held onto notions of independence and sociability built on normative standards of American communication.

War Wounds and the Impulse for Speech Correction

115 “Report on the Section of Defects of Hearing and Speech” RG 112, Series NM 31 (K), Box 224, US National Archives.
116 Pemberton, “First Impressions of a Deaf Soldier,” 40.
Speech rehabilitation gives insight into some problems veterans had with chronic, long-term wounds and alleged barriers to communication. After shrapnel tore off part of Wallace Becker’s jaw and split his tongue, surgeons sewed his tongue together and constructed a wire contraption “running from a tooth on the left side of his mouth to a tooth on the right side” to take the place of the jaw he no longer had. Unable to talk for two months and fed through a tube, Becker’s recovery was stunted only by the fact that he needed what was left of his jaw to be broken again and bone grafted properly through a succession of seven operations, the final one at Walter Reed Hospital, in between his speech training at the Section at Cape May. Becker joined a group of veterans who, according to the Army, required speech therapy to correct defects and make aural communication easier for the listening public, in similar ways their deaf and hard of hearing counterparts trained.

In Becker’s case, speech defects resulted from a physical wound that shattered his jaw, yet not all cases manifested from battlefield wounds. The FBVE classified the types of speech defects that warranted correction as aphasia, imperfect phonation from wounds, aphonia, stammering or stuttering, and loss of control of tone or pitch from deafness. Aphonia was classified as the loss of voice from a variety of afflictions ranging from gas poisoning, neuroses, disease, or physical wounds from bullets or shrapnel. Stammering or stuttering, one of the most common afflictions the Bureau tried to remedy, developed from “defects” prior to the war that often re-surfaced, or from those that never went away in the first place. The program was similar to rehabilitation for deaf veterans and aimed at producing men who could hide their disabilities.


Early reports of veteran speech correction experiences were remarkably redemptive in tone. Henry Koopman was operated on for mastoiditis – evidence that disease was often more common than battlefield wounds – and the operation resulted in “complete motor and sensory aphasia” and thus “he could neither speak nor understand speech.” The training was painstaking, though he continued his Cape May work at a New York Public Health Service Hospital. By May 1920 Koopman’s speech instructor noted that he could “talk for twenty minutes without stopping.”119 Another soldier suffered facial paralysis and was “melancholy and despondent” but within three months he learned lip reading and speech. The report commented on his visual presence as well, as “the paralysis had been relieved… his repulsive expression had disappeared” and “he has now returned to his former occupation, and is carrying on as an electrician.”120 Speech therapy for these veterans was therefore central to social relations and work, and was as varied an experience as the myriad wounds and illnesses that led to it. Yet despite early optimism, case reports of speech-disabled veterans into the 1920s reflect medical and public frustration over chronic wounds and illnesses.

After the closure of Cape May in August 1919, the US Veterans’ Bureau decentralized rehabilitation more broadly. The main areas of speech training into the 1920s were at private speech clinics and US Veterans’ Bureau hospitals such as the one at Waukesha, Wisconsin. The patients at speech clinics into the postwar years reflected the chronic wounds of war. Places such as Waukesha included more neuro-psychiatric patients, many of whom had trouble continuing with work. Additionally, physicians interpreted more directly what they considered the connections between defective speech and what they termed “inadequate behavior” through

120 “Deaf Soldiers Hear With Eyes” New Castle Herald, September 26, 1919, 9.
classifying them as psychiatric illnesses. The prevalence of neuro-psychiatric patients among speech clinic records reflects the existence of long-term war wounds as well as physician uneasiness about the chronic wounds of war into the 1920s.

Chronic illnesses and wounds are among the most recurring byproducts of war, yet they often occupy a small portion of postwar histories. For example, while amputations were only a small fraction of war wounds they gained cultural traction after the American Civil War, while Americans spent far less time speaking about complicated hidden wounds and illnesses. After the First World War veterans, bureaucrats, and physicians engaged in complex power negotiations over the meanings and visibility of disability as well. Speech defective veterans entered speech clinics in the 1920s when rehabilitation was supposed to have cured their disability, but many still struggled.

The Veterans’ Bureau proclaimed in 1922 that in most cases of stammering or stuttering the defect “is only one of the symptoms of a nervous or mental condition which must be treated by a neurological expert.” Despite relatively small numbers of speech defective cases at Cape May, by June 1922 the Veterans’ Bureau had registered almost 350 cases, a number that increased further to almost 1,000 by June 1923. The period between 1920 and 1923 was a high point in treating speech defective veterans. In these years state efforts to categorize, pathologize, and train them in the early 1920s at various speech clinics represents a continued tendency to see

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123 Jessica L. Adler, Burdens of War: Creating the United States Veterans Health System (Baltimore: Johns Hopkins University Press, 2017), 192-203.
non-normative speech patterns as a problem for notions of acceptable communication within American society.

There are few records relating to the treatment of speech defective soldiers in Veterans’ Bureau hospitals and private speech clinics. Those available do shed light on the difficulties veterans had communicating in the postwar years and on the social expectations that shaped treatment. A patient classified as private “W.V.L.” served in an artillery regiment and was diagnosed with psychoneurosis and anxiety, which manifested in stuttering. Psychiatrist Chester Carlisle at US Veterans’ Hospital 37 at Waukesha, Wisconsin recorded that this patient was hit by a shell in the Argonne that killed four of the six men in his detachment. This soldier then developed neuropsychiatric symptoms with speech defect, including a tic in the left eye, sensitivity to voices, excessive excitability, shakiness, and nightmares. In this veteran – as well as with many others – “the blocking of utterance is accompanied by quick, jerky movements of the hands and legs, shaking of the head, and a tic in the left eye.”

Carlisle’s conclusion had little to do with wartime experiences under fire, or postwar medical treatment. Instead he argued that the patient’s condition grew worse because of “undue sympathy from his mother” during his stay with her after returning home. Carlisle’s observation of the personal history of his patients is representative of broader efforts of neuropsychiatrists to look at the whole history of the patient. W.V.L. began speech training in September 1921, and also underwent relaxation, deep breathing, and positive suggestion, and symptoms “gradually disappeared.” Yet Carlisle warned that his environment would determine whether or not his symptoms returned. If he received too much sympathy, he could relapse.

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126 Carlisle, “The Interpretation of Inadequate Behavior,” 243-244.
127 Carlisle, “The Interpretation of Inadequate Behavior,” 244.
128 Carlisle, “The Interpretation of Inadequate Behavior,” 244.
W.V.L. gave Carlisle a means of examining the effect of home life on psychiatric causes of speech disturbances. Private C.L.K. shows how non-combat war service could aggravate pre-war symptoms, and the effect it could have on veterans returning to work. C.L.K. left school at fifteen years old knowing he did not want to go to college, and worked at a stone quarry where he started losing his voice in 1912. He was drafted in May 1918 and his voice got worse in training camp while drilling with a machine gun battalion. The private served overseas, doing arduous work in Brest with no active service in the trenches, but lost his voice completely when his work in the wind and rain brought on laryngitis. C.L.K. could not return to work at the stone quarry, because his voice was still weak and it was so noisy that he “had to resort to pencil and paper to communicate his thoughts to anybody.” He moved to two separate jobs at a shipbuilding company and a railroad company, where at both places he was laid off because of “slack work.” He tried, in vain, to return again to the quarry before admitting himself to Veterans’ Hospital 37.129

Private J.C. served in the medical department and encountered similar problems with postwar employment. He served in a veterinary company after enlisting in 1917. According to Carlisle, J.C. was from a Jewish family from Poland, and had a mild speech defect since nine years old. J.C. told Carlisle that because Jews were always discriminated against in school, he attempted to overcompensate through getting better grades than the other students. In the war he was hospitalized after falling off a horse left him unconscious. His war service aggravated his speech, and after the war he left both a government job and dental school. Carlisle writes that “his speech defect became so aggravated that he was sent to Hospital No. 37 July 17, 1921.”130

130 Carlisle, “The Interpretation of Inadequate Behavior,” 234.
Neither C.L.K. nor J.C. served in the trenches or had battlefield wounds like W.L.K. Yet their war service significantly irritated their pre-war speech disorders, making post-war work particularly difficult. They also show that speech defects broadened to cover not just stuttering, which the Section at Cape May focused on in particular, but also vocal problems such as obstructed voice, as was the case with C.L.K. And the methods the men learned typically did not cover their needs in the workplace. C.L.K. for example resorted to pencil and paper to communicate despite his speech training, a reality that deaf civilian workers faced after leaving their oral communication training and undertaking factory labor.\(^{131}\) The experiences of C.L.K. and J.C. indicate that wartime aggravation of complex pre-war conditions created more complicated and problematic situations that made post-war labor particularly challenging. Their experiences also show how early wartime redemptive and successful stories of speech rehabilitation did not account for the longer-term challenges some veterans faced into the 1920s.

**Conclusion**

Citizenship within the war context remained important to the Deaf community after the war years. In the second week of August 1926, the National Association of the Deaf held its fifteenth convention in Washington, D.C. The event included tours of the city and a rendition of the Gettysburg address in sign language on the steps of the Lincoln memorial.\(^{132}\) That Friday, despite sweltering heat, a large group of delegates traveled to Arlington National Cemetery, where the association’s President Arthur Roberts laid a wreath at the recently-inaugurated Tomb of the Unknown Soldier, and a delegate recited the memorialized Great War poem “In Flanders Fields” in sign language. From there, they walked across the cemetery to the grave of Clyde

\(^{131}\) Buchanan, *Illusions of Equality*, 35.
Sawhill, who was the child of two deaf parents and died fighting in the Argonne. After President Roberts placed flowers at the grave, Sawhill’s father signed, “Clyde was a good lad… I only ask you younger ones to… decorate our boy’s grave through the generations yet to come, as a respect to all we deaf did directly or indirectly in those dark and dire days.” As with their wartime experiences between 1914 and 1918, the Deaf community held onto claims of citizenship earned through wartime sacrifice, highlighting the centrality of citizenship and the senses to deaf experiences in the war.

The wartime experiences of the Deaf community, the treatment programs of the Section of Defects of Hearing and Speech, and other programs that continued into the 1920s are important parts of the broader history of the First World War in the United States, and experiences related to deafness and citizenship in the war years. Normative speech, displayed through organizations such as the Four Minute Men and the Liberty Loan, or public displays of “Americanness” such as the pressures placed on German-Americans, were often held up as

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examples of exemplary citizenship and patriotism in national conversations. The Deaf community inserted itself into these conversations, despite its members’ inability to “hear” these discourses as their fellow hearing American citizens could, as it aimed to prove its citizenship through contributions to the war effort.

Regulating deafness and citizenship was critical for veterans in particular. Deaf individuals had long entered the Deaf cultural community in schools or in institutions or clubs that reinforced Deaf culture. Oral educators and advocates such as Alexander Graham Bell contributed to broader Americanization efforts to assimilate deaf individuals into mainstream hearing society. Oralists saw veterans as uncomplicated individuals who were – by virtue of their late-onset disability and their status as fighting citizens and government property – easily sheltered from the Deaf cultural community. Teaching soldiers to lip read was, therefore, a way for the state to include deaf veterans into society as seamlessly as possible for the broader American public. And the veterans’ use of lip reading served as further justification for oralists in their advocacy for speech training in American society more broadly.

The Section’s efforts were also central to government efforts to position communication within veteran rehabilitation. The rehabilitation of hearing, speech, and language therefore must be included within the broader history of rehabilitation. Similar to vocational ability, state rehabilitation included communication – hearing and speaking – among standards of American citizenship in postwar healing. It was Isadore Warshoevsky’s success in communication, after all, that entitled him to be considered “a better citizen than he was” before the war. Learning to speak and lip reading were just as important as learning to use a prosthetic leg or arm.

Mastering these skills represented a seamless transition back into society. Yet as C.L.K made

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136 “Seeing is Hearing,” 15-16.
clear at US Veterans’ Hospital 37, a transition to productive life even with government aid was
difficult for some. Citizenship, therefore, partially depended on independence, sociability, and
normative conceptions of speech and hearing.

Most importantly, at least for the American state, was that deaf and speech defective
patients provided relatively uncomplicated imagery for the public who sought a return to
normalcy. Redemptive stories positioned deaf soldiers as having been “fixed” through little
medical effort relative to other wounded or ill patients. And when rehabilitating deaf and speech
defective veterans, the state argued that it was up to the individual patient to thrive in lip reading.
Though physicians’ assessments were usually shaped by assumptions of racial and inferiority. In
doing so, the state positioned itself outside of direct responsibility for the successes or failures of
individual veterans and distanced itself from the wounds of war. If the man did not succeed it
was a failure of the man and not the state, society, or the methods used. The Section of Defects
of Hearing and Speech highlights the ways society categorized and classified citizenship,
inclusion, and aural communication within the broader rehabilitation framework in war and the
efforts of veterans to make good.
Chapter II: Devices of Adjustment: Managing Disabled Bodies through Touch and Physicality

The Red Cross Institute for the Blind gave Sergeant Ivan Robb Saunders a Braille watch upon his arrival at the rehabilitation school in Baltimore in 1919. The 29 year old from Binghamton, New York, along with 74 other wounded veterans of the First World War, received the Waltham watches with embossed print that helped them tell time through their sense of touch, since their sight had been destroyed during the war. The braille watches were one of many examples that demonstrated how postwar American veteran care integrated the sense of touch into veterans’ processes of making good. Rehabilitation mobilized the tactile sense as an example of what American psychologist Robert H. Gault would later call “devices of adjustment.”

While Gault was writing well after the immediate postwar years, the US Army actuated Gault’s idea that veterans should use their able senses to compensate for their disabled senses. To become economically and socially independent, for example, a blinded veteran could simply feel his way through training and into new relationships. The sense of touch was, therefore, important to physical and social negotiations in the various healing atmospheres of rehabilitation.

Touch’s utility was significant specifically for blinded veterans who learned Braille, for deaf veterans who, according to Gault, would feel the vibrations of sound, and for physicians who attempted to heal peripheral nerve injuries that resulted from shrapnel wounds. The sense of touch and feeling, however, had social and cultural significance in the war years beyond the physical necessities of healing. Rehabilitation hospitals mobilized touch in important ways. Officials, social workers, and physicians tied it to remedies for deaf veterans, relied on the touch

of women at dances for blinded veterans, and regulated bodily autonomy through dress codes and disciplinary measures. Touch even had implications when programs marked physically strong and fit bodies as successful, rehabilitated bodies.

In its broader context, the sense of touch rippled through the cultural landscape of the First World War. The famous John Singer Sargent painting* Gassed* relied on the connective touch of blinded soldiers who sought to guide one another through the rhythm of their movement. The Western Front more broadly was rife with examples of soldiers who were conscious of the grasp of sucked mud all around them, as Henri Barbusse expressed so vividly in his novel* Under Fire.* Soldier-engineers substituted their sight for touch to navigate the pitch-black underground tunnels that enabled them to detonate explosives under opposing trenches. The vulnerability of male bodies brought themes of intimacy to the fore in complicated ways as the touch of male bonding in the shell hole corresponded with the exposed nature of wounded bodies in the hospital.

When American soldiers reported to US Army General Hospitals they navigated complex power dynamics between their own bodies and those around them that further showed how American rehabilitation was a means by which the state sought to control the meanings of citizenship, sociability, and inclusion. The senses were central to the disability experience and the healing process in veterans’ quest to make good, as men used their senses in new ways to navigate previously familiar worlds that, upon return, the state and society continued to inscribe with heightened expectations about sexuality and bodily autonomy. Touch carried meanings far more significant than simple reintegration into an economically productive postwar life. Touch

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139 Das, *Touch and Intimacy in First World War Literature*, 54.
was also a site through which complex physical, psychological, cultural, spiritual, and emotional issues were played out. Rehabilitation actors assigned the sense – and with it, the body of the man in question – social and cultural meanings as they sought to shape men into strong, moral, hard-working, and heterosexual individuals. Gender and sexuality were significant to the processes of reconstructing the male body through touch. The sense of touch helps to elucidate the complex social and economic expectations society had of disabled veterans after the war.

*Regulating the Touch Organ: Healing Peripheral Nerves and Silencing Pain*

In the First World War artillery joined other weaponry such as bullets, poison gas, and flamethrowers, combining into a “dynamic of destruction” that left few bodies untouched by the sensation of pain. In his training at Camp Wadsworth, Lieutenant Kenneth Gow describes being gassed, which “causes a very painful irritation of the eyes.” Pain narratives of the battlefield reflect a more chaotic atmosphere than training narratives. William Triplet observed his own wound – a bullet to the head – commenting on how it felt. Partially unconscious, he “wanted to stay dead” to “get away from the headache.” His friend “pried open an eye and told me to look, but I couldn’t move, talk, or see anything but a painfully bright light. I could just feel, hear, and grunt my protests about being brought back into this cruel world.” As Triplet observed in his experiences in the Meuse-Argonne, soldiers of the Great War encountered a variety of sensory experiences that pushed the limits of pain. The weapons of war also destroyed some soldiers’ sense of touch, leading to extensive US Army efforts to correct peripheral nerve

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injuries. Hospitals in the war years attempted to regulate the sense of touch, the ability to feel, and the extent to which one could voice or regulate one’s own pain.

Drugs and alcohol were an important part of the war experience, both as prescribed and self-prescribed for relieving physical and mental pain. Regularly used during the American Civil War, military doctors used morphine to treat pain from severe wounds in the First World War. Some even used it as a humanitarian measure for the wounded, such as a casualty at the Battle of Aubers Ridge in May 1915 with “no eyes, no nose, no chin, [and] no mouth” but who was still alive. Alcohol and tobacco also calmed the nerves of men “engaged in a nerve-wracking campaign,” which in many cases subverted public vice campaigns in various countries. The appeal of tobacco was so substantial that the US doubled its tobacco revenue between 1917 and 1918. Yet psychoactive remedies did not always mask war wounds, and hospitals in France and the United States were full of men in pain.

Absent immediate remedies to their pain, patients who made their way to the hospital wards entered transnational social and cultural spaces that pressured patients not to voice pain too vocally. In Casualty Clearing Stations during the war, physicians found it remarkable that men withstood pain in silence. Far from suffering minimal pain, the environment of military medicine instead encouraged the suppression of pain, as medical staff encouraged restraint and stoicism and were insulted when soldiers resisted this prescription.

Baker recalled being on a hospital train with a leg wound: “My leg was on a long wooden splint and the pain was awful it was all I could do to keep quiet.”¹⁵² The masculine response to pain was to silently endure at the wishes of the physician, and some men took to writing about their pain in diaries as a form of narrative resistance to the dominant medical narrative of the physician case notes.¹⁵³

American rehabilitation hospitals also encouraged restraint from patients who felt pain. The rehabilitation magazine *Carry On* welcomed new readers in its first issue with a poem, influenced by Rudyard Kipling’s “If,” about what it took to be a soldier. “If you can hold your head up while the others are drooping theirs from marches and fatigue… If at parade you stand fast at attention, when every muscle shrieks aloud with pain… You’ll be a reg’lar soldier yet, old top.”¹⁵⁴ Hospital newspapers were filled with exposés meant to encourage disabled veterans to “make good” with little complaint. One story on Theodore Roosevelt, for example, highlighted his health struggles, including the asthma he suffered from as a child. Roosevelt “determined to conquer the weakness of his body,” and he eventually became a “tower of strength” after twenty years of struggle. The patients who read *Carry On* were supposed to learn from Roosevelt. According to the article, those with weak eyes could remember that he, too, had weak eyes but became a successful hunter and reader. A man with poor hearing could look to him because he lost the use of an ear but could still “distinguish the calls of birds.” “Men stricken with pain” should look to Roosevelt who “worked at his correspondence until he fainted and the couch on which he lay was drenched with blood… a few with terrors to face will always cherish most the

¹⁵² Carden-Coyne, “Men in Pain,” 57.
¹⁵³ Carden-Coyne, “Men in Pain,” 62-64.
¹⁵⁴ “If” *Carry On: A Magazine on the Reconstruction of Disabled Soldiers and Sailors*, 1, no. 1 (June 1918), 32.
man who overcame.” The message was clear: patient pain was no excuse for complaint while in recovery. They were instead supposed to overcome.

Writers emphasized similar inspiration and overcoming narratives in other articles. One man with paraplegia who was “in a sad condition mentally,” found respite in drawing, and “had drawn himself back to a normal condition and was discharged.” Another “mental case” took up work as a draftsman. But the “most surprising” thing one saw at Fort McHenry was “the impudent optimism of the men” and “their absolute disregard of pain and discomfort.” The man who openly suppressed pain was worthy of admiration. Corporal Peter Gnacinski became an object of inspiration for others who sought to make good. A former printing apprentice from Chicago, Gnacinski served in the 132nd Infantry and was wounded when shrapnel hit his back, arm, and jaw at the Somme front. But Gnacinski “hasn’t been wasting his time in the army hospitals.” Instead, while recovering, he has been “an enthusiastic student” in the print shop. The steadfastness as a patient in the hospital, according to the piece, would surely translate to a more lucrative printing career for the young veteran upon his release from the hospital. Feeling pain, therefore, was no excuse for a failure to succeed.

Among the short musings patients at Fort McHenry published in their paper The Trouble Buster, was one about a man who needed further treatment. Though the patient wrote it in a comical fashion, it reflected how influential the atmosphere was about discouraging patients from vocalizing the pain they felt. Doctors consulted each other next to his bed and contemplated whether or not he needed an operation. One said, “I believe that we had better wait and let him get a little stronger before cutting into him.” The patient, thought to be asleep, overheard the

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155 Herman Hagedorn, “The Man Who Overcame,” Carry On, 1, no. 6 (March 1919), 3-4.
doctors, grinned, and replied, “What do they take me for – a cheese?” The author’s message to patients in the hospital was that they should stand up to pain and medical procedures with little fear and overcome their disability. The culture of healing in American hospitals, therefore, encouraged suppression of vocalized pain, and embraced stoic optimism. Feeling too much was not part of the successful healing process. At the same time, physicians sought to chart and restore feeling to men with peripheral nerve injuries who could not feel parts of their body, and therefore implicitly attempted to mark acceptable and unacceptable healing processes.

Battle casualties as well as illness caused nerve injuries. George Bond from Westville, Connecticut entered General Hospital No. 9 at Lakewood, New Jersey on November 20, 1918 with neuritis – or nerve inflammation – of all extremities. He suffered this in line of duty after his second injection of typhoid serum seven months earlier at Camp Devens, Massachusetts. After some hospitalization and treatment with splints and massage he was able to walk and regained slight use of his hands. Markvey Kalakowski of Albany, New York arrived at Lakewood, New Jersey around the same time as Bond. A gunshot wound in the right forearm at Belleau Wood caused poor circulation and sluggish use of the hand and impaired sensation in the fingers. These men were part of the numbers of soldiers who returned with peripheral nerve injuries or other losses of the sense of touch.

Bond and Kalakowski joined 2,300 veterans of the Great War who were treated at peripheral nerve centers in the United States. Most often from shrapnel, the wound severed the nerve that controlled the feeling and movement of the leg or arm, and military surgeons worked

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158 “As You Were,” The Trouble Buster, 2, no. 48 (December 20, 1919), 3, RG 112, Series UD 8, Box 852, Folder: The Trouble Buster, US National Archives.
159 Commanding Officer to the Surgeon General, “Patients in Hospital Two Months or More,” March 1, 1919, RG 112, Series UD 8, Box 942, Folder 705: Reports of Overseas Cases, US National Archives.
on the patients to surgically join the nerves back together. While the condition was fundamentally mechanical, some Anglo-American physicians saw it neurologically related to hysteria, and argued that remedies such as hypnosis could help them overcome sensory wounds. The US Army, however, constructed programs in many hospitals to treat what they saw as primarily a physical wound.

The peripheral nerve injury center at Fort Des Moines, Iowa was among the most robust. There the Army treated over 200 cases between May and December 1918, and neurologists and surgeons used therapeutic methods such as physiotherapy, hydrotherapy, and psychotherapy. At the beginning of its service, nerve injuries only factored into the hospital randomly, but then it became a specialty hospital for peripheral nerve injuries as more cases arrived. Dr. Edward Hummel built the program upon his arrival in August 1918, recognized many cases that were not classified properly, and organized diagnostic equipment to chart and record sensory changes in the patients.

Peripheral nerve centers such as the one Hummel built at Fort Des Moines joined a longer history of physicians’ use of technological development to supplement the senses in medicine. Prior to the nineteenth century, physicians practiced medicine less intrusively, saw touch as taboo, and argued that unlike surgeons who used their hands, they practiced through dignified reason. Aided by the popularization of the stethoscope, medical practitioners turned

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increasingly to physical examination.\textsuperscript{165} By the late nineteenth and early twentieth centuries, medical education used new diagnostic equipment and laboratory analysis to train and supplement the human senses in diagnosing and treating illnesses.\textsuperscript{166} Equipment deployed at Fort Des Moines and other military hospitals therefore charted sensory wounds, or the loss of touch, in ways the human senses simply could not.\textsuperscript{167}

![Determining the extent of a patient’s paralysis by electrical treatment. Courtesy of the US National Archives.\textsuperscript{168}](image)

The peripheral nerve injury centers worked in conjunction with most areas of the hospital. At Fort Des Moines the nerve center benefitted from an orthopedic shop that provided


\textsuperscript{167} Borell, “Training the Senses,” 260.

\textsuperscript{168} Photograph of electrical treatment at U.S. Army General Hospital No. 9, RG 112, Series NM 31 (K), Box 215, Folder 353.91-1 (G.H. #9) K April 1919 to date, US National Archives.
patients with arm and leg prosthetics, and supplied splints for the wrists and fingers under

treatment. Prostheses were a part of a broader effort to insure postwar productivity through

labor. By April 1919, most cases were being discharged, though the Surgeon General stressed

the need to follow up with them and understand if the maximum degree of recovery had been

assured to each patient. Fort Des Moines joined most other major US Army General Hospitals

in efforts to remedy the loss of touch and movement.

Fort McHenry’s Neuro-Surgical ward, for example, treated over 600 nerve cases, and

completed roughly 200 nerve operations. Many of the cases there had gunshot wounds that

causd injury to the bones, muscles, and nerves. Surgeons prescribed whirlpool hydrotherapy,

electrical baking for flexibility, and massage that aided in the range of movement. Lakewood,

Cape May, and Walter Reed used similar physio-therapeutic techniques, and created a larger

culture of physical manipulation for restoring the sense of touch. In the peripheral nerve centers

at Fort Des Moines and Walter Reed therefore, physicians sought to address the primary

functionality of bodies, and restore feeling and movement to men with peripheral nerve injuries.

Wounded soldiers endured pain silently or vocally. At the same time social and cultural

discourses in camp newspapers inscribed moral ideals of discipline and manhood into silencing

pain narratives. The rehabilitated man did not voice his pain too readily. US Army rehabilitation

also tried to heal the sense of touch with regard to peripheral nerve injuries and, therefore,

regulated the functionality of the sense itself. The sensitivity of the nerve could not be too absent

nor too heightened in a way that generated cries of pain. Yet the symbolism of touch and feeling

rehabilitation went far beyond pure function. The sense had to be useful for vocational training

169 Colonel George F. Juenemann, “History of Hospital at Fort Des Moines Iowa – 1918: Orthopaedic Service,” RG


170 The Surgeon General to the Chief of Surgical Service, “Peripheral nerve injuries” April 16, 1919, RG 112, Series

UD 8, Box 16, Folder 730: Peripheral Nerve Cases, US National Archives.

171 Commanding Officer to the Surgeon General, “Report of Hospital” January 21, 1920, RG 112, Series NM 31

(K), Box 184, Folder 319.1-2: General Hospital #2 (K), US National Archives.
and economic independence. And the sense of touch fit within the broader culture of healing spaces through recreational activities and disciplinary procedures all meant to regulate the male body and sexuality after the war.

*Educating the Senses: Touch, Vocational Training, and Economic Independence*

Touch was a fundamental sense of re-adjustment particularly for blind and deaf veterans who attempted to make good. At US Army General Hospital No. 7 in Baltimore blinded soldier-patients mobilized their sense of touch in Braille reading and typewriting courses as necessary adjustments to life without the use, or with limited use, of their eyes. Psychologist Robert Gault argued that touch could help deaf individuals read vibrations of sound and better enable them to communicate with others when he posited the idea of devices of adjustment, which implied that with the loss of one sense an individual could rely more on the other senses. Rehabilitation challenged assumptions that the loss of one sense – in this case sight – precipitated the strengthening of the other senses. Instead, some commentators argued that patients needed to educate their senses for success, rather than relying on their amplification. For example, while deaf individuals could allegedly use their eyes or their sense of touch to read or feel the human voice, blind individuals could use their “eyes in the fingertips” to read Braille.\(^\text{172}\) Whether it was eyes in the fingertips or devices to adjust to the loss of any of the other senses, touch became a crucial site to regulate the terms of social re-integration.

Prominent figures in society influenced how Americans conceived of the idea that losing one sense triggered heightened ability in the others. For instance, deaf-blind Laura Bridgman and Helen Keller allegedly exhibited increased tactile sensitivity. Tactile sensitivity tests on Bridgman showed at least double the sensitivity on her tongue and index finger as the “normal

\(^{172}\) “Eyes in the Finger Tips,” *Scientific American*, 119, no. 9 (August 31, 1918), 167.
person.” Yet some writers argued that it was not a physiological change in the sense itself. Helen Keller, too, did not gain better sense of touch because her sight or hearing was gone. Instead, the argument went, she did so largely because of her “admirable intelligence” and “careful and painstaking teaching.” Soldiers – like Keller – therefore must also be taught the importance of tactile education.\textsuperscript{173} At a time when physicians increasingly relied on technology to supplement what the senses could not detect, doctors in American rehabilitation hospitals emphasized the senses as crucial for adjustment to postwar life.\textsuperscript{174} But positioning sensory mastery as a product of hard work and education rather than heightened sensory adaptation saddled the individual soldier-patient with responsibility for his success or failure in civilian life after the war.

Blinded veteran rehabilitation therefore focused on educating the sense of touch. Much like the other reconstruction hospitals for all wounded veterans, General Hospital No. 7 employed reconstruction aides who gave instruction in Braille, typewriting, English, and arithmetic, as well as other vocational programs. Vocational programs utilized tactile perception to help men make various articles such as hammocks, baskets, matchbox holders, and coat hangers. Braille however was the introduction to the work in places such as the wood shop. Reading through the Braille system, writes the educational director there, was a means by which the patient “has made a new step forward and some light has been brought into his world of darkness.”\textsuperscript{175}

As rehabilitation authorities focused attention partially away from the assumption of an acquired heightened sense of touch by arguing for the individual will and work ethic of each veteran, vocational pursuits they offered to the men had tactile perception at the core of their

\textsuperscript{173} “Eyes in the Finger Tips,” \textit{Scientific American}, 119, no. 9 (August 31, 1918), 167.
\textsuperscript{174} Reiser, “Technology and the Use of the Senses in Twentieth-Century Medicine,” 262.
\textsuperscript{175} Harold Molter to the Commanding Officer, “History of Educational Department,” April 22, 1919, RG 112, Series NM 31 (K), Box 206, Folder 331.4: U.S.A. Gen. Hosp. #7, Baltimore, Md. (K), US National Archives.
requirements. Work in the woodshop or on the typewriter established the elevated role of touch in labor. Agricultural pursuits in particular used the sense of touch for successful education, that included feeling the quality of newly laid eggs and de-feathering chickens. Blinded soldier-patients who learned agriculture navigated the lands at the Red Cross Institute for the Blind by feeling their way down the side of the fence that enclosed the farmland.

One vocation the hospital promoted in particular for blinded men was anatomy and massage. James Copeland was a graduate of the Pennsylvania Institution for the Instruction of the Blind, also called Overbrook. After he taught briefly at the Perkins School for the Blind in Watertown, Massachusetts, Copeland was inducted into the US Army Medical Department to assist with blinded soldiers. He recorded that massage and anatomy classes among blinded soldiers were effective. All of the students there were later employed in a private or Veterans’

176 Photograph 002813: “Blind assistant taking the refuse from the barn and guiding the horse by means of a wire stretched along his path,” PP 148.42: Evergreen-Red Cross Institute for the Blind, ca. 1918-1920, Maryland Historical Society.
Bureau hospital. William Zimmerman, for example, used his newfound tactile-based profession to treat wounded patients at the Fort McHenry hospital. Blinded soldier rehabilitative education was based on the sense of touch for successful productivity.

Blinded soldiers learned anatomy by feeling a skeleton. Courtesy of the Maryland Historical Society, PP148.52

179 PP 148.42: Evergreen-Red Cross Institute for the Blind, ca. 1918-1920, Maryland Historical Society.
Blinded soldiers “learn to use sense of touch to the best advantage” to make hammocks in occupational therapy. Courtesy of the National Museum of Health and Medicine.  

While there were not enough deaf soldiers to necessitate the larger mobilization of touch similar to blinded veterans in Baltimore, psychologist Robert H. Gault recognized the importance of the sense in relation to deafness after the war. As blinded soldiers were to find new eyes in their fingertips, he argued that deaf individuals would ‘hear” through touch, and feel the rhythm of, for example, a piano through the floor by distinguishing the pitch of a musical tone. This could translate into normative speech patterns. The organs of touch, which Gault called “devices of adjustment,” compensated for the loss of hearing and were to be properly trained to catch the “musical phrases of the human voice” and therefore aided in the process of lip reading. Private Edward Boyle, for example, “got his at Wipers [Ypres]” when a high explosive shell burst near him and shattered his ear drums and left him “stone deaf,” according to Army doctors in New

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180 “Hammock making. A recently blinded man has to learn to use sense of touch to the best advantage. Hammock making is an excellent means to this end,” OHA 80, Box 41362-41533, National Museum of Health and Medicine.
York. Ear specialists claimed he had paralyzed auditory nerves, and perforated Eustachian tubes, yet Boyle found respite in the piano playing of Margarete Anderson of New York City. While Anderson played the piano, the sound vibrations allegedly allowed some of his hearing to return to him by registering the low vibratory chords that he felt.  

Deaf and blinded veterans educated their sense of touch through music therapy, braille, massage, and other pursuits and made up for the loss of their hearing and sight in their pursuit of economic independence. The problematic implications of educating the senses becomes clear when society marketed blinded veteran success stories as the byproducts solely of individual effort, a topic that will be expanded on below. The US Army, however, mobilized the sense successfully. Rehabilitation efforts led many to use touch to re-integrate deaf individuals through feeling the human voice, and the sense was crucial to healing blinded veterans. Men at General Hospital No. 7 used the sense from the beginning of their post-wound journeys, as they navigated the tactile halls of hospital wards, wood shops, Braille typewriters, and anatomy classes. Rehabilitation, therefore, positioned human touch as a tool integral to entering civilian life and making good. Accordingly, touch was the vehicle to economic prosperity and effort was the driver.

Morality of Touch: Feeling, Sexuality, and Manhood

The sense of touch had broader implications than simply the medical or economic need to feel. Sociologist Mark Paterson argues that touch embodies proprioception, or navigating the state and movement of human bodies, whether wounded or not. Along Paterson’s logic,

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feeling allowed a US Army patient to use his body to the fullest potential in rehabilitation. What men did with these bodies in and out of the hospital was critical to regulating touch and also to maneuvering through gendered and sexual landscapes. Ultimately, making good in American rehabilitation hospitals entailed certain ideas about what male bodies did, or more simply, what they touched. Examples of touch that hospitals deemed acceptable included controlled interactions with women.

Rehabilitation hospitals provided ample opportunity for soldier-patients to exercise their masculine energy through sports. Athletics was made possible through extra-curricular investment from charitable organizations such as the YMCA or the Jewish Welfare Board. While they exercised the physical capabilities of their bodies through athletics, many patients also engaged their sense of touch as they performed their sexuality by attending the many dances hospitals held, accompanied by women. Most US Army General Hospitals promoted physical education in ways that reinforced notions of the masculine and fit male body. And rehabilitation magazines and newspapers publicized athletic patients as the pinnacle of manliness. Through sports, American rehabilitation infused into the process of “making good” the requirement to display early-twentieth century forms of masculine fitness.

The early 1900s saw a retrenchment of older ideas about manhood that relied on self-restraint. By 1917, the United States had experienced rapid industrialization, and American culture emphasized the body, strength, and competitiveness as vital to manhood in a world of economic uncertainty. Many Americans defined masculinity at least in part through recreation and outdoor activities that freed one from hectic and enclosed city life. Men such as Theodore

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184 Linker, War’s Waste, 127.
186 Rotundo, American Manhood, 6.
Roosevelt saw the outdoors as an “arena for manly exertion.” And across the Atlantic, British onlookers were infatuated with the physicality of strong men such as bodybuilder Eugen Sandow.

Physical education professionals like Sandow made their way into at least one American hospital as well. The recreational director at General Hospital No. 7, for example, arranged for body building expert Antone Matysek to speak to the men there in 1919. Advertising for the event asserted, “The way to strength: The MAN of Tomorrow must be built strong Today. Matysek physique exercise is a sure and rapid method of acquiring an EFFICIENT BODY.” The advertisement reflected broader social tendencies that emphasized bodily efficiency in ways similar to how rehabilitation officials emphasized re-educating the senses for economic efficiency. In bringing Matysek to the men in Baltimore, medical and recreation officers aimed to transfer the ideology of the “efficient” and strong body into the military process of making good after a disabling war wound. Not only did men there need to use touch and feeling for economic and medical rehabilitation, but they also had to use touch and feeling to make their bodies as masculine as possible.

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Other programs and events were aimed at emphasizing the male body as well. Sports were universal in Army hospitals in the United States. Some were informal athletic activities, as with the patients who exercised an hour a day at Fort Des Moines. Physicians also prescribed graded exercises, or increasingly strenuous activities that ranged from light stretches to more strenuous weight training, to cardio-vascular patients in the development battalion at the Lakewood, New Jersey hospital. Recreational activities, particularly for Lakewood’s development battalion, allowed doctors to observe heart condition during activity and determine the need for discharge. Yet the exercises also served for this set of soldiers and arthritic

190 “Gymnastic Cure in Mental Cases Base Hospital #2, Ft. McHenry, Md.,” OHA 80, Box 41362-41533, National Museum of Health and Medicine.
patients to build strong bodies, not dissimilar to the efforts to bring Matysek to speak with blinded soldier-patients.

There were also larger events meant to promote the fit masculine body. The Inter-Hospital Telegraphic Field Meet on August 25, 1919, for example, pitted patients from Fort McPherson and Fort Des Moines against one another. The results of the 50-yard wheel chair race, the “efficiency walk” among patients with artificial legs, and the baseball throw for one-armed men were broadcast in hospital newspapers throughout the country. According to The Des Moines Register, the one-legged race “provoked some hearty laughter when the contestants, bobbing like corks, hopped across the green in ridiculous manner.” The tug-of-war match between shell-shocked patients lasted merely two minutes, and one-armed men trounced one-legged men in the baseball game because of their “superior base running ability.”

"Big Crowd Enjoys Contests at Fort: 110 Crippled Soldiers Take Part in Merry Making Games and Races,” The Des Moines Register, June 7, 1919, RG 112, Series UD 8, Box 13, Folder 353.8: Athletics & Amusements, US National Archives; The Surgeon General to the Commanding Officer, “Inter-Hospital Telegraphic Field Meet,” October 8, 1919, RG 112, Series UD 8, Box 12, Folder 250: Morale, US National Archives. "Wheel-chair-race,” RG 112, Series NM 31 (K), Box 265, Folder 314.7-2: G.H. #26 (K), US National Archives.
The Inter-Hospital Telegraphic Field Meet and other sporting events at places such as Walter Reed Hospital emphasized the physical strength and capabilities of the male body. These events were also part of a complex negotiation that disability scholars identify as “passing.” For disabled veterans in sporting events, passing meant to highlight athletic capability as a way to reduce, erase, or “overcome” their disability. The process “helps create concepts of normality”

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196 “One armed vs. one legged men baseball game,” RG 112, Series NM 31 (K), Box 265, Folder314.7-2: G.H. #26 (K), US National Archives.
197 “One legged hop,” RG 112, Series NM 31 (K), Box 265, Folder314.7-2: G.H. #26 (K), US National Archives.
by focusing on ideal images of the body. Passing is about maintaining markers of “normalcy,” like silencing pain, and dislocating disability identity. Passing has been common in the histories of disabled veterans in the modern era. Sport therefore joins a broader history of disabled veterans, the state, and society negotiating the meanings of disability and manhood through sensory applications like touch and feeling. Sport and passing helped legitimize both the program of rehabilitation and the disabled body, and sublimated the responsibility for the violence that had disabled the men in the first place.

The state and charitable organizations stimulated bodily development through sport and labor by investing in hospitals. General Hospital No. 7, for example, added a swimming pool and a bowling alley. The hospital emphasized the abilities of men there as patients, publicizing their ability to feel their way through open water or rely on their sense of touch to roll a bowling ball. And Fort Des Moines built volleyball and basketball courts, as well as soccer and field hockey fields. Charitable organizations played a major role in aiding the veterans' physical training as well. The Red Cross stations at various hospitals sponsored excursions to baseball games and parades to inspire the men to at least think about exercise. The YMCA at Fort McPherson’s hospital took it a step further and coordinated a successful loan station where men could borrow bats, gloves, golf balls, and other sports gear. By May 22, 1919, just three weeks after it had

201 Rembis, “Athlete First,” 128.
202 Eugene B. Stebbins to the Commanding Officer, “State of Morale at this Hospital,” September 15, 1919, RG 112, Series UD 8, Box 12, Folder 250: Morale, US National Archives.
opened, the loan station served approximately 300-400 men every day.\textsuperscript{203} While sport enabled opportunities for exercise more broadly, it also gave veterans opportunities to physically manipulate their own wounded bodies, which in some cases included engaging the sense of touch.

While sports engaged the senses only indirectly, the Red Cross worked on men’s masculinity and sense of touch in other, more direct ways, and women were usually central to these efforts. In an article in \textit{Carry On: A Magazine on the Reconstruction of Disabled Soldiers and Sailors}, rehabilitation specialist Alice Miller wrote, “Practical experience of the war shows that the degree to which a soldier can recover is in a large measure a question of his state of mind; and his state of mind is usually a reflection of the state of mind of his wife or his mother… In every step the help of women is essential.”\textsuperscript{204} Most hospitals held dances for the men. Fort McPherson sponsored a dance every week in the Knights of Columbus building, as well as parties for patients with “the women of Atlanta acting as hostesses.”\textsuperscript{205} For the blinded men in Baltimore, dances were particularly important in regenerating their sense of touch specifically in connection with women. There, staff staged many events that included women from Baltimore, where they would guide the soldier-patients in rhythmic dances in close concert. The events aimed to help the patients’ moral adjustment and engage their sense of touch in the process of

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\textsuperscript{203} John L. Riley to the Commanding Officer, “Report of Activities Tending to Promote Morale,” May 22, 1919, RG 112, Series UD 8, Box 905, Folder 250.1: Morals & Conduct, US National Archives.  
\end{flushright}
making good.206 The close proximity of dance helped the men restore a sense of normality through the sort of physical touch with women that emphasized heteronormative relationships.

While important to enabling the physicality of soldier-patients, the existence of charitable organizations within hospitals was not entirely uncontroversial. The morale officer at Camp Devens, Massachusetts for example argued that the presence of so many feminine aides had led to a loss of discipline, particularly their inclusion in tactile occupational work such as knitting and basket-making, which he considered “juvenile and feminine.” “To this atmosphere” he writes, “agencies have sometimes unwillingly conformed.” The morale officer at Fort McHenry

207 Dance at the Red Cross Institute for the Blind, November 11, 1919, PP 148.42: Evergreen-Red Cross Institute for the Blind, ca. 1918-1920, Maryland Historical Society.
agreed. And the public donations that made many of the activities in hospitals possible also came under scrutiny. After Evergreen received large sums of money from various organizations to help provide for the men there, the War Department ordered the hospital to return the funds to its most recent donor to make sure patients there did not feel like they were “being made objects of charity.”

Officials at US Army General Hospital No. 30 at Plattsburgh, New York, a hospital primarily for “insane” soldiers, argued that there was too much “entertaining” and “molly-coddling” by the Red Cross, and it was lowering morale and causing the men to overstay at hospitals to gain these advantages. Fort McHenry’s commanding officer saw the issue differently from many of his counterparts, reflecting on the rise of Progressive Era social reform organizations. “I view this whole question,” Henry Page wrote, “as a part and parcel of a great social movement which each Commanding Officer must meet in his own way. We cannot stop the wave of feminism, hence we must learn to swim.” In this light, while Page did little to alter the role of charitable organizations there, he saw to “direct feminine energy into productive channels.” Despite the debates, charitable organizations still provided numerous extracurricular activities such as sports, films, plays, and dances that helped men utilize their sense of touch and socialize during rehabilitation.

Rehabilitation leaders built a new program of physical and moral reconstruction within broader political changes that included women seeking political rights in the United States. In

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1914, American women had been assuming larger roles in political life as Progressive Era maternalist reformers. In the midst of fighting for the vote, pacifist, socialist, and anarchist women in the war years also fought against American involvement in the Great War. Progressive reformer Jane Addams and the Woman’s Peace Party sought an early end to the war and argued against American preparedness measures. Ideas about gender shaped women’s confrontations with legal authorities as they came up against anti-radicalist state repression. Many women rejected the kinds of political involvement that resulted in state repression, and instead supported preparedness as a way to expand their roles in politics while also rebuffing their socially prescribed roles as mothers and wives, and supporting husbands and sons in the war. As young American men entered rehabilitation hospitals, the state scrutinized the ways women could and did serve to help heal the wounds of war.

The nature of women’s help – in many cases tied to charity and femininity – was carefully calculated. Officials often conflated negative ideas about femininity with the presence of women occupational therapists and charitable organizations. Hospital commanders and Army administrators worried by October 1919 that there was too much entertainment in hospitals. The YMCA, the Knights of Columbus, the Jewish Welfare Board, and the American Library Association provided crucial aid to government efforts that made patients far more comfortable in their recovery. Yet the Adjutant General argued that the excessive amount of free entertainment and gifts could have “a demoralizing effect” on the men, and the Army sought to

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215 Kennedy, Disloyal Mothers and Scurrilous Citizens, xix.
216 Sullivan, “Finding ‘the Man Behind the Handicap.’”
limit the number of events in hospitals, though with little success.\textsuperscript{217} As the US Army regulated male-female interactions in hospitals they encountered broader conversations about charity and modern feminism.

Rehabilitation officials regulated the presence of women in hospitals in an effort to combat the perceived feminization. Officials sought to limit what they perceived as “meddlesome” women near Army hospitals.\textsuperscript{218} And military standards in the recruitment of women for rehabilitation, for example, prioritized rigorous physical standards for reconstruction aides – including Occupational and Physio Therapists. By 1918 over 20,000 women served in the Army Nurse Corps.\textsuperscript{219} Qualifications required that they had to be between 25 and 40 and, “If married… can be accepted only for work in hospitals in this country.” Additionally, “Applicants must not be less than sixty inches or more than seventy inches in height; must weight not less than 100 or more than 196 pounds. Marked disproportion between height and weight may be a cause for rejection.”\textsuperscript{220} Being aesthetically fit was an important criterion for acceptance, in line with the promotion of fit bodies for disabled soldiers more broadly.

Nurse duties were subject to specific criteria as well. Women’s qualifications and professional abilities were often overlooked in favor of their moral character.\textsuperscript{221} The Orthopedic Advisory Council wanted specific therapists, looking for individuals with a background in physical education, as they argued the women would be more like a drill sergeant than a bedside

\textsuperscript{218} Linker, \textit{War's Waste}, 132.
\textsuperscript{220} M.E. Haggerty, “‘Where Can a Woman Serve’: A Big Field is Open for Reconstruction Aides,” \textit{Carry On} 1, no. 3 (September 1918), 29.
\textsuperscript{221} Joshua S. Goldstein, \textit{War and Gender: How Gender Shapes the War System and Vice Versa} (New York: Cambridge University Press, 2003), 314.
nurturer. Military planners were careful not to disrupt sexual norms and sought to construct nurses and men as nonsexual. Military and medical authorities wanted strict nurses to attend to veterans. Fears of massage being too sensual caused women in Britain to form the British Society of Trained Masseuses. Leaders in the United States, though less organizationally concerned, emphasized that women therapists should not look at the veteran “as a sensual, aesthetic being,” but as “a collection of mechanically oriented units.” The example of massage reveals that authorities attempted to de-sexualize the bodies of both women and men, and the contact between them.

In other examples, officials positively mobilized perceived feminizing influence toward disabled male bodies. At General Hospital No. 7 – later called Evergreen –, the Red Cross House allowed women at the institute to lend emotional support to the blinded men, and had large lounge and reading rooms “supervised by attentive and pleasant young women” which gave the men “the home touch.” The use of the word touch signifies that rehabilitation authorities were aware of, and encouraged the right kind of touch, while also on the lookout for the wrong kind. They walked a perilous line. Similar to the dances held there, women acted as positive conveyors of male sexuality, and touch served as the conduit through which sexualized relationships might be re-introduced. The Red Cross House promoted heteronormative relations in other ways as well, with strict rules. Women were not allowed in the dormitories, but could be entertained in the recreation rooms or in the Red Cross House. To visit friends who resided at Evergreen, women “may call their friends by using telephones in the ‘double barracks,’ Red Cross House, or

222 Beth Linker, War’s Waste: Rehabilitation in World War I America (Chicago: University of Chicago Press, 2014), 64.
223 Goldstein, War and Gender, 316.
224 Goldstein, War and Gender, 69.
225 Linker, War’s Waste, 70.
226 Sullivan, “Finding ‘the Man Behind the Handicap.”
227 “Courses of Instruction: Red Cross Institute for the Blind,” Evergreen Review 1, no. 1 (January 1920), 7.
American women, if controlled properly, were a welcome presence in the daily negotiations over the meanings and uses of men’s bodies and what they could feel. Rehabilitation success stories in this context boasted about the sexuality of blinded veterans, and “challenged” women to live up to their sexual “responsibility.” An article in the *Boston Herald* posed the question, “Are you, Miss America, ready to take a blinded husband?” appearing shortly after the same challenge to French and British Women. Ewald Wegner was “one of the most popular” patients at Evergreen. He trained in the poultry department and fell in love with his “attractive instructor,” Mrs. Gilmore. The two “have ‘flown the coop’” after cultivating a relationship from their mutual interests in the chickens. The marriage was just one of many relationships there. By January 1921 there had been between thirty and forty weddings at Evergreen. Called “The Match Factory” and “Cupid’s Cottage,” the men there “graduate into matrimony almost as fast as they do from their classes in merchandizing, vulcanizing, poultry-raising, cigarmaking and the rest of it.” And the “blinks” make the “best husbands.” Here, sexuality was paired with labor productivity through the sense of touch, as veterans re-entered acceptable tactile relationships with women and work and became images of successful rehabilitation.

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This theme extends to other examples of blinded veteran relationships. One Evergreen bride, Zoe Beckley writes in a song, “For he sees no faults that other men see!” referring to the men’s blindness. The blind man is the best husband because he “belongs so COMPLETELY to the girl he marries.” John Rapp, a poultry farmer, returned to marry his wife, who argued, “But what is affliction so long as you still have love and work.”233 One of the most widely publicized veterans there, William Zimmerman, returned for the girl he left behind. “You see” he writes, “I have got to get a job now, because they sent for my girl to come down here to see me and she said, ‘Bill, if you make good I am going to marry you.’ Well, blindness is a handicap of course but it’s not going to stop me.”234 Blinded veteran’s sexuality and disability identities intersected. Their efforts to display or validate their masculine values through heteronormative relationships

232 “Blind Soldiers and Brides Living in Cupid’s Cottage,” The Palm Beach Post, January 5, 1921, 8.
233 Ibid.
in an attempt to return to pre-war life was in part an attempt to counteract contemporary notions that their disability made them less of a man. Yet the nature of their disability meant they navigated a new world without sight and subverted those male norms through a partial reliance on women in everyday life.

The Evergreen men’s encounters with women during the course of treatment complicated early twentieth century gender norms of male socio-economic independence, as the disabled male patients relied on women for much of their postwar training. And their experiences highlighted more specifically the importance rehabilitation placed on women’s touch in navigating the postwar world. *The Red Cross Magazine* included prints in a 1918 edition from artist L. Levy. One called “The Mother of the Blind Solder” depicts a mother with her son in uniform – in this case a uniform from the American Civil War – guiding his hand toward an object off the page.

Another example of female guidance focused on Marion and Helen, who were two daughters of a blinded veteran and who lived at Evergreen. Marion showed her father the pictures in her bunny book by pressing his finger over them to “feel the colors.” Imagery such as this focused on male reliance on the guidance and touch of women, but also on the men’s eventual familial and gendered re-integration. Rehabilitation, and making good, therefore, relied on the tenuous regulation of women, sexuality, and the perceived feminizing influence in most instances of rehabilitation.

The US Army infused morality into touch as it built the male body and regulated sexuality in postwar rehabilitation. Physical training experts spoke to wounded men about the importance of the male physique, which had significant implications for productive post-war life. The Inter-Allied Telegraphic Field Meet tested the abilities of male bodies and through events

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237 “Blind Soldiers and Brides Living in Cupid’s Cottage,” *The Palm Beach Post*, January 5, 1921, 8.
such as races, volleyball, and baseball games. And charitable organizations organized tactile experience through dances where blinded men relied on the sensuality of touch to regain social relationships with women. Yet Army officials challenged the presence of charitable organizations and women in hospitals as detrimental to the manhood of patients.

But the US Army and the veterans in rehabilitation delineated clearly between good and bad touch in other contests over clothing and venereal disease. Soldier-patients at Fort McPherson, for example, gathered on the parade ground at the hospital in late-August, 1919 to watch a moving picture, The Training of the Soldier. The film aimed to instill in the men the virtues of rehabilitation, addressing among other topics the proper fitting of clothing and shoes. “The exhibition of the picture was met with jeers, cat calls and hoots of ‘take it away,’ ‘stop it,’ and ‘we don’t want to see it.” According to the report, the soldiers believed the film was contradictory because they had been forced to wear re-issued, salvaged clothing and were restricted from wearing clothes purchased in Atlanta stores. Many left the parade grounds in response.²³⁸

The episode at Fort McPherson highlights how the state regulated male bodily autonomy to promote morality within rehabilitation. Bodily autonomy – what the body felt, what it wore, and how and where it moved – was crucial to men’s ideas about dignity and of their place in rehabilitation and American society. Patients at Fort McPherson clearly articulated that clean clothing, or what their bodies came into contact with, were legitimate grounds for contesting the US Army.

The negative response to The Training of the Soldier emanated from longer-term issues within the hospital. Patients there had evidently been wearing salvaged underwear and uniforms.

²³⁸ T.S. Bratton, Memorandum, August 27, 1919, RG 112, Series UD 8, Box 905, Folder: Morals & Conduct, US National Archives.
The impression among them was that the clothing had been previously worn by “negro troops formerly in cantonements [sic] near the hospital. It is reported that the men are very reluctant to wear this clothing, and that many at personal expense are wearing clothing purchased outside.” The patients’ sentiments coincided with broader social and pseudo-scientific currents that portrayed black bodies as inferior and threatening to white manhood. Convalescent soldiers took the opportunity on day trips to Atlanta to obtain clothing at their own expense, though in many cases the Military Police arrested them for it, producing more resentment against camp officials. The issue proved problematic enough that Commanding Officer Bratton suggested returning to the policy of granting a clothing allowance so soldiers could purchase and wear their own clothing.

Bratton recognized the importance of bodily autonomy and feeling dignity in the perception of clean clothing in the healing process, and perhaps he was even cognizant of the racial dynamics of shared clothing. Nevertheless, Bratton argued it was useless to talk about morale and “write high-sounding phrases” and then issue second-hand clothing and underwear to the men. “The American soldier is no fool, and when he is handed pamphlets, and is given talks about high morale, self-respect, etc., and then is treated in the manner mentioned above by Officials of the Army, he soon develops a disgust for the whole Army administration.” Hospital administrators recognized how important clothing one’s body was, and accommodated the wishes of wounded men for bodily autonomy.

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239 C.R. Darnell to the Surgeon General, August 16, 1919, RG 112, Series UD 8, Box 905, Folder: Morals & Conduct, US National Archives.
Not all patients had the same level of power over their own bodies. Many faced restrictions on their ability to move where they wanted. The right to movement was particularly important for morale, and hospitals took steps to regulate this. Fort McHenry instituted an “honor card” program, allowing patients with good behavior to travel to Baltimore and back with few restrictions. “Are You An ‘Honor Card’ Man?” reads an article in the Trouble Buster, the camp newspaper at Fort McHenry. The honor card was given to those who had won the hospital’s confidence. Yet, it warned, “honor card men” could have their privileges taken away abruptly for bad behavior. Patients who were absent without leave were typically placed in the hospital guardhouse or sent to the Disciplinary Squad, and had their card taken away. The Fort McHenry honor card was a coercive, though unsurprising means by which the military adapted field regulations, which would have strictly controlled soldiers’ movements, to postwar hospitals. Patients marked as morally compromised and contagious, in particular those with sexually transmitted diseases, usually had fewer liberties than men with honor cards. Progressive social hygienists and physicians sought to curb venereal disease in the AEF. The Commission on Training Camp Activities (CTCA) sponsored campaigns aimed at controlling soldiers’ sexual desires, and developed programs for recreation in training camps. General John Pershing also issued General Orders that made contraction of a venereal disease punishable by court martial, and later stipulated that failure to take chemical prophylaxis after a sexual encounter was a separate offense and considered a neglect of duty. Despite the military’s best efforts, however,

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246 Brandt, No Magic Bullet, 101-110.
almost 400,000 soldiers were diagnosed with a venereal disease between April 1917 and December 1919.\textsuperscript{247}

Diseases such as syphilis and gonorrhea were costly to the AEF. Around 18,000 men missed action each day during the war, and each case cost the Army around seven dollars per day for an average of 33 days. The AEF established camps to confine the men, and they were not released until being declared non-infectious. One Medical Corps officer noted, “The moral effect of segregation has undoubtedly been felt,” and a sign hung over the camp at Gièvres that said, “This is a Venereal Camp. These Men are Helping the Hun.”\textsuperscript{248} The military, physicians, and social reformers feared the spread of venereal disease through sexual contact and took drastic steps to prevent it during the war. But soldiers at hospitals in the United States after the war still contracted venereal diseases and were confined because of it.

Patients at Fort McHenry’s Genito-Urinary (GU) department provide an example of the continuation of progressive reform efforts on the bodies of American soldiers. In 1919 the hospital had almost 700 cases there. Most cases were gonococcal infections, and all cases of syphilis were given Arsphenamine injections.\textsuperscript{249} General Order 31, which prohibited light duty for men in that department, limited patients’ abilities to work and rehabilitate at the hospital while they were still under treatment. Because of this, men often went unpaid.\textsuperscript{250} The lapse between cure and actual discharge, imposed by the curative discourses of rehabilitation itself, contributed to poor morale.

The men were also isolated from much of the hospital staff and patients, similar to their counterparts in France during the war. They were “messed separately, must be kept away from

\textsuperscript{247} Brandt, \textit{No Magic Bullet}, 115.
\textsuperscript{248} Brandt, \textit{No Magic Bullet}, 115-116.
\textsuperscript{249} The Commanding Officer to the Surgeon General, “Report of Hospital for the Calendar Years, 1919, RG 112, Series NM 31 (K), Box 184, Folder 319.1-2: General Hospital #2 (K), US National Archives.
\textsuperscript{250} The Commanding Officer to the Surgeon General, “Report of Hospital for the Calendar Years, 1919, RG 112, Series NM 31 (K), Box 184, Folder 319.1-2: General Hospital #2 (K), US National Archives.
contact with the feminized portion of the Hospital, and… cannot attend our dances and classes conducted by young ladies from the city of Baltimore.” The hospital and administrative fear of the moral failures of these patients was allegedly well-founded in the view of the Commanding Officer, who referenced a report that in one corridor “a young lady was met in a lonely angle by one of these venereals and so grossly insulted and threatened with assault, that it is probable that an attempted lynching would have occurred had the man been caught.” The same report cites a general dislike among Medical Detachment men toward GU patients as well.\(^{251}\)

Patients in the GU ward faced not just moral assumptions that at times affected their pay and proximity to others. Their confinement was problematic as well. In a letter to Newton Baker, a patient at Fort McHenry complained that men were being held in the guardhouse for almost a month before trial for minor offences such as gambling and being absent without leave. When they were tried they were given long terms of confinement without treatment, and patients in treatment were being made to work in close proximity. “Men with running sores of venereal diseases are mixed in with and use the same toilet, in the guard house as the other men.”\(^{252}\) The only rebuttal the Commanding Officer gave was about the length of pre-trial confinement, making no reference to treatment. The soldier was concerned about the closeness of bodies perceived as morally suspect. And Medical Department staff gave far less consideration to their case than the men protesting dirty clothes.

The experience of GU patients at Fort McHenry is telling. Unsurprisingly, the men there were confined and limited in who they could come in contact with, and where they could go.

And the patients’ confinement was a means to quarantine the diseases, most of which required

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\(^{251}\) The Commanding Officer to the Surgeon General, “Report of Hospital for the Calendar Years, 1919, RG 112, Series NM 31 (K), Box 184, Folder 319.1-2: General Hospital #2 (K), US National Archives.

touch for transmission. But the detachment men’s disdain for GU patients – especially when in proximity to women – highlights the negative association between the confined patients and their disease, and the moral assumptions that accompanied it. Touch, in this case, could be morally and medically dangerous, and complicated the goal of making good.

Conclusion

The examples of blinded veterans after the war demonstrate the role touch played in shaping successful social reintegration after the war. Veterans relied on touch to train for postwar work and navigate new sensory environments. Men involved in Cupid’s Cottage included gender and sexuality in their postwar rehabilitation as they relied on the sense of touch at dances or to interact with their children. Touch was a mechanism that displayed the veterans’ complete devotion to healing and loving. The role of touch in American rehabilitation, therefore, was broad and infused with the social expectations of sexual roles and productivity predominant during the years surrounding the First World War.

But the sense of touch was also highly regulated. Recreation involved using touch and feeling to strengthen the male body and accompany women to dances. Yet the very existence of women and organizations that provided these services called into question the morality of charity and labor. Hospital staff sought to control how touch could be used for the benefit of male bodies. In this way, medical officers indicated that, for some bodies, touch could be dangerous. This was the case with genito-urinary patients, whom hospitals isolated and staff disparaged. These experiences in particular indicate how some disabled and sick bodies had more power within the rehabilitative framework than others, depending on the “morality” of their wounds or sickness. Touch, therefore opens the windows and doors of the hospitals and reveals acute
negotiations over the meanings of disabled male bodies in their pursuit of successful rehabilitation.
Chapter III: Gustatory Healing: Taste, Ingestion, and Power in Rehabilitation

Gustatory experiences, and ingestion more broadly, played an important role in disabled veteran experiences and their efforts to make good. Nutrition was a vital component to healing, and diets could help or hinder the process. The physical health of each soldier determined the delivery mechanisms of his meals either in mess halls or in wards. Poor food quality created strains and animosity between US Army patients and staff, and therefore threatened to undermine the credibility of the entire process of rehabilitation. American authorities in charge of rehabilitation recognized how food could heal patients and generate positive morale. Food, after all, was the theme of Camp Merritt’s hospital newspaper, called “The Mess Kit.” And medical officers at places such as US Army General Hospital No. 7 for blinded men in Baltimore recognized that the attitude of the men there depended on their being well nourished with good food. Soldiers and their families complained to hospital staff throughout the country and made clear the deficiencies in the state’s attempts to provide good tasting meals. Food and taste provoked yet another regulatory debate among the Army, veterans, and society about the meaning of rehabilitation and disability.

While food and taste remained important to rehabilitation, the US Army also made efforts to restrict patients’ access to ingesting alcohol. But patients and medical staff alike found ways around the restrictions, and therefore shaped the healing and postwar processes in their own ways. Management of food and alcohol reveals positive and negative taste and digestive negotiations between the state and veterans. These negotiations, though, must be understood

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253 A portion of this chapter appears in Battlefields and Homefronts: Expanding the Boundaries of Food and Warfare, 1840-1990, edited by Justin Nordstrom (Fayetteville: University of Arkansas Press, forthcoming). My thanks go to Justin for his helpful feedback, as well as Tina Peabody and Elana Krischer.

within the morally infused taste landscape in the broader United States, as well as the complexities of First World War rehabilitation. Food, disability, and sensory experiences in hospitals highlighted how patients exercised power in their relationship with the state in their quest to make good, and thus attempted to subvert the top-down power structures within military hospitals.\textsuperscript{255}

\textit{Food, Voluntarism, and the American War Effort}

Food was important and political during the war years. For Europeans in particular, years of war strained military and civilian life, and contributed to devastating food shortages in 1916-17.\textsuperscript{256} Germany had imported around a third of its food supply in 1914, but the British blockade of goods to that country during the war, combined with poor domestic harvests led to considerable civil strife in German cities.\textsuperscript{257} In Britain, the state’s coercive propaganda aimed at women argued that patriotic motherhood could be achieved by, among other activities, saving slices of bread.\textsuperscript{258} And in France, conscription and requisitioning left women, children, and the elderly to work long hours on farms with fewer calories to sustain them.\textsuperscript{259} European states faced broad uncertainties regarding food during the war years.

When the United States entered the war Americans recognized the importance of feeding the population. In order to save more food for the Army, environmentally conscious individuals

\textsuperscript{255} For a discussion of the importance of sensory history in war, see Mark M. Smith, \textit{The Smell of Battle, the Taste of Siege: A Sensory History of the Civil War} (New York: Oxford University Press, 2015); Nicholas J. Saunders and Paul Cornish, eds., \textit{Modern Conflict and the Senses} (New York: Routledge, 2017).


\textsuperscript{257} Davis, \textit{Home Fires Burning}, 22-23.


in cities across the country organized victory gardens. President Woodrow Wilson established the US Food Administration and, headed by Herbert Hoover, the Food Administration and various state Councils of National Defense politicized food consumption through compelling and vibrant posters that appealed in particular to women and children’s sense of taste to convince them not to waste. One war bond aimed at children, for example, argued, “You know, Mr. Ice Cream Cone, I hate a slacker and you are one.”

Although, food consumption policies were far from mandatory, they constituted coercive moral appeals for Americans to do their part to support the war. The Lever Food and Fuel Control Bill, passed in August 1917, intended to shape federal regulations on food. But Hoover declined to use many of its powers, and instead relied on voluntarism. Progressive Era reformers embraced coercive voluntarism with Americans’ eating patterns, and argued that rational food consumption and self-restraint could strengthen the moral fabric of the nation. In New York, organizations such as the Orange County Food Preservation Battalion embodied the voluntary sentiment to save food for the war effort through, for example, establishing canning kitchens. The Food Administration’s motto, “Food Will Win the War” demonstrates how food served as a positive and coercive means by which the state attempted to shape the lived experiences of Americans.

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262 Veit, Modern Food, Moral Food, 8 and 19.
263 Sarah E. Wassberg, “Preserve or Perish: The Orange County Food Preservation Battalion and Food Conservation Efforts in New York State during the Great War, 1917-1919.” (MA thesis, University at Albany, 2015), iii, 41.
Coercive voluntarism shaped much of American society during the war years in ways that were not directly related to food policy. Citizens who organized victory gardens to conserve food sought to exert patriotism and serve the country at war. However voluntarism sometimes took negative forms as well. For example, some hyper-vigilant groups such as the American Protective League (APL) pressured workers, “slackers,” and immigrants to conform to patriotic ideals by, for example, getting rid of German language programs in schools. The wartime culture of patriotic voluntarism led many Americans to embrace name changes for foods as well. Foods such as sauerkraut and hamburgers became “liberty cabbage” and “liberty steaks.”

In the broader sense, the First World War forced a reconceptualization of the meanings of citizenship through ideas, practices of patriotic voluntarism, and civic obligation as seen through victory gardens, the APL, and pressures to change food names.

Coercive voluntarism brought many civilians into military service, and from their training camps recruits recorded the world around them, often including their gustatory observations. When the US Army mobilized in 1917, thousands of soldiers entered training camps across the country. Robert Kirk Brady wrote to his parents from Camp Doniphan, Oklahoma, a camp that held between 25,000 and 30,000 soldiers and looked “like a big tent city.” In this environment, recruits usually consumed around 4,761 calories daily. Despite their large diets, food quality was not always good. Brady commented that, though the camp was a fine place, “The water…

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has a funny taste.”

Kenneth Gow of the 27th Division wrote of the poor nutrition of mess food: “We cannot get fresh vegetables or milk here. Milk is very scarce, and what you do get is like water… Nearly everyone’s digestion is upset.” Training at Fort Slocum, New York, George Brown had a similar experience with milk, which “didn’t look much like Jersey milk and certainly did not taste like it. At first I thought we must be late & someone had put dish-water in the pail by mistake. I found out later that it was plain water with just enough condensed milk in it to make the right color.”

Training put particular strains on Army recruits, and their sensory observations contributed to the broader experiences of food and the war.

When not under direct fire, soldiers at the front sometimes ate better quality food compared to what they had in training. Many in the American Expeditionary Forces (AEF) relied on canned beef and hard tack biscuits in combat, but also had daily rations of meat and vegetables. The AEF’s bakery in Is-sur-Tille baked 750,000 pounds of bread every day. Mess officers served food directly or put them in insulated cans to transfer to the front. But, in the hectic and dangerous atmosphere of war, not all soldiers had positive experiences with the food. Many noted in correspondence the body weight they had lost from the lack of calories compared to what they ate at home. In the atmosphere of the war, Americans encountered varying degrees of food standards and tastes. States and organizations politicized food consumption on the battlefield and the home front. And soldiers experienced and described the inconsistent caloric intake and often poorly prepared meals they had to family members and friends back home.

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273 Keene, World War I, 152.
Yet in the AEF soldiers often had far more to worry about than food. The First World War devastated bodies and minds. And newer technologies of killing such as long-range artillery and gas sent roughly 200,000 American soldiers home with amputations, respiratory problems, and other disabilities.²⁷⁵ Policymakers tried to avoid paying the large veterans’ pensions that followed the American Civil War, and instead looked to rehabilitation and insurance payments to produce self-sufficient men.²⁷⁶ Progressive Era reformers shaped rehabilitation, a program that aimed to medically heal the individual as much as possible before discharge, and to provide industrial or agricultural training so as to avoid having the wounded man become a public charge.²⁷⁷ General Hospitals therefore served as sites of social and economic engineering, as well as healing atmospheres.

Much of the literature on food and the Great War does not extend to the postwar experiences of hospitals and disabled veterans.²⁷⁸ In American hospitals, food production was a tool of rehabilitation that was promoted as a way to help heal the wounded. It joined many other vocational programs such as business, telegraphy, education, and massage.²⁷⁹ Agriculture was a popular venture in US Army hospitals. One broader, practical reason for this was a fear of underproduction after the war. Another reason to promote agriculture was a fear that city life could be detrimental to the morality of men returning from war. With the ease of travel, “a man with a taste for the pleasures which town life affords is easily able to gratify it by occasional evening excursions.” Veterans in the countryside, however, would instead be frugal, industrious,

²⁷⁹ “What About the Farm?” Carry On: A Magazine on the Reconstruction of Disabled Soldiers and Sailors 1, no. 6 (March 1919), 23.
and honest. And with the ownership of a farm, “comes stability of character.” Finally, officials argued that the relatively slow-paced nature of the work, and its predominantly outdoor labor were therapeutic for most wounds because of the fresh air. This was in contrast to the hectic cities and factories that might disrupt the physical health of sick veterans. These were just some of the reasons federal and state governments emphasized farming.

Secretary of the Interior Franklin Lane orchestrated a failed American attempt to resettle veterans on the land. In his appeal to President Woodrow Wilson in May 1918, Lane argued that, due to the active nature of army life, veterans might seek outdoor vocations like farming. Lane tried to organize a program to reclaim over 200,000 acres of “undeveloped land” in the Midwest, Northwest, and South that, without federal intervention, would remain an un-fertile “No Man’s Land” because of swamps and an overgrowth of trees. The land in the charted areas, according to Lane, could be made into planned farming communities that the veterans themselves would construct and purchase under generous federal financing. In the lands near the Everglades in Florida, and in places like Idaho, veterans could expect comfortable homes where, “you and your girl can move at once and start housekeeping.” It was clear that one of the unacknowledged goals of land settlement was also to promote heteronormative gender roles.

Lane and his supporters optimistically looked to European communities as models for veteran farms. France’s rural farming communities served as just one example to follow.

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284 “Memorandum for Mr. Tiller,” December 6, 1918, RG 165, Series NM-84, Box 2, Folder: Advertisements, US National Archives.
According to Lane, many of the communities there provided all the necessities of life so individuals would not need to go to the city.\textsuperscript{285} But Lane also pointed to existing agricultural training for veterans in Europe. Germany organized training schools for veterans early in the war.\textsuperscript{286} And on the outskirts of Vienna, veterans organized a relatively self sustained “Cripples’ Town” that included land for farming.\textsuperscript{287} Yet, despite the widespread publicity about land resettlement, Secretary Lane overestimated American veterans’ willingness as a group to live on the land, the ability of the federal government to undertake the large project, and the pushback from prosperous farming communities in other states such as New York that might suffer because of competition from thousands of new, veteran-owned farms.\textsuperscript{288}

While state efforts to reclaim land and resettle veterans may not have been wholly successful, the initial publicity surrounding it accompanied comprehensive agricultural training programs in hospitals. One of the largest of them was at Fort Des Moines in Iowa, where professional agricultural specialists taught courses in farming, science-related fields, tractor mechanics, chicken raising, and many other topics crucial to beginning a career. There, the Red Cross furnished two tractors for the hospital, the American Poultry Association gave four hundred chickens, and Iowa State’s Agricultural College provided plans for carpentry students to build poultry houses.\textsuperscript{289}

Agricultural programs at places such as Fort Des Moines, Walter Reed, and Fort McHenry were not solely for vocational training purposes, however. While the administrators

\textsuperscript{285} “When the Boys Come Marching Home,” 138.
\textsuperscript{286} Gutsinspektor Hoyer, “War Cripples at the Agricultural Training Institution, Gross-Tarpen, near Graudenz, Germany,” American Journal of Care for Cripples 5, no. 1 (September 1917): 175-176.
\textsuperscript{287} “War Cripples in Austria and Germany,” American Journal of Care for Cripples 4, no. 2 (June 1917): 244-250.
\textsuperscript{289} “A Brief Historical Sketch of Physical Reconstruction Work at U.S. General Hospital #26, Fort Des Moines, IA,” RG 112, Series NM 31 (K), Box 266, Folder 353.91-1: General Hospital #26 (K) 1918, US National Archives.
purchased some food from the nearby towns and cities for hospital consumption, the food
patients grew on site was often used for the hospital mess, and contributed to broader wartime
conservation efforts. Tuberculosis patients at the hospital in New Haven, Connecticut, for
example, grew a garden. Walter Reed had a vibrant greenhouse. And patients at Lakewood, New
Jersey grew food for the hospital while they took in the fresh air that physicians argued was
beneficial for their health.\(^{290}\)

Military and rehabilitation officials, therefore, positioned growing food as beneficial not
just for the institutions and wartime food conservation, but also for healing. The products of
reconstructive vocational healing sometimes ended up in the mess kitchens to feed the men in
another component of the journey to recovery: eating. It was in the hospital mess areas where

\(^{290}\)“What About the Farm?,” pp. 22-23; T.B. Kidner, “Guiding the Disabled to a New Job,” *Carry On: A Magazine on the Reconstruction of Disabled Soldiers and Sailors* 1, no. 3 (September 1918), 21.

\(^{291}\)OHA 355, WRAMC Historical Collection, Series 003: Photographs and Slides, Box 014, Folder: Photos – WWI – Patients, Otis Historical Archives, National Museum of Health and Medicine.
food was an important site through which wounded and sick soldier-patients tried to control their relationships with the American state and the US Army. Patients, in many cases, challenged officials for better quality gustatory experiences as central components of healing.

_Sensory Problems and Curative Environments_

In October 1918, an anonymous letter arrived for authorities at US Army General Hospital No. 9 at Lakewood, New Jersey accusing staff of serving poor quality meals. An investigation found that the soldiers complained that the meat and fish were tainted by inadequate refrigeration, and the bakery and kitchen were both dirty. A planned inspection that same month found the food was of “excellent” quality and the meal, made special for the inspector, was prepared well. Upon further questioning, the patients maintained that the food was often served cold, likely because the men were not allowed to help themselves. Instead the staff served the food by placing the meals on plates to be carried out in batches into the mess halls, which was more time consuming. The mess officer argued that there were simply not enough serving dishes to do that.292 The soldier-patients who voiced concern about food held the state to a certain standard in their postwar recovery. Food and taste were not just a means of caloric intake. They also symbolized the level of care and concern the state gave to men returning from war.293

Lakewood was not alone in fielding complaints about food. Patients at other hospitals, including Fort McPherson, Cape May, and Evergreen in Baltimore, all encountered inadequate dietary provisions. In August 1919, US Army Medical Corps staff at Fort McHenry addressed

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292 Director of Military Intelligence to the Surgeon General, “Bad Food for Wounded Soldiers, Genl. Hospital No. 9, Lakewood, N.J.” October 15, 1918, RG 112, Series NM 31 (K), Box 218, Folder 720.1-General Hospital #9, Lakewood, N.J. (K); Colonel D.C. Howard, “Memorandum for Secretary of War,” November 2, 1918, RG 112, Series NM 31 (K), Box 218, Folder 720.1-General Hospital #9, Lakewood, N.J. (K), US National Archives.

293 Duffett, _The Stomach for Fighting_, xi-2.
the situation there, as complaints about the mess arrived “in considerable numbers.” The medical officer took a decidedly defensive stance, and assured those concerned that the patients were fed well, and that most men were simply “appealing to public sympathy.”294 The broader patient-staff-familial interactions reveal how each group viewed the role of the state in the healing process. At the same time, soldier-patients navigated a rehabilitative system built on the assumption that disabilities, wounds, and illnesses could, and would be, cured. In many cases, this idea collided with the reality of war disabilities that continued long after the war ended.295 The lack of adequate and healthful food also called into question the military’s commitment to the soldier-patient’s rehabilitation.

Fort McHenry’s officer personnel remained skeptical after receiving notice of patient discontent. Though it was not just the soldiers who voiced concern. The overall cleanliness of the hospital came under acute scrutiny from inspectors and soldiers’ family members who visited as well. E. Francis Briggs, a then recently discharged Reconstruction Aide, called attention to conditions at Fort McHenry in a letter directed to the Surgeon General. She claimed to have seen staff sweeping wards while physicians dressed wounds nearby without gloves or gowns. She also asserted that patients had to wear dirty uniforms while recovering.296 Hospital staff vehemently disagreed with the charges against their conduct.297

Despite administrative disagreements about one portion of the hospital, however, soldier-patients there made clear that conditions were far from satisfactory. And administrators at least took the complaints seriously enough to investigate them. A patient there found the “frankfurters” he was served “were a trifle old – the coffee was weak and the string beans we had looked as though they were cooked in curdled milk.” He and his fellow patients joked about the milk. He wrote, “They say that the way the milk is made is to take a pitcher of water and put a dime in the bottom. Then they pour milk into the water. As soon as the dime can’t be seen it is called milk.”

Upon subsequent inspections, the mess officer explained that the condensed milk did consist of equal parts water and milk, however, until the hospital switched to fresh milk shortly after the soldier’s complaint.

The bad-tasting milk was not out of the ordinary for the time. The Army could have used condensed milk in hospitals for a variety of reasons. Around the turn of the century there were significant fears about the beverage, as it often carried diseases such as typhoid and diphtheria. As cities grew, and as milk production stretched further from urban environments, the time it took for milk to travel from farm to customer increased. And transport services often lacked adequate temperature control to keep it cold. Army hospitals also frequently struggled to maintain working iceboxes, which made storing milk a challenge as well.

The hospital at Jefferson Barracks, Missouri gives evidence of some difficulties the Army had in securing safe milk, even without obtaining it from relatively distant sources. Jefferson Barracks had a modern dairy plant on site, with well-constructed stables and a cooling system for the milk. The hospital kept a herd of over 40 cattle, and maintained a dairy to supply milk to the

298 Representative Julius Kahn to General Ireland, July 31, 1919, RG 112, Series NM 31 (K), Box 184, Folder 330.14-1: U.S.A. Gen. Hosp. #2, US National Archives.
men there until around 1923, when the post veterinarian found almost all of the cattle had tuberculosis. The dairy had to get rid of the herd so as not to spread tuberculosis to the sick and wounded there. Condensed milk was, therefore, a safer alternative, especially considering one of the goals of rehabilitation was to cure illness or disability, not spread them further.

Bad tasting milk was just one of many problems soldiers encountered in rehabilitation hospitals. The Army sent Sergeant Isaac Anderson to General Hospital No. 11 in Cape May, New Jersey after his diagnosis of rheumatism while in France in the summer of 1918. He was unhappy with his experience in the New Jersey hospital. He claimed that he was detained longer than necessary in the Army so as not to receive his War Risk Insurance payments. He also argued that his condition had not improved, that sanitary conditions there were “far from satisfactory,” and that he was half fed at times with tainted meat. The Inspector General’s August 1918 investigation into Anderson’s claims is revealing. They found that sanitary conditions were far from satisfactory. The plumbing was old and, on account of leakage, “pools of water stand on the floor in many places.” The leaky and unsanitary ice boxes contributed to the puddles of water that collected on the floors. And their poor functionality meant that any food being kept in them went bad.

Cape May’s administration was partially to blame for Anderson’s experiences there. Colonel Brechemin, who was in charge of the hospital, failed to exercise supervision over the mess, and officers there did not make regular inspections of the meals or the stored meat. In addition to poor administrative standards, the kitchen lacked sufficient numbers of experienced cooks. The inspector concluded that the hospital building was “entirely unsuited for a General

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In preparing for wounded and sick patients, the US Army relied on the promise of curing disability or illness quickly, which made mediocre structures not designed for hospital use a viable option. Anderson’s complaints about being kept too long in the hospital, where he was fed tainted meat, was one of few avenues by which he could attempt to assert control over his healing experience. In this case, making good also included critiquing care.

Cape May was not isolated in its haphazard handling of food, as US Army sanitary reports suggest. And evidence shows that the problems spanned from unappetizing to rotten ingredients. The hospital at Camp Dix, New Jersey served food that was coarse and unappetizing, with “almost universal complaints from patients.” While meals that arrived to ward patients at Fort McHenry were typically insufficient or in some cases burnt. The hospital at Lakewood was the subject of patient complaints about tainted fish, where ice boxes and cooking equipment were “dilapidated and in need of replacement.” General Hospital No. 1 in New York City, a large facility that cared for a number of neuro-psychiatric patients, served tainted hamburger meat. And inspectors found the butter at Otisville, New York’s hospital for tuberculosis patients “rancid and unfit for serving.” The inadequate food that was often traced to outdated equipment and poor supervision over preparation, sheds light on more entrenched issues that made poor gustatory experiences a regular reality for soldier-patients.


304 Duffett, Food for Fighting, 233.


307 Director of Military Intelligence to the Surgeon General, “Bad Food for Wounded Soldiers” October 15, 1918; Colonel D.C. Howard, “Memorandum for Secretary of War,” November 2, 1918, RG 112, Series NM 31 (K), Box 218, Folder 720.1: General Hospital #9, US National Archives.

Greasy Forks, Squeaky Carts, and the Experience of Ingestion

One reason for the soldiers’ inadequate gustatory experiences was the meager use of trained dietitians or other qualified personnel in hospitals. Despite the military’s use of dietitians before 1917, it was not until their service overseas in the First World War that the state fully recognized their efficiency in nutritional science. The American Red Cross recruited dietitians, predominantly women, as civilian employees of the US Army Medical Department, where they served domestically and with the AEF in France. The Red Cross had trained women as dietetics through a series of courses such as “Home Care of the Sick” and “Dietetics and Household Economy.” During the war, the organization identified that, to qualify for military duty, women must have had two years of training in home economics at the college level, four months of work experience, and an endorsement from their school. These women strived to improve the nutritional health of the nation and its soldiers and veterans.309

The military employed dietitians at Lakewood and other hospitals to address special diets. However, they “played a rather minor role” and were there usually to supervise the preparation of food rather than plan meals. The mess officer there fared little better, having “little technical competence” in dietary science in comparison to his dietitian counterparts.310 Women dietitians often found themselves with a wealth of expertise, but in an anomalous position, without adequate authority to do their job effectively.311 This was not new to Army hospitals. Among the over 80 women who served overseas as dietitians, many recalled not being utilized property. Anne Upham, for example, served in a British hospital where she was assigned to

310 Major R.G. Hoskins to the Surgeon General, “Nutritional conditions in U.S. Army General Hospital #9, Lakewood, N.J.” October 3, 1918, RG 112, Series NM 31 (K), Box 218, Folder 720.1-General Hospital #9, Lakewood, N.J. (K), US National Archives.
housekeeping work, and had to prove her value in planning meals. Other dietitians had fewer obstacles. Caroline King took comfort that her food planning generated “bright faces of a whole ward full of desperately wounded boys.”\textsuperscript{312} Despite the numerically smaller successes of women who served overseas, dietitians on the whole struggled to prove their expertise to the Army brass.

Reports from military hospitals across the country reflect this fact. Otisville’s hospital, for example, served heavy diets to sick soldiers, due in part to the mess officer writing the menu rather than the dietitian.\textsuperscript{313} Hospitals at Fort McHenry and in Boston both requested more dietitians for their staff.\textsuperscript{314} In September 1919, the inspector at the Army hospital in Oteen, North Carolina reported the need for more dietitians, and that the those already there were being paid half of what less qualified civilian cooks were paid in the same location.\textsuperscript{315} Hospitals therefore relied heavily on civilian cooks. At Lakewood, 14 cooks who “lacked practical experience in cookery” struggled to feed a population of over 1,000 soldiers.\textsuperscript{316}

\textsuperscript{312} Hodges, “Military Dietetics in Europe during World War I,” 899.
\textsuperscript{313} Major W.S. Shields, “Extracts from Reports of Sanitary Inspectors Made during the World War, Volume I,” p. 84, RG 112, Series NM20-29A, Box 408, US National Archives.
\textsuperscript{314} Major W.S. Shields, “Extracts from Reports of Sanitary Inspectors Made during the World War, Volume I,” p. 84, RG 112, Series NM20-29A, Box 408, US National Archives.
\textsuperscript{315} Shields, “Quotations from Reports of Sanitary Inspections,” p. 27.
\textsuperscript{316} Major R.G. Hoskins to the Surgeon General, “Nutritional conditions in U.S. Army General Hospital #9, Lakewood, N.J.” October 3, 1918, RG 112, Series NM 31 (K), Box 218, Folder 720.1: General Hospital #9, US National Archives.
While dietitians at Oteen coped with inadequate pay and subordinate positions, those at Fort Bayard had to use the same kitchen as regular cooks, rather than working in the special diet kitchen that many hospitals had. The lack of resources reduced their efficiency in cooking for soldiers who needed light diets of fresh fruits and vegetables and lean meat for particular illnesses.\footnote{318} In Carlisle, Pennsylvania many bedridden patients received a full diet that was too heavy in fatty foods because the diet kitchen was not sufficient to the hospital’s needs.\footnote{319} Other patients felt that they were not getting enough food. For example, one soldier at the hospital for blinded veterans in Baltimore, wrote about the connection between food and morale, and argued that the hospital provided too much starch and not enough “blood making” and “energy producing” foods such as vegetables, fruit, and meat.\footnote{320} Patient experiences with inadequate meals were widespread, as was vocal patient dissatisfaction.

\footnote{317} OHA 355, WRAMC Historical Collection, Series 003: Photographs and Slides, Box 014, Folder: World War I People & Activities, Otis Historical Archives, National Museum of Health and Medicine. \\
\footnote{318} Shields, “Quotations from Reports of Sanitary Inspections,” p. 5. \\
\footnote{319} Shields, “Extracts from Reports of Sanitary Inspectors,” p. 151. \\
\footnote{320} Jesse A. Whaley to the Surgeon General, April 29, 1919, RG 112, Series NM 31 (K), Box 206, Folder 331.4: U.S.A. Gen. Hosp. #7, Baltimore, Md. (K), US National Archives.
Despite numerous instances of inadequate use of dietitians, poor diet preparations were not universal. Camp Sherman, for example, used a dietitian gastroenterologist to prepare menus, and the hospital at Lakewood tried to replicate the model. At Lakewood, patients had an extensive menu. For a normal breakfast, a patient could expect bacon, sautéed potatoes, peaches, bread, butter, and coffee. A patient on a light diet ate oatmeal, eggs, toast, butter, and coffee.\textsuperscript{321} Far from “light,” the diet menu at Lakewood could still prove too heavy for a sick patient.

Another hospital with a good record in hiring and using dietitians was the Base Hospital at Camp Wheeler, Georgia. There, the hospital employed a mess officer, a senior dietitian, and six assistant dietitians.\textsuperscript{322} However, Camp Wheeler and Camp Sherman were outliers, as most military hospitals kept women dietitians largely subservient to far less qualified male civilian cooks.

Another reason for the poor taste and quality of food in rehabilitation hospitals was the lack of sufficient equipment. In the mess halls, soldier-patients either stood in line for service or had food delivered to their tables, using dishware that was often chipped and usually poorly washed. Many hospital kitchens hand-washed plates and silverware, and because of the small number of workers in the kitchen, tableware was not always properly cleaned. Inspectors regularly found knives, forks, and plates “greasy” or “unsightly.”\textsuperscript{323} Clean utensils were particularly important so as not to transfer pathogens to other patients, as one officer stated in the midst of the 1918 influenza pandemic.\textsuperscript{324} If it was not the plates and utensils that contaminated the patients’ gustatory experiences, it was the dirty tables they ate on, as was the case in Fort

\textsuperscript{321}“Officers Mess”; “Light Diets”; “Enlisted Men Mess,” October 15, 1918, RG 112, Series NM 31 (K), Box 218, Folder 720.1-General Hospital #9, Lakewood, N.J. (K), US National Archives.
\textsuperscript{322}Shields, “Quotations from Reports of Sanitary Inspections,” p. 79.
\textsuperscript{323}Shields, “Extracts from Reports of Sanitary Inspectors,” pp. 86 and 150.
McHenry and Colonia, New Jersey.\textsuperscript{325} The eating environment was important, as historian Rachel Duffett argues about the British Expeditionary Forces, because in the face of so much disorder in war “decent table manners and clean cutlery assumed an even greater importance.”\textsuperscript{326}

Organizing the arrival of patients and serving techniques proved an issue as well. Some hospitals had regulations that prohibited patients from going to mess halls until they were summoned, and forbid “lounging in the hall-ways or porches before meals.”\textsuperscript{327} In the mess halls, the Medical Department tried to control the aural atmosphere, and argued, “Loud talking, rattling of dishes, and banging of chairs are disturbing to the sick.”\textsuperscript{328} Staff members, however, had trouble when they tried to uphold the rules, specifically about patient lines for food, which caused long wait times and confusion. At the General Hospital in Richmond, Virginia, for example, the lack of coherent system for dispatching patients to the mess halls “resulted in a staggering to breakfast and a large number of patients… waiting in line outside of the mess hall for a chance to get inside for breakfast.” Many of them were dressed only in their pajamas on that cold morning.\textsuperscript{329} Fort McHenry had a similar problem, which led to men in crutches allegedly forced to stand in lines for close to an hour.\textsuperscript{330} Some problems, therefore, came not from the taste of the food, but instead from the mechanisms of serving.

Not all patients could travel to the mess halls, as many were too ill or wounded, and instead ate in the wards. Ward service was often as haphazard as mess hall service. While many hospital kitchens had food carts for transport, they often did not work properly or did not travel

\textsuperscript{325} Shields, “Extracts from Reports of Sanitary Inspectors,” pp. 267-8.
\textsuperscript{326} Duffett, \textit{The Stomach for Fighting}, 18.
\textsuperscript{327} Colonal Edger, “Memorandum #9: Regulations Governing Patients in Hospital,” January 23, 1919, RG 112, Series UD-8, Box 1159, Folder: Hospital Regulations, US National Archives.
\textsuperscript{328} “Regulations for the Mess,” January 26, 1918, RG 112, Series NM 31 (K), Box 300, Folder 300.9-1: Gen. Hospital #40 (K), US National Archives.
\textsuperscript{329} Shields, “Quotations from Reports of Sanitary Inspectors,” p. 78.
\textsuperscript{330} Thomas Bell to Representative Julius Kahn, July 30, 1919, RG 112, Series NM 31 (K), Box 184, Folder 330.14-1: U.S.A. Gen. Hosp. #2, US National Archives.
well. The Biltmore, North Carolina hospital was the exception. The repurposed resort hotel had electric heated carts that worked well. By contrast, Fort Ontario used 14 large carts but they were too heavy to travel far. And Fort McPherson’s carts quickly became unserviceable through regular use.\textsuperscript{331} Sometimes the carts had less to do with efficiency and more to do with hospital layout. At the hospital in Richmond, the carts could not withstand the irregular graveled walkways from the kitchen to the wards.\textsuperscript{332} As a result the food regularly arrived cold. Patients in the wards in Fort McHenry, for example, ate their food cold and, because of a lack of plate ware and tables, “the trays were placed on the floor instead of on tables and the food served from the floor.”\textsuperscript{333}

![Patients at mess – Camp Purnell, Maryland. Courtesy of the US National Archives.\textsuperscript{334}](image)

\textsuperscript{332} Shields, “Quotations from Reports of Sanitary Inspectors,” p. 78.
\textsuperscript{333} Shields, “Extracts from Reports of Sanitary Inspectors,” p. 150.
\textsuperscript{334} “Patients at Mess – Camp Purnell,” RG 112, Series 31 (K), Box 185, US National Archives.
The problems of food provision were sometimes the result of medico-administrative practices of separation and isolation. Patients with neuro-psychiatric wounds at Plattsburgh, New York, for example, felt that the government regarded them as “useless junk,” complained of being improperly fed, and cited that the officers had an arrogant attitude toward them. A group of convalescent men from Plattsburgh transferred to a hospital in Wilkes Barre, Pennsylvania and did not receive any food for their long trip. They were only fed after Red Cross personnel heard their complaints on a stop in Albany, New York. Soldier-patients with sexually transmitted diseases such as syphilis or gonorrhea were particularly vulnerable to moral assumptions that permeated into food service. At Fort McHenry, hospital staff often resented

335 OHA 355, WRAMC Historical Collection, Series 003: Photographs and Slides, Box 014, Folder: Photos – WWI Patients, Otis Historical Archives, National Museum of Health and Medicine.
336 “Transfers of Our Wounded Soldiers” RG 112, Series UD 8, Box 1107, Folder 201.23: Complaints, US National Archives; Assistant and Chief Clerk of the Medical Detachment to the Secretary of War, April 18, 1919, RG 112, Series UD 8, Box 1107, Folder 201.23: Complaints, US National Archives.
337 Asher Miner to Chief of Staff of the Army, “Transfer of wounded troops,” September 26, 1919, RG 112, Series UD 8, Box 1107, Folder 201.23: Complaints, US National Archives.
patients in the Genito-Urinary ward, and staff regularly fed them separately from the general population, which mirrored other exclusionary practices there.\(^{338}\)

Racial exclusionary policies determined how veterans ate as well. The US Army had segregated most African Americans primarily into subservient labor roles during the war.\(^{339}\) African Americans did serve under French command in combat roles and experienced some hospitality. But despite the geographical separation from the American South, “Jim Crow sailed to Europe” with the US Army, and Army leadership and white soldier perpetuated regular hostility toward black soldiers.\(^{340}\) When black soldier-patients returned to American hospitals, they experienced inequitable treatment as well. Official policy held that black and white patients would be treated in the same wards, though the policies were vague enough to be misinterpreted, and discrimination still remained.\(^{341}\) For example, officials did not always forward all necessary medical evidence, leaving black servicemen’s claims for compensation incomplete.\(^{342}\) Many black patients’ medical ailments were either doubted or racialized. For example, Bureau physicians argued that tuberculosis was more natural in “the colored race as a whole,” ignoring other factors such as housing conditions or lack of medical care.\(^{343}\) And officials in charge of vocational training often pushed black patients toward agricultural education.\(^{344}\)

\(^{338}\) Commanding Officer to the Surgeon General, “Status under G.O. 31,” October 27, 1919, RG 112, Series NM 31 (K), Box 184, Folder 250-1: General Hospital #2 (K), US National Archives.
\(^{341}\) Adler, Burdens of War, 62; Kinder, Paying with Their Bodies, 134.
\(^{344}\) Lawrie, “Salvaging the Negro,” 332.
Black patients, therefore, experienced widespread inequities even before sitting down to the table to eat. While not in different rooms, black patients typically ate at segregated tables. And deviating from the status quo created issues among patients. A group of white patients at Fort McPherson, Georgia, for example, wrote a letter to the hospital in 1920. Among their complaints of poor food and medical treatment, they also argued they should not have to “eat in the mess hall with negroes.” Historian Adriane Lentz-Smith argues, “though the South lay claim to it, Jim Crow had long since outgrown the… Confederacy,” and black patients in northern hospitals faced similar restrictions. A complaint at Lakewood, New Jersey led to an investigation and statement from the Surgeon General that advised against discrimination in food service. The hospital argued that while there was no discrimination in policy or service, “the colored patients… eat at tables especially reserved for them.” The particularities of race and

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345 Negative No. 41503, Occupational Therapy: Farming, OHA 80, Reeve Collection, Otis Historical Archives, National Museum of Health and Medicine.
347 Lentz-Smith, Freedom Struggles, 113.
disability could, and did, dictate the relative power of patients in their gustatory and broader food experiences.

US Army rehabilitation hospitals therefore inadequately prepared and administered food production for sick and disabled soldier-patients. Medical officers underutilized and underpaid dietitians in the organization and cooking of meals. And there was a general lack of equipment, from forks and knives to tables, trays, and food carts. Civilian cooks, who were also lacking in numbers, served cold and unappetizing food on often greasy or dirty plates to patients who waited in long lines. The realities evident in the sanitary reports lend legitimacy to patients’ complaints about the indignities related to the assaults on their sense of taste, and confirm that the patients responded by seeking to push back against the bureaucratic administration that the state deployed to care for them.

“A Nuisance to the Country”: Patients and Alcohol Consumption

In the aftermath of the war, soldier-patients voiced criticism about the food they tasted and ingested, and the atmospheres within which they ate. The critiques challenged ideas about how the state should have responded to, and adjusted, hospital policies. But the veterans also asserted their own authority over their healing experiences, rather than leaving care management completely to the US Army. In similar ways, soldiers and soldier-patients challenged Army regulations about alcohol consumption. In particular, patients and personnel sought ways to obtain and consume alcohol while biding their time in rehabilitation, or while stationed at hospitals. Army officials and civilians exercised control over the men during a period of heightened temperance activism. And debates about alcohol that played out in wider society
contributed to contentious conversations about the morality of alcohol-indulging patients in particular.

The US Army Morale Department was the primary means of regulating alcohol consumption in and around General Hospitals. The Morale Department spearheaded efforts to appeal to manhood through social and cultural programs such as hospital newspapers, sporting events, and dances. The ultimate goal was to shape the social lives of men along normative masculine lines that included, similar to other avenues of rehabilitation, sexual and economic standards. For example, while General Hospital No. 7 worked with the Red Cross to organize dances between blinded men and the women of Baltimore, officials there were also concerned with a variety of issues that related to drunk and disorderly veterans. Through their regulations, the US Army marked alcoholic beverages as immoral when consumed and made more of an effort to direct gustatory expectations than they did through typical daily food and drink consumption. The state’s priorities were primarily cultural rather than caloric.

Guarding against vice was not new to the military, but was an important concern from the induction of the first soldiers into the Army. President Woodrow Wilson’s administration created a federal agency in 1917 called the Commission on Training Camp Activities (CTCA) with the express goal of curtailing vice at military training camps. To shape the social lives of recruits stationed near large cities, the CTCA organized camp activities that attempted to dissuade soldiers from engaging in a variety of illicit activities that included alcohol consumption and sexual encounters with prostitutes. The state’s efforts to remake the American soldier according to middle-class moral standards of individual restraint and Protestant work ethic proved to be a

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training ground for similar efforts in the rehabilitation of sick and disabled veterans after the war.\textsuperscript{350}

The early CTCA and postwar efforts in hospitals reflect broader cultural negotiations about the illicitness of alcohol in late-nineteenth and early-twentieth-century America. Nineteenth-century temperance activism was intimately connected to evangelism and characterized saloons as dens of sin and moral threats. And the emergence of the Women’s Christian Temperance Union served as an organizational mechanism for advancing women’s politics.\textsuperscript{351} Despite the wide, cross-class, and interracial culture of alcohol consumption, which included women, the temperance movement and wider society disseminated imagery that positioned drunken men as failing in their roles as male heads of families.\textsuperscript{352} Drinking was, therefore, both a socially entrenched activity, and a divisive political issue by the time the Army extended the CTCA efforts to postwar hospitals.

By the end of the war, authorities reported on the vice that surrounded the proposed sites of rehabilitation hospitals. In Fort McPherson in Atlanta, Georgia, one investigator reported that vice conditions in hotels and lodging houses were bad, that liquor was sold freely to soldiers, and that “the hotels are still infested with prostitutes” where “the bell boys demand $1.00 for each engagement they make for the women.” To have a well functioning military hospital nearby, vice conditions needed to improve. But morality officers there looked to the future with hope, as a


change in local police administration seemed likely to promote a crackdown on vice conditions throughout the city more generally.\footnote{Alan Johnstone, Jr., “Report on Atlanta, GA.” November 1917, RG 112, Series UD-8, Box 902, Folder: Morals and Conduct, US National Archives.}

Other hospitals noted conditions in nearby towns and cities as well. Officials at US Army General Hospital No. 3 at Colonia, New Jersey recognized toward the end of 1918 that there was no prohibition in the neighboring towns, which lead to “several cases of drunkenness.” Officials also argued that the relative lack of strict disciplinary standards among the patients, compared to what they experienced in France, might have contributed to the debauchery.\footnote{Commanding Officer of General Hospital No. 3 to the Surgeon General, November 30, 1918, RG 112, Series UD-8, Box 859, Folder: Historical Data, US National Archives.} Alcohol investigations demonstrated the extent to which hospitals were not isolated from the cities closest to them, or the broader social currents that perpetuated temperance reform. Yet, despite factors external to hospital administration, it fell to military authorities to police morality and morals among the returning soldier-patients within the walls of their facilities.

One hospital administrative memorandum in St. Louis, Missouri, provided a brief outline for alcohol policy, and mirrored the efforts of the CTCA. “Everyone knows the value of the reputation of a man who does not drink,” and only men of “Excellent” sobriety could hold positions of great responsibility. But, according to the memo, alcohol consumption had a detrimental effect on one’s morals and led to a weak mind. “It is then that evil associates are found and habits are formed that mark a lowering of the moral standard.” The alcohol-affected man then sought “bad women” and became a “drunken slob” and an “annoying pest.” But it was not just the individual who suffered from intoxication. For “when a soldier is drunk in public, those who see him charge his disgrace to the entire class of soldiers. For this reason it is the military duty, as well as the personal responsibility, of every soldier to do all in his power to save
his comrades from the dangers of strong drink.”³⁵⁵ The Army rehabilitation apparatus made restricting alcohol an individual as well as an organizational imperative. Alcohol regulations were unsurprising, given the prevalence of the issue throughout military history, but the tone adopted significantly from the temperance debates of the war years.

Fortified by the social and cultural imperatives of anti-vice campaigns, hospitals enacted pre-emptive policies to keep men in line with what they considered the proper ideals of socialization, which largely borrowed from Progressive Era moral imperatives. Among the well-known activities administrators allowed were dances, athletics, reading, and industrial vocational training. Free time, as well as scheduled activities, was under administrative scrutiny. At US Army General Hospital No. 7, for example, blinded patients were allowed passes each evening from 6:30 until 10:30, “and for three evenings a week for absence not later than midnight.” Those who were completely blind at the hospital were to be accompanied by a hospital attendant to visit the city, a gesture that stemmed more from medical necessity than to social control.³⁵⁶

While the Army endeavored to shape the surrounding areas, hospital staff sought hospital policies more directly related to alcohol consumption. The institution at Lakewood, New Jersey contemplated a “half mile zone” surrounding the hospital where no liquor could be sold.³⁵⁷ But as hospitals took efforts to instill discipline among veterans, and establish strict policies of movement and sales, patients found ways around restrictions in order to shape post-war recovery.

³⁵⁵ “Alcoholics and Drug Habits,” January 23, 1919, RG 112, Series NM 31 (K), Box 300, Folder 300.9-1: Gen. Hospital #40 (K), US National Archives.
in their own ways. Patients and detachment men purchased liquor from nearby towns, drank bottles of “Eau De Quinine Pinaud” hair tonic, and men secured homemade “peach brew.”

Patient and detachment drinking often provoked disruptions in nearby towns. In February 1919 police near the hospital in Colonia, New Jersey intercepted two patients when they demanded liquor from a bartender in Newark. When refused, they threatened to “clean up the place.” The following month near the same hospital two privates were arrested at the Pennsylvania Railroad Station and charged with “being drunk and disorderly, resisting arrest, and attempting to incite a riot.” A multitude of reports reflect similar instances that chronicled soldier-patients and medical staff who attempted to resist the social pressures of temperance as well as the Army establishment, which aimed to maintain military regulations while it demobilized hundreds of thousands of soldiers who were eager to exhibit their freedom to ingest as they pleased.

The hospitals in Baltimore saw their share of disturbances as well. On May 22, 1920 a group of soldiers from the Medical Department at Fort McHenry got into an altercation with civilians that resulted in a soldier firing several shots from a pistol over the heads of a nearby crowd. The reports of misconduct among veterans and soldiers at US Army General Hospitals through 1920 reveal that returning soldiers and patients did not easily fit into the rehabilitation ideals of the moral veteran. Instead, in many cases, they attempted to live their postwar lives in

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359 Commanding Officer of the Provost Guard to Commanding Officer of General Hospital No. 3, February 27, 1919, RG 112, Series UD-8, Box 862, Folder: Military Prisoners, US National Archives.
the ways they wanted and expressed their desire for alcohol despite regulations. The most interesting examples of this type of defiance are the instances of disorder at Evergreen hospital for blinded veterans.

In February 1919 Sir Arthur Pearson, founder of St. Dunstan’s Hostel for British veterans blinded in the war, sent a letter to US Secretary of War Newton Baker. In the letter, Pearson urged Baker to de-militarize the Baltimore hospital. Pearson was a leading advocate for blinded veterans and was intimately connected to the proliferation of specialized training centers in many other countries, including the United States. Pearson’s suggested de-militarization and discharge for the blinded soldier-patients because they should not feel compelled to undergo training. Instead, he argued, they should feel “that they are free and normal citizens who are being given the opportunity of working out their own salvation along independent lines.” Military authorities worried about a lack of morale, morality, and discipline if hospitals did not adhere to military standards. Yet Pearson reasoned that if the British case could predict American success in de-militarizing their hospitals, there would be few problems. After all, there were only 21 “habitual drunkards” out of the 1,400 blinded veterans at St. Dunstan’s in Great Britain.362

Pearson’s appeal for de-militarized hospitals in the beginning of 1919 was an extension of his other attempts to make disabled veterans as independent from the state and public assistance as possible. Yet, it was not until April 1919 that the federal government relinquished responsibility of General Hospital No. 7, discharged the soldier-patients, and placed the institution under the jurisdiction of the American Red Cross. But from the time of Pearson’s letter in February through the spring, when the change from military to Red Cross control

occurred, the veterans themselves showed few inclinations to demonstrate the morality that others so readily prescribed for them.

The military tracked the supply of alcohol among soldier-patients at the Baltimore hospital in the rehabilitation years. After realizing that some soldiers there had access to alcohol, one investigator found that rumors abounded in March 1919 that patients obtained liquor near the [railroad] car barn “through an intermediary, either boys or the employees of the railway company.” A patient was seen in the city of Baltimore, where he was drunk and caused a disturbance, being rushed into a car by “two well dressed ladies” before the military police could apprehend him. Despite these instances, the Medical Corps claimed that “very little trouble has been noticed from blind soldiers,” and that the Army should not conduct searches of patients unless drunkenness became more serious.  

Many patients, however, continued drinking alcohol. On the evening of April 30th, two blinded men from the hospital, intoxicated at a Baltimore bar, “had been fighting with a negro,” which led to their arrests and return to the hospital.  

Thus, when the Red Cross took over in April 1919, soldier-patients and members of the Medical Department obtained alcohol with relative ease now that a private charitable organization controlled the hospital. Alice Garrett, a wealthy Baltimore resident, owned the large estate in the neighborhood of Roland Park on which the hospital stood, lending it to the government during the war years. Garrett voiced opposition to the estate’s transfer to the Red Cross, and to the patients’ alcohol consumption. Without military enforcement, she argued, some men were being “permanently ruined” by lack of discipline there. The initial offer of her

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363 J.T. Boyd, Medical Corps to Commanding Officer of General Hospital No. 7, March 13, 1919, RG 112, Series UD-8, Box 916, Folder: Complaints, US National Archives.

364 W.B. Bradley, Quartermaster Corps to Adjutant of Evergreen, May 1, 1919, RG 112, Series UD-8, Box 916, Folder: Complaints, US National Archives.
property, she continued, was to the government, not the Red Cross. “Had my sons and I been
told when we offered our place… to the Government, that it would be given to some
organization… we would have withdrawn our offer.”

When the General Hospital demobilized and transferred to Red Cross control, the Army
discharged all blinded men who were still there as civilians in training through the Federal Board
for Vocational Education. Garrett challenged Newton Baker. She argued that guards meant little
if the men were not disciplined. “Their habits… now are such that they will be only a nuisance to
the country. Many drink… liquor on my place.” She also contested the presence of women in the
hospital, fearing, “I dare not think of what goes on at night…” The patients in residence at
Evergreen did not live up to Garrett’s moral requisites, which included not only temperance, but
also sexual restraint.

Garrett argued that Sir Arthur Pearson did not see what she did. Instead, he merely heard
positive stories told to him by the proprietors of the institute. Yet, she stopped short of blaming
the veterans themselves. Instead she argued that the veterans “have done so much for us, it is
pathetic that we do nothing for them.” For Garrett, the patients’ alcohol problem was not an
individual one, a narrative that reflected broader temperance arguments of the previous century,
which placed blame on saloons or other drinkers for influencing young men. Instead, however,
Garrett alluded to government responsibility for the lack of discipline. Garrett implicitly argued
that, had the hospitals remained under government control with military guards and stricter

365 Floyr Kramer to Mr. Fardwell, American Red Cross, November 14, 1919, RG 112, Series NM 31 (K), Box 206,
Folder 323.7-5: General Hospital #7 (K), US National Archives.
366 Mrs. Harrison Garret to Newton Baker, RG 112, Series NM 31 (K), Box 207, Folder 680.1-1 U.S.A. General
Hospital #7, Baltimore, Md. (X), US National Archives.
367 Mrs. Harrison Garret to Newton Baker, RG 112, Series NM 31 (K), Box 207, Folder 680.1-1 U.S.A. General
Hospital #7, Baltimore, Md. (X), US National Archives.
368 Parsons, Manhood Lost, 11.
standards, the men who attempted to re-integrate into civilian life would have been better taken care of, and, perhaps, would not have turned to alcohol.

These events demonstrate clearly that soldier-patients often attempted to take control over their own postwar gustatory experiences despite military regulations and the pressures of temperance reform throughout society more broadly. The state, society, and many patients had very different ideas about the meanings of individuality and manhood. State and society dictated that men overcome their disabilities through hard work and state approved social activities. But many soldier-patients contested state standards of manhood and obtained relief and exercised their independence through drink where they could. The experiences show the extent to which state and non-state actors infused the healing process with moral standards, and how ingestion became an arena to elucidate and contest those moral standards.

**Conclusion**

Examining the role of food and alcohol in rehabilitation from the perspectives of disability and sensory studies helps one understand the social history within the walls of American hospitals, as well as agency at all levels of healing. Patient experiences in sanitary reports show that many aspects of hospital cleanliness and preparation were lacking, and that not all patients had the same access to quality food. Similar to soldiers in the hectic battlefield and camp environments, patients who recovered from oftentimes-horrific war wounds had little control over their post-war world within the larger bureaucratic military structures. The sense of taste, and ingestion more broadly, therefore, were crucial sites for soldiers to self-manage their rehabilitation after the Great War.

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Part of the issue was rehabilitation itself. Policymakers envisioned a system of re-training that took in wounded soldier-patients and dispensed morally-upright, pliable industrial worker-civilians. Many military preparations aimed to construct healing environments conducive to these goals, including surveying nearby cities as part of broader vice campaigns. There was simply little room for deviation from the state’s goals of a soldier’s economic independence and social cohesion. The state gave other areas far less consideration, such as diet kitchens and food preparation. The long-term repercussions of war disabilities clashed with rehabilitation’s presumption that men could be cured quickly. Inadvertently, hospitals meant to be temporary sites of healing did not always invest in kitchen appliances and staff adequately, leading to poor quality food.

Yet exploration of the men’s attempts to control their sensory experiences, in this case taste, shows how the men returning from war did not stand passive in the face of the mechanisms of demobilization. Making good, in soldier-patients’ view, did not just include adhering to the state’s moral prescriptions, but also entailed challenging the foundations of care. Patients who complained about their taste experiences or consumed alcohol despite institutional regulations joined a broader history of veteran discontent after the war.\(^{370}\) As in pre-war training, post-war patients recorded their encounters with food. Patients commented on the poor quality and quantity of food and drink, and held the state to higher standards of care. In hospitals in particular, food was important not just for nutrition and healing, but also for maintaining high morale. Yet, some aspects of patient power were more hotly contested, as with the case of soldiers who consumed alcohol. These debates revealed the fraught negotiations between soldiers, the state, and society over the meanings of rehabilitation and disabled veteran identity.

Chapter IV: Seeing Blinded Veterans: Sight and Culture in War and Healing

The January 1919 neuro-psychiatric report the Army Medical Department conducted at US Army General Hospital No. 7 on blinded veterans of the Great War reflected an unembellished reality. The men who lost all or part of their vision were not only blind, but they often showed signs of other serious and complex wounds including traumatic neurosis, loss of limbs, and sensory problems such as deafness, and loss of smell, taste, or feeling. George Anastase, for example, suffered shrapnel wounds to both eyes at St. Quentin in September 1918, but also had a nerve injury that caused him to lose feeling in his left middle finger and scalp. Lucian Berryhill lived with “potentially permanent brain damage” after a shell explosion. And George Calvert suffered severe emotional instability and excitability. Nonetheless, redemptive news stories in newspapers and journals in the interwar years overlooked much of that reality, and, instead, provided sanitized anecdotes about their postwar lives to help civilians feel better about the human costs of war. These even included stories of Calvert’s stoicism in the face of his blindness, with no mention of his other difficulties. The immediate publicity of blinded veterans’ re-training efforts highlighted their happiness and productivity, and often the idea that one “couldn’t even tell” that the man was blind. Journals and magazines also mobilized them as motivation for other veterans to “make good.” Postwar rehabilitation narratives, therefore, obscured the comprehensive human costs of war by relying on an uncomplicated view of the blinded veteran.

371 “Brief History: Neurological Diagnosis and Prognosis in the Permanent Patients, U.S.A. General Hospital No. 7” RG 112, Series NM 31 (K), Box 206, Folder 314.7-2 (G.H. #7) K, US National Archives.
Stories that did not focus on sanitized productive veterans instead appealed to public sympathy. They highlighted parts of the postwar journey that promised to gain public attention, such as the heavy presence of blinded veterans at the Disabled American Veterans of the World War convention in El Paso, Texas in 1927. Still, some blinded veterans argued vehemently against being used for sympathetic purposes and, instead, sought a legitimate and equal chance to “make good” on their own terms. The media stories relied on the visuals of bodily whole blinded veterans and set them apart from other disabled veterans or civilians as the standard for success by evoking an emotional appeal. Few articles conveyed the real medical and social re-integration challenges many veterans faced after the war.

Publicity about blinded veterans, therefore, attended as much to public perception, or how the public saw the wounded, as it did to the goals of rehabilitating unseeing men. Stories did not reflect the harsh realities of what war did to human bodies, which may have generated public debate about the wisdom of participating in the war.\footnote{There were some conversations about preventing American involvement in the war, in particular among members of the Women’s International League for Peace and Freedom. But their ideas did not gain as much traction. See Foster, The Women and the Warriors.} Instead, they emphasized whole and uncomplicated bodies with singular wounds, as part of a broader yet subconscious management of how best to include war wounds in public remembrance and discourse.\footnote{John M. Kinder, “‘Lest We Forget’: Disabled Veterans and the Politics of War Remembrance in the United States,” in Disability Histories, eds. Susan Burch and Michael Rembis (Chicago: University of Illinois Press, 2014), 165-166.} Stories of blinded veterans, aimed at the public and other veterans, served to justify the war through sanitized imagery to show the “success” of government rehabilitation through stoic anecdotes. Public newspapers and hospital magazines also produced cheerful, overcoming, or inspiring narratives to motivate other disabled veterans, arguing that if they could do it, so could you.\footnote{Beth Linker, War’s Waste: Rehabilitation in World War I America (Chicago: The University of Chicago Press, 2011), 123.} Narratives
such as these have persisted through the aftermath of nearly every modern American war. Efforts to mobilize a positive visual culture of blinded veterans reflected the broader American justification for war and rehabilitation, using the human senses to regulate the culture of postwar disability.

*Oh Boy, That’s Sure Worth Working For!: Visual Aids in War and Rehabilitation*

Blinded veteran stories existed within a larger context of using visual aids to make war seem less problematic, and to generate medical and social recovery. The US Army used visual aids as important tools in the rehabilitation process in hospitals. Some aids took the form of entertainment, and welfare agencies staged vaudeville acts or screened motion pictures to improve morale among the wounded men. In other examples, patient art classes served as a means by which hospitals produced motivational posters to hang in the hallways, an activity that simultaneously trained men for postwar work. The visual culture of First World War American rehabilitation hospitals reflected the value systems the state injected into veterans’ lives in the healing processes. It also makes clear how important sight was to the everyday workings of hospitals for veterans more broadly.

The US Army’s regulation of wartime visuals extended at least as far back as the construction of recruitment camps. Camp observers worried that war posters that depicted German soldiers as “a super-brute of mammoth physical proportions” would be detrimental to the morale of recruits from “the more unintelligent classes.” Images such as Harry Hopps’s 1918 propaganda poster, “Destroy This Mad Brute: Enlist” was meant to instill fear into

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Americans by illustrating German soldiers as massive blood-lusting creatures who ravaged European women and children, and who would eventually do the same in the United States.  

Some in the Army advised artists to represent Germans in a way that would “inspire contempt rather than terror.” Others framed the issue in pseudo-scientific terms. For example, General Munson of the Surgeon General’s Office suggested that most German Americans “occupy a very comfortably mediocrity” in American life, but that those who came to America were more self-reliant than those who stayed in Germany. “If then” Munson argues, “those of German blood in America are not supermen… it would seem that the average American citizen


need fear little when pitted man to man against the Germans.” Munson recommended representing the American soldier “as a big, clean-cut man of the college athletic type, playing the game to win but playing it fairly,” looking at the Hun “with an air of amused tolerance… yet with disgust at his contemptible nature and code of ethics.” And the “Hun should represent a type fairly powerful, yet physically no match to the clean-cut American. He should have the physical attributes of the criminal, and his mental qualities should be shown up as both criminal and treacherous.”

Army officials deployed turn-of-the-century racial and ethnic constructions of the male body that appealed to nativist American anxieties about Europeans.

General Munson’s report reflects broader US Army efforts to control what new recruits, soldiers, and, eventually, wounded patients saw within the context of the Great War. Also within that purview, other officials attempted to curb the use of the word “propaganda” in relation to American artistic mobilization, as they feared it would have been tied too closely in American minds to “distasteful” German methods of spreading information. In its attempt to build morale among American troops, the US Army turned to what the soldiers would see on the way to war, and continued to do so when many of the same men returned with war wounds.

Postwar hospitals regularly turned to visual activities to help men make good, such as film, vaudeville, or other entertainments that relied on sight. The reconstruction service in Lakewood, New Jersey, for example, relied on welfare agencies to provide entertainment to the

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383 Richard F. Fuller to Captain Perkins, October 15, 1918, RG 165, Series NM 84, Box 2, Folder: Publications, US National Archives.
healing patients every night of the week. Monday and Wednesday evenings were reserved for motion pictures. On Tuesday and Thursday nights soldiers saw vaudeville acts and concerts. And on Friday and Saturday evenings soldiers could expect entertainment from local artists or even boxing contests. At Fort McHenry patients took part in plays, and Walter Reed had a special “Post Theater” for patient entertainment. Entertainment media such as these fit within a broader print culture at hospitals. For example, patients printed and circulated their own newspapers, and helped motivate the men by publishing stories on the importance of rehabilitation as the best avenue to success.

Many patients also saw the many posters on the walls of hospitals. In 1919, the US Army Morale Department sought cartoonists to join rehabilitation work by sending posters “encouraging soldiers regarding their educational opportunities” and to fit themselves “for the ‘Battle of Daily Bread.’” The Morale Department sent posters to many of the General Hospitals and the imagery encouraged patients in the journey to recovery, which often included appeals to economic independence. One poster sent to Corpus Christi stated, “Oh Boy: That’s sure worth working for.” The other exclaimed, “We don’t put down our tools till quitting time.” The hospitals at Lakewood and Colonia, New Jersey had art departments, and the

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384 Paul Van Repir, “Historical Sketch of Reconstruction Service at U.S. Army General Hospital No. 9, Lakewood, New Jersey,” April 11, 1919, RG 112, Series NM 31 (K), Box 215, Folder 353.91-1 (G.H. #9) K April 1919 to Date, US National Archives.
388 Commanding Officer to the Chief of Morale Branch, “Small Morale Posters,” December 28, 1918, RG 165, Series NM 84, Box 2, Folder 123.38: General Hospital 15, Corpus Christi, Texas, US National Archives; Shipment
patients who took classes there kept the bulletin boards full with the motivational posters they

patients who took classes there kept the bulletin boards full with the motivational posters they painted. \(^{389}\)

Patients in a sign painting class at Walter Reed Army Hospital. Courtesy of the National Museum of Health and Medicine. \(^{390}\)

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\(^{390}\) OAH 353: Vogel Collection, Series 004: Scrapbooks, Box 005, Otis Historical Archives, National Museum of Health and Medicine.
In some cases, art was a tangible representation of recovery. Seeing and creating pieces of art in rehabilitation courses, activities that women reconstruction aides led, allowed recuperating soldiers to re-acclimate to their visual and tactile senses within the hospitals. Soldier-patients drew and painted landscapes, and created jewelry, wooden toys, and baskets. One patient expressed his appreciation for the aides’ patience while helping him visualize recovery in the artistic form. In a poem “to an aide,” E.R. Nicholson at Walter Reed wrote, “For they are always smiling and you know what a smile can do. When you’re up against it, and are feeling awful blue. For they will get you working on a basket or a tray, or perhaps type-writing lessons to pass the time away.”

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391 RG 112, Series NM 31 (K), Box 215, Folder 353.91-1 (G.H. #9) K April 1919 to date, US National Archives.
Visual aids such as motivational posters, toy-making, and nightly films and vaudeville shows were important to the cultural landscapes of US Army rehabilitation hospitals. They helped soldier-patients envision daily what successful medical and economic rehabilitation looked like – or what making good entailed –, and what it took to get there. In many cases, being involved in the creation of the artistic products provided further therapeutic benefit for the wounded and sick men, as it also gave them occupational training. Yet, for longer-term rehabilitative goals, officials turned the sight of disabled men from hospital therapy to the actual bodies and experiences of those who could not see. Blinded veterans were motivational figures for veterans and society more broadly, and their published images often lent unrealistic expectations and sanitized views of war wounds. Despite their complex wounds, blinded veterans became models of success well into the 1920s, regardless of post-war realities of bodily suffering.

393 RG 112, Series NM 31 (K), Box 215, Folder 353.91-1 (G.H. #9) K April 1919 to date, US National Archives.
Other veterans, and society more broadly, entered the postwar years with regular stories of veterans who had made good. War stories on blinded veterans, in particular, focused overwhelmingly on sympathetic appeals to the public. Arthur Holmes, a writer for *Outlook for the Blind*, recognized the sympathy the blind elicited from the public when he contemplated their relation to deaf soldiers. The principal difference between the two, he argued, “is in the attitude of the men themselves and the attitude of the public toward them. Blindness… is in almost every case a self-evident disability, which appeals strongly to the sympathies of the general public. As a result the blinded soldier has received sympathy from the beginning; his disability has been regarded as one of the most, if not the most, severe handicap suffered by any disabled soldier.”

Why was Holmes’s point, that the blind elicited such heavy sympathy, so apparently entrenched in social and cultural discourses of the early twentieth century? Part of the answer lies in the assumption that blind men could not compete in the economic sphere with their seeing counterparts. When the United States economy transitioned to factory-based labor in the nineteenth century, state workmen’s compensation laws made hiring employees with disabilities or impairments a liability for companies. Between the 1890s and the 1920s many people with disabilities, therefore, lost access to the paid labor market. There were some limited exceptions, such as the case of a company in Philadelphia that hired around 20 disabled workers, including one “partly blind” individual. While they were good workers, the author wrote, the manufacturer still worried about potential accidents with the workers who went up and down

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flights of stairs. Yet, isolated instances such as this were not representative of the whole, and most disabled workers were displaced from labor.

While this was the case for civilian disabilities, American manufacturers at least paid lip service to hiring disabled veterans. The National Association of Manufacturers, for example, appealed to the “men who have fought the good fight” and came back disabled. In the spirit of cooperation, they argued, as long as disabled veterans came back with the same spirit they showed in fighting, “The American manufacturer will see that you have every opportunity to realize your ambition” and therefore “you’ll make good.” The state of Pennsylvania tried to help disabled veterans find work as well, and conducted a survey of factories throughout the state to find out who would hire the men. Around 900 companies agreed to employ close to 50,000 disabled workers, or around one quarter of the number of disabled American veterans. The state consolidated the survey results by particular disabilities. Firms opened employment for over 4,000 men who lost fingers. If a man lost one arm at the shoulder he could expect close to 400 possible job openings. Partial loss of a foot opened around 2,000 potential jobs. A veteran with one eye could expect a choice of close to 6,000 job openings, though if one were completely blind, companies only offered two open positions. Complete blindness, therefore generated few prospects in the industrial workforce.

Visual representations of, and contemporary ideas about, blindness as sympathetic or a liability were firmly entrenched in other ways as well. Western societies had long emphasized
vision’s importance as a sense, particularly during the transition to modernity and with the advent of modern printing and science. Physicians and scientists gained knowledge through the experiences they saw, and placed sight at the forefront of their practice. To deprive one of sight, according to associated ideas, signified a tragedy in that one could not connect visually with other people, or the material world. The connection between blindness and socially isolated blind beggars, one that dates back to the Middle Ages, also triggered compassion that in many ways continued into the twentieth century. Therefore, by the time stories on blinded veterans appeared in newspapers and journals during the war years, Americans had long encountered sympathetic ideas about blindness.

Efforts to mobilize sympathy toward blinded soldiers first occurred within the United States with aid to blinded French soldiers. One of the first American philanthropists who organized to aid the French war blind was Winifred Holt and her New York Association for the Blind. Holt’s training center for blind civilians began in 1905 in New York City, and gained support from Helen Keller and public officials like Grover Cleveland. Holt sent relief to Europe in 1915 with news of the first blinded soldiers there. Holt’s “Committee for Men Blinded in Battle” was one of the first American humanitarian efforts to aid Europe. The British,

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401 Moshe Barasch, Blindness: The History of a Mental Image in Western Thought (New York: Routledge, 2001), 147.


French, and Belgian Permanent Blind Relief War Fund also mobilized during the war years and funded re-training efforts for allied war blind.

Organizations such as these relied on visual representations of blindness to signal sympathy and elicit more donations for their cause. New York artist F.C. Yohn, for example, contributed to the proliferation of images of sanitized war wounds and themes of sympathy. He sold his drawing *The Blinded Soldier* at a 1916 fundraiser for the Permanent Blind Relief War Fund. Yohn’s drawing depicted the blinded soldier “with his hand raised palm outward – to express complete helplessness and supplicate Divine aid.” He explained of his drawing, “In conceiving the figure of a soldier, suddenly blinded in battle, I tried… to convey the single insistent idea of appeal.” He wrote that it represented “an overpowering human calamity.”

Yohn’s image was clearly meant to elicit donations by continuing the long history of associating blindness with public sympathy. Many subsequent literary and artistic images of blinded soldiers of the war followed Yohn’s style and promoted sympathy and imagined bodily and cognitive wholeness. The imagery therefore positioned blind veterans as uncomplicated and in need, and worthy of public support.

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Blinded veterans were central figures in prominent public events that elicited public sympathy, and that often positioned the men as the pinnacle of sacrifice. In his run for president in 1920, Senator Warren Harding focused a speech in Ohio on two blinded soldiers. The speech addressed important political topics such as reducing the cost of living, advocating for federal maintenance of highways, paying tribute to the recently deceased Theodore Roosevelt, and appealing to women voters. Elmer Stevens and Joseph Hulin, however, were the centerpieces. Both men were blinded from their wartime service and accompanied Harding at his campaign event. “They were blinded under the flag,” Harding professed. “I want to publicly pledge to them and to their comrades who suffered impairment the republic’s unfailing and grateful

Harding highlighted blinded veterans, rather than the more than 200,000 other disabled veterans, and signified the political power of sympathy that the figure of the blinded veteran generated.

Blinded veterans shared public sympathy with other poignant symbols of wartime sacrifice after 1918, such as Gold Star Mothers and the missing and dead. War remembrance of the dead was politically contentious within the United States. While disillusion over the cost of the war made public remembrance a difficult issue, society elevated Gold Star Mothers – mothers who had lost sons in the war – as the “sacrificial mother.” At the Disabled American Veterans of the World War (DAVWW) convention in El Paso Texas in June 1927, a DAVWW commander, William Dodd, organized a presentation of the US flag to the blinded veterans there. Dodd stated, “Men have given their lives for the colors. You have given your eyes… There is nothing we would not do for you, if you called on us.” The interaction evoked tears from many in the crowd, as C.S. Kemp, a blinded veteran “groped for the standard. Sympathetic hands caught his and placed them on it.” And R.E. Sherman, a Gold Star Mother who helped organize the event, stated, “The entire nation owes a great debt to all who served in the World War, particularly to those men who made the supreme sacrifice and next to these, the men who lost their sight… These are now carrying affliction’s heaviest cross.”

Carl Bronner also encountered the sympathetic gaze usually turned toward the war dead. The Outlook for the Blind’s article on Bronner’s rehabilitation began with the image of the sacrifice of the Unknown Soldier. “But” it continues “this unknown hero is beyond the need of sympathy and the reach of trouble.” The article imagined the wishes of the dead: “We could

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406 “Pledge is Given to Blind Heroes” Morning Register, August 26, 1920, 1.
please him best by giving aid and comfort to the known heroes.” According to the *Outlook*, Bronner, who lost both eyes and both hands in France, was worthy of the averted sympathy. Charting his path through war to his disability, the author argued that to men like Bronner “patriotism, poetry and history should bring garlands, should sing hymns of praise, should offer every word and work of sympathy and admiration” in the work they do to move forward with their lives.\(^\text{409}\)

Sympathy was, therefore, a cornerstone of publicity about blinded veterans in a society hoping to move on from the war. The stories focused on the singularity of blindness that often sanitized the wounds they received in battle. When Elmer Stevens and Joseph Hulin stood for Senator Harding they did so as blind men, and not veterans who also suffered from facial and neurological wounds.\(^\text{410}\) Journals and newspapers used public performances of remembrance and positioned the men as emblematic living relics of wartime sacrifice. Cast as “affliction’s heaviest cross,” sympathetic portrayals of blinded veterans often ignored the myriad human costs of war and relied on singular notions of disability as “the most” sympathetic and worthy of public attention and support, and further entrenched long-held ideas about blindness and society.

*New Eyes for the Old that War Closed: The Politics of Sanitizing Wounds*

The sympathetic portrayal of blinded veterans was not uncontroversial. Blinded veterans challenged the society that imagined them as tragic heroes. Michael Aaronsohn, also called “Fighting Mike” in most newspaper articles, regularly spoke out to combat such sympathetic portrayals. Twenty-two-years old at the time of the war, Aaronsohn fought for five days in the

\(^{409}\) “Heroes Known and Living” *Outlook for the Blind* 15, no. 3 (Autumn 1921), 121.

\(^{410}\) Elmer took shrapnel to the eyes and upper part of his face and suffered from war-induced psychoneurosis while Hulin’s wound included a bullet that penetrated the right side of his face causing blindness and damage to his sense of smell, along with “neurasthenia”; “Brief History: Neurological Diagnosis and Prognosis in the Permanent Patients, U.S.A. General Hospital No. 7” RG 112, Series NM 31 (K), Box 206, Folder 314.7-2 (G.H. #7) K, US National Archives.
Meuse-Argonne Offensive when a piece of steel from an artillery shell entered his head and destroyed his sight. He returned to the Baltimore hospital where American physicians recorded that he had both eyes enucleated, or removed, and that he was diagnosed with “concussion & shock,” as well as psychoneurosis, likely from a form of combat trauma. After his rehabilitation, he wrote, “I came out of the toddling period of childhood and began to walk erect and blithesome.” “Fighting Mike” was adamant in his resistance to sympathy. He argued that he did not want a “temporary wave of sentimentality” but instead demanded a “sense of justice… that will make America put over a worth-while and just program” of re-integration.

But instead of using his anti-sympathetic stance to argue against an infantilizing view of disability in society, Aaronsohn saw his wound primarily in economic terms that would match his personal effort in rehabilitation as well as his relatively conservative upper-class privilege.

In his postwar life, Aaronsohn became almost a celebrity veteran. He returned to his schooling after rehabilitation and graduated from the University of Cincinnati and Hebrew Union College. He was prominent in American Jewish life. He became a rabbi in 1923 and gave numerous speeches around the country. According to contemporaries, Aaronsohn “symbolized the triumph of the human will over blindness” through his journey to recovery. And while he did have difficulty learning Braille, with work he was able to master it so that the “dots bristled with meaning and thoughts.” Aaronsohn’s story was among the most motivational for veterans and the public alike, and relied on a message that he overcame his disability through hard work and persistence.

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412 “Brief History: Neurological Diagnosis and Prognosis in the Permanent Patients, U.S.A. General Hospital No. 7” RG 112, Series NM 31 (K), Box 206, Folder 314.7-2 (G.H. #7) K, US National Archives.
413 Gene Cohn, “Blind Chaplain is Given New Honor,” 8.
Aaronsohn recognized his close relationship with the press and argued against sympathy and instead embraced rhetoric that emphasized personal hard work. He counted members of the press as among his best friends in the recovery process, as journalists accompanied him in his travels and public appearances. However, the coverage of his success almost universally ignored his class background and family support. Aaronsohn had extensive training with typewriters before the war, a luxury not afforded to every disabled veteran. When he entered rehabilitation, Aaronsohn wrote, “I amazed my companions… with the speed and ease with which I was able to swing along on the mechanical keyboard,” a feat not as accessible to the other men. And in his postwar life he used this to his advantage, and wrote correspondences, papers, sermons, theses, lectures, and at least three books.415

Aaronsohn also stated most of his reading was through people reading to him, and he found it “necessary to employ three readers a day.”416 One of the readers was his sister, who helped him through the rest of his education at Hebrew Union College.417 Having three readers meant Aaronsohn had both the familial stability to allow his sister to aid in his education, and the financial capacity to hire an additional attendant above the one that federal compensation allowed for blinded veterans. For example, under the War Risk Insurance Act, a veteran who lost both eyes received $100 per month, with an additional $20 per month if he needed a nurse or attendant.418 Aaronsohn qualified for compensation for complete blindness and one attendant. Therefore, while Aaronsohn did succeed in his postwar goals, the stories about him neglected the

416 Michael Aaronsohn, “Resurrection: A Blind Veteran Tells His Story” The American Legion Weekly 6, no. 22 (May 30, 1924), 16
details of his aid, focused almost entirely on his own personal effort, and obscured the class status that made his success far more attainable for him than for the average veteran.

Aaronsohn held onto the near-celebrity status that was intimately connected to his perceived ability to overcome war-induced blindness. The status was his identity, and the source of much of his acclaim as he used it as a springboard for his advocacy efforts for other disabled veterans, disabled civilians, and the founding of the Jewish Braille Institute.\textsuperscript{420} Aaronsohn, however, constructed and deployed his identity in a way similar to deaf-blind celebrity Helen Keller. While Keller’s politics of racial and economic justice were radical, her disability politics were relatively conservative. She depoliticized disability “by relegating it to the realm of coping

\textsuperscript{420} Herman, “NFTS and the Jewish Blind, 1927-1952,” 289.
and personal character.” Her disability, argues historian Kim Nielsen, was her public image and her image depended on perpetually overcoming her disability.  

Keller’s individualism was not unlike Aaronsohns, and Keller had even visited the Baltimore hospital to motivate the newly returned blinded veterans. Aaronsohn, similar to Keller, focused his image not on sympathy, and not on his pre-war education or social status, but on the hard work that enabled him to perpetually overcome his blindness and succeed in postwar life. Aaronsohn positioned rehabilitation success as a product of individual effort, and de-politicized the state and social mechanisms that stood in the way of true accessibility such as affordable Braille books, or inclusive institutions. The focus on the individual, rather than the state, allowed for writers to portray rehabilitation without calling into question war or the role of the state in healing wounded veterans. Paradoxically, Aaronsohn discounted the very public sympathy that allowed for his celebrity status. Men such as Aaronsohn, who had allegedly succeeded based on their determination, served to motivate other veterans, disabled and nondisabled, and to justify to the public that what the government was doing for the men was worthwhile, and therefore so was the war.

Michael Aaronsohn was one of many veterans whose image was of performative motivation. The American Legion Weekly, for example, featured regular columns on blinded veterans and their successes in postwar America. These highlighted themes of strength, persistence, thrift, and, ultimately, success. The weekly magazine was distributed widely in the interwar years to disabled and non-disabled veterans. Its columns deployed motivational imagery and signified the political power of blinded veterans for the benefit of inspirational prose. The

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American Legion Weekly’s use of sanitized rehabilitation images widened the gap further between the realities of complex wounds and the pictures Americans saw of rehabilitation success. Performative motivation was, therefore, a political tool that further justified wartime sacrifice and government-led rehabilitation.

John Tunis, a reporter from the American Legion Weekly, observed the men at Evergreen going about the business of rehabilitation in 1922. Most men, he wrote, wore no glasses or eye coverings. They walked “with an easy swinging gait” and did not use canes “for the same reason they don’t use attendants – they don’t need them.” “In fact,” he wrote, “it would be pretty hard to discover… a more self-reliant man than the blind veteran.” Using hands as substitutes for the eyes, the blinded veteran achieved “new eyes for the old that war closed.”

Evident in Tunis’s piece was a sanitized view of both the process of re-integration and the wound itself. In his retelling, artillery did not ravage men’s faces. It did not cause excruciating pain and suffering. Instead, the war simply closed the men’s eyes. Men also did not suffer through psychological or physical problems in their journey to civilian life. Instead, one might not even know they were blind.

Stories on blinded veterans professed ideas of self-determination and grit in rehabilitation and served primarily to motivate other veterans who struggled to find their way after the war. Other depictions of blinded veterans mirrored the American Legion Weekly’s. Similar to Tunis’s observations, they portrayed the blinded American veteran as nearly immune to suffering. At the Blinded Veterans of the World War (BVWW) convention in St. Louis in 1923, the men were cheerful and happy “despite their misfortune,” and the characterization seemed peculiar to observers. “One might expect that having suffered the worst deprivation one may suffer, they

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would feel sorry for themselves.” Instead “they were only interested in bringing sunshine to the lives of others.” While the depictions acknowledged the disability for sympathetic reasons, they positioned the blind body as serving the interests and needs of society, rather than the needs of the veterans themselves. War’s scars were nowhere present, save for the small references to blindness. The men were merely objects for the non-disabled world.

Not all of American Legion’s blinded veterans featured as serious motivational pieces that erased much of their disability. Frank Pyle, for example, was a blinded veteran and contributor to the magazine, and wrote comical pieces that reflected his real or imaginary interactions with society after the war. Pyle was a 28-year-old civil engineer when he left for the war. He contracted cerebro-spinal meningitis and influenza while in France. And after being sent to a hospital near Brest, he lost his ability to see. Pyle returned to the hospital in Baltimore in December 1919 and trained as a Dictaphone operator. His articles with the American Legion Weekly depicted a humorous account of his fellow “blinks,” as they called themselves.

Pyle published lively anecdotes about the “blink” experiences in rehabilitation and used his own image to illustrate the blind reality. He wrote that he was simply a blind man until he arrived at the hospital and became a “blink.” Comparing his experience to that of a caged animal, Pyle explored how Baltimore civilians regularly visited the rehabilitation center on Sundays to take veterans for rides, bring them to the theater, or bring presents. One of his comrades had written home one Sunday, “This is the day the people come out and feed the blind

425 “Brief History: Neurological Diagnosis and Prognosis in the Permanent Patients, U.S.A. General Hospital No. 7” RG 112, Series NM 31 (K), Box 206, Folder 314.7-2 (G.H. #7) K, US National Archives.
The article reflected a comical uneasiness about public perceptions of the blinded men.

Pyle also recounted instances where the blinded veterans used the gawking civilians’ ignorance of the war and the soldiers’ disability to their own advantage. When one woman asked how they had lost their vision, Pyle joked, “I was leaning up against a barrage when it went over with me,” or, “I was watching the soldiers go across and the strain was too much for my sight,” or finally, “I tried to stop a shell from exploding in front of a Y.M.C.A. man who had lost his way.” He also told stories of men in their daily activities, like one veteran who, late for breakfast one morning, was found searching for his prosthetic eyes. “He had taken them out the night before and had misplaced them. He told the nurse he could not see to go to breakfast without them.” Pyle’s recollections, whether based in fact or fiction, do reflect a divergence from the predominant sympathetic or motivational anecdotes on blinded veterans. Instead, he used the experience for comical purposes, and drove a wedge between nondisabled visualizations of the blinded veterans and the veterans’ own perceptions. Pyle’s stories also served to further sanitize blinded veterans’ experiences through humor, to make the audience more comfortable with the wounded by making them comical rather than recipients of war trauma, and, therefore, comfort civilians who might otherwise have felt guilty about the sacrifices these men made.

Yet, more often the American Legion’s publication rested on the motivational tale that catered to their readers, a predominant number of whom were veterans themselves. Ewald Wegner, for example, gave the magazine another competent success story after he opened his “Red Arrow” chicken farm in Gillette, New Jersey, which was named after his old division. Wegner was a 23-year-old farmer before the war. While serving in the Meuse-Argonne

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Offensive in October 1918, a piece of shrapnel destroyed both of his eyes, wounded his right hand and left knee, and also caused psychological distress.\textsuperscript{430} Despite the extensive wounds, his rehabilitation story almost exclusively featured his work. His wife articulated how Wegner attended to the duties better than any sighted person. He counted the chickens every few nights, “running his hands over them” after they went to roost.\textsuperscript{431} There was no mention that the hands and arms he used to complete the tasks suffered from weakness and atrophy from the shell explosion that had also blinded him.

Still, his war story was a comprehensive success, as he had a successful business and a family with two young children. One article on Wegner even misleadingly claimed that he supported himself and his family “without any help whatsoever from the Government.” The depiction doubtless referred to his postwar economic status, which ignored the fact that government rehabilitation, compensation, and loans available specifically to him as a veteran contributed at least partially to his business success.\textsuperscript{432} The article also noted that Wegner used thrift and determination, and saved his earnings to re-invest in the growth of his business. His success, according to the author, was representative of “the kind of common sense that is the mainspring of ambition, foresight and action,” all qualities inherent in the moral training of rehabilitation.\textsuperscript{433}

Frank Shamy was another of the American Legion Weekly’s blinded veteran icons. A salesman before the war who sold sporting goods, Shamy enlisted in 1917 and fought at Chateau-Thierry and later in the Somme sector where a shell explosion blinded him, wounded

\textsuperscript{430} “Brief History: Neurological Diagnosis and Prognosis in the Permanent Patients, U.S.A. General Hospital No. 7” RG 112, Series NM 31 (K), Box 206, Folder 314.7-2 (G.H. #7) K, US National Archives.
\textsuperscript{431} “The Red Arrow Emblazons a Dark Trail” The American Legion Weekly 6, no. 48 (November 28, 1924), 21.
\textsuperscript{432} Tunis, “New Eyes for the Old That War Closed,” 23.
his shoulder and knee, and left him with a concussion and limited shoulder mobility. He arrived at the rehabilitation center in Baltimore in 1919, struggled with recurring bouts of depression, and did not find his professional calling until the US Veterans’ Bureau recommended that he try massage. After training in anatomy and massage, he worked at Johns Hopkins Hospital, and then gained further experience at the University of Maryland and Mercy Hospital of Baltimore before he established his own practice. His example proved to American Legion Weekly that the fate of the blinded veteran, or the veteran more generally, depended on his “will power and courage.” It was his hard work that was important, according to the Weekly. And Shamy proved up to the task.

The American Legion Weekly emphasized the blinded veteran as compelling evidence of rehabilitation’s capacity for promoting success and motivating other veterans. If Wegner or Shamy could do it, the articles implied, so could any disabled or non-disabled veteran. If the blind man could do it, with what many considered the worst war affliction one could endure, so could any man. The messages about making good relied on sympathetic themes, and served the observer at the expense of the blinded veteran, by perpetuating the performative nature of their postwar lives. They served to highlight messages of job security and success through individual hard work, but, in the process, sanitized the wound experience, as many of the wounds were downplayed through vague phraseology or euphemism. And, finally, the stories offered audiences the idea that rehabilitation success depended upon individual effort, and therefore shielded the state rehabilitation apparatus from criticism if the men failed in their duty to become economically independent.

434 “A Stout Heart and a Strong Arm” The American Legion Weekly 6, no. 50 (December 12, 1924), 9; “Brief History: Neurological Diagnosis and Prognosis in the Permanent Patients, U.S.A. General Hospital No. 7” RG 112, Series NM 31 (K), Box 206, Folder 314.7-2 (G.H. #7) K, US National Archives.
435 “A Stout Heart and a Strong Arm,” 24.
436 “A Stout Heart and a Strong Arm,” 9.
Conclusion: Garlands, Hymns, and Praise

With the aid of society and media outlets such as the American Legion Weekly and Outlook for the Blind, blinded veterans took center stage as they symbolized successful rehabilitation. Carl Bronner’s war experience was extraordinary to the public, and straddled the line between sympathy and stoicism. He had lost both his hands and his eyes in France, and thus was eligible for maximum disability benefits from the state. And his traumatic wound caused “the American heart” to respond to his enormous sacrifice. Yet, according to accounts of his postwar activities, he was “beyond the need of sympathy” because he carried on with heroism “even greater in peace.” His example caused this impressed observer to ask, “If Carl Bronner can make such a gallant fight, should not all undisabled soldiers meet the world as bravely as he?” To men such as Bronner, according to the well-known journal Outlook for the Blind, “patriotism, poetry and history should bring garlands, should sing hymns of praise, should offer every word and work of sympathy and admiration.”\(^{437}\) Carl Bronner stood at the intersection between the ideals of motivation, performative patriotism, and sympathy.

Bronner and other blinded veterans contributed to a broader visual culture of rehabilitation that mobilized civilian and veteran sight and perception as important components of healing. In the aftermath of war, hospital administrators hung motivational posters through their institutions that were meant to infuse the moral qualities of hard work and industriousness into daily routines. Welfare agencies provided regular entertainments of film screenings and vaudeville shows, as they imagined it improved the moral welfare of the healing men. Art and occupational therapy programs engaged the senses of sight and touch in helping men to transition to a life of productivity. And hospital publications allowed disabled veterans to spread news and

\(^{437}\) “Heroes Known and Living” Outlook for the Blind 15, no. 3 (Autumn 1921), 121.
entertainment to their fellow men, to provide respite from the lasting physical trauma of their military lives.

Yet, the visual culture of rehabilitation continued into the 1920s, when society sought to move on and justify its role in the war despite its human costs. Seeing a certain version of a veteran who had made good was a way for the public to return to their lives, as carefully crafted image of the blinded veteran appealed to the civilian sense for patriotic purposes. While many soldiers, blinded through military service, returned with complex wounds and illnesses, cultural representations of them relied primarily on veterans’ abilities to overcome their singular blindness. Newspapers downplayed most wounds, and presented uncomplicated and often physically whole bodies. Journals such as the Outlook for the Blind relied on performative sympathy to keep public attention focused on blinded veterans as symbols of the war. The American Legion Weekly portrayed blinded veterans as stoic figures to motivate disabled veterans more broadly in their re-integration to society. Only in a few instances such as with Michael Aaronsohn and Frank Pyle did the men attempt to take control of their own image, becoming subjects rather than objects. Yet, in appealing to the sense of sight, in portraying blinded veterans in a certain way for public consumption, Americans avoided the difficult but necessary conversations about war and trauma. To the civilian, society had made good.
Chapter V: Seeing Wounds: The Problem of Invisible Wounds and the Promise of Making Wounds Invisible

In the days that followed the Armistice Major E.W. Cleary of the Orthopedic Division at US Army General Hospital No. 9 in Lakewood, New Jersey wrote to the commanding officer there that the recent order that reduced medical staff was discouraging, considering the extensive medical needs of returning veterans. The Surgeon General viewed the federal government’s care of veterans as temporary in nature, and so Cleary felt restricted in his ability to develop long-term treatment plans for men with chronic illnesses at Lakewood. “Neglect of many important details” he wrote, “will be an unavoidable consequence of insufficient staff assignment. The unfortunate results of this most deplorable necessity will be indelibly recorded upon the bodies of many of our wounded soldiers, so long as they shall live, and in the clinical records of their cases so long as the archives of our government endure.”

The Lakewood veterans’ hospital organized four short-lived chronic disease centers that included the Cardio-Vascular Service, the Diabetic Service, a center for nephritis, and the Service for the Study and Treatment of Arthritis. The centers were part of the larger reconstructive programs during the war years, but while the US Army claimed to give equal treatment to all veterans, the rehabilitative work on chronic disease for veterans – including physical and psychiatric conditions – was marginal at best. Conversations about wounds and illnesses walked a tenuous line between the military’s needs to enable patient recovery and to address the lack of visibility of chronic illness in a society that, very often, regarded invisible wounds with doubt. The ability to see a wound or illness was important to postwar conceptions.

438 E.W. Cleary to the Commanding Officer of U.S. Army General Hospital No. 9, November 15, 1918, RG 112, Series UD 8, Box 934, Folder 730.8: Orthopedic, US National Archives.
of healing. But the experiences of veterans whose damaged health could not be readily seen complicated rhetoric about making good.

While some wounds were problematic because hidden, the problem with other wounds was that they seemed especially to require concealment. At the same time the US Army struggled to address chronic illness, thousands of American veterans returned with highly visible physical wounds such as facial disfigurement. Facially wounded veterans in particular joined ongoing conversations about how best to mask the visual scars of war. American societal and institutional discourse emphasized that men who returned with burns on the face, or jaws destroyed by shrapnel and bullets, need not remain permanent victims of the war. Instead, modern surgery promised to help the men make good by making their wounds invisible. Sight, or the public’s gaze, therefore, was particularly important in managing public cultures of aversion from ghastly wounds as a way to move on from war without having to confront difficult conversations about its human consequences.⁴³⁹

Left to His Own Desires: Confronting the Problem of Invisible Wounds

The US Army struggled to treat soldiers with chronic ailments such as arthritis, diabetes, and heart disease. Chronic disease had captured the attention of many in the United States in the first decades of the twentieth century. Economists had flagged chronic disease as a waste of American health and productivity, an idea that contributed to the growth of life insurance companies.⁴⁴⁰ Americans in the public health movement were confident in the future because of the decline of infant mortality and the promise of science and rational management. But they

were also anxious about the growth of non-infectious diseases such as cancer, heart disease, and diabetes. Despite some emphasis on long-term health, much of the underlying concern about chronic disease focused on the economic impact on society. Surveys taken in the first decades of the twentieth century, for example, measured cities’ capacities for care, but also showed the overwhelming degree to which chronically ill individuals were on welfare rolls. In society more broadly, therefore, invisible illnesses and chronic diseases were increasingly becoming both social and medical problems, and barriers to making good. After all, with these illnesses it was difficult to determine their legitimacy merely through seeing or visual examination.

For the US Army in particular, some of the first contact with chronically or invisibly ill soldiers came with the organization of development battalions, or convalescent camps meant to utilize men for service who, because of their health, could not serve on the front lines. During the American Civil War, the War Department organized the Invalid Corps for men deemed unfit to continue to perform tasks directly useful to the war effort. In this context, soldiers separated into a separate unit were stigmatized as unfit without any visibly evident wound, and some chafed at being labeled in that way. One soldier in the Invalid Corps, for example, reflected on the anxieties about not fulfilling the masculine soldierly role. He recalled, “Here I am, an unwilling member of the corps, denominated in Washington, ‘The United States Paupers.’” Managing the bodies and abilities of sick and wounded men, and the definitions of impairment, continued into the post-Civil War years.

The American Expeditionary Forces had its equivalent of the Invalid Corps in France. The hospital center at Savenay, for example, had a Convalescent Camp, where men who

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441 Weisz, Chronic Disease in the Twentieth Century, 17.
442 Weisz, Chronic Disease in the Twentieth Century, 59-61.
443 Sarah Handley-Cousins, Bodies in Blue: Disability in the Civil War North (Athens: The University of Georgia Press, 2019), 7-11; For a discussion of the politics of disabled veterans between the American Civil War and the First World War, see: Beth Linker, War’s Waste.
recuperated from diseases or wounds contributed to the war effort in a less strenuous atmosphere. It had between 300 and 1,400 men who contributed to the workings of the camp and hospital. The camp was a place for rest so the men could ideally return to full service at the front. Patients with “Effort Syndrome” – or heart disease – made up most of the soldiers there, who were given duties or exercises designed for their conditions. Men at the convalescent camp occupied a liminal position in the war, a grey area where they were neither fully healthy, nor fully wounded, with little or no outwardly visual markers of injury or illness.

Rehabilitation specialists aimed to project a welcoming atmosphere for soldiers with chronic and invisible illness, and proposed ways for society to welcome them without judgment. Captain Arthur Samuels, for example, contributed a number of articles to the rehabilitation magazine *Carry On*. He argued that the public regularly recognized outwardly visible wounds, but should lend more sympathy to those with wounded nerves, lungs, or with various diseases. “It is not the picturesque side of reconstruction that will afford the most troublesome problems for this country.” The public must understand that most soldiers “are suffering from internal rather than outward surgical injuries.” Samuels argued that employers and society needed to alter their minds not to pamper veterans with chronic illness or invisible wounds too much, but also not to scrutinize whether their disability, and therefore the civilian’s sympathy, was legitimate.

At the outset, it seemed promising that Army rehabilitation could treat invisible illnesses or wounds as it did with maxillofacial wounds. But in practice, treatment left much to be desired.

Managing men’s bodies and health continued at US Army hospitals once patients returned to the United States. Lakewood hospital was the destination for many chronically ill

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men. The hospital was located in the Lakewood Hotel, a large five-story building close to New York City with over 1,000 beds, and had adjoined buildings for barracks and hospital staff.\textsuperscript{446} Its proximity to New York City allowed the hospital to coordinate with the Rockefeller Institute for Medical Research, a major medical institution. The hospital recruited physician Francis Peabody of Harvard University, and Donald Van Slyke of the Rockefeller Foundation, to organize a Cardio-Vascular Service in May and June 1918.\textsuperscript{447} The Diabetic Service, while not as large as the former and slow to organize, employed physician Frederick Allen as its organizer over the following months.\textsuperscript{448} And Major Alfred Pemberton formed the orthopedic department, which included a section for arthritis treatment.

The most concerted effort on the part of the Army Medical Department was in the Cardio-Vascular Service. The hospital set aside 100 beds for heart cases and a number of rooms for medical treatment and rehabilitation work. It built a “Galvanometer room” – an electrocardiogram – constructed with the help of Columbia University.\textsuperscript{449} Peabody worked for over eight weeks planning the Cardio-Vascular unit, and the organization worked to treat chronically ill patients and train new medical personnel in cardiac medicine.\textsuperscript{450} The desired goals were reduction in the length of hospital stays, establishment of criteria for a return to service, and to lower the number of inappropriate disability pensions. The Lakewood physicians used

\textsuperscript{446} Annual Report of U.S. Army General Hospital No. 9, Lakewood, New Jersey, for 1918”, January 1919.
\textsuperscript{447} The Surgeon General to the Commanding Officer of General Hospital No. 9, “Organization of the Cardiac Service” May 18, 1918, RG 112, Series UD 8, Box 943, Folder 730.6: Cardio-Vascular, US National Archives.
\textsuperscript{448} Frederick M. Allen to Colonel Charles F. Mason, July 11, 1918, RG 112, Series UD 8, Box 943, Folder 730.7: Diabetes, US National Archives.
\textsuperscript{449} The Surgeon General to the Commanding Officer, “Cardio-vascular Service in U.S. General Hospital, No. 9,” February 7, 1918, RG 112, Series UD 8, Box 943, Folder 730.6: Cardio-Vascular, US National Archives.
\textsuperscript{450} The Surgeon General to the Commanding Officer, “Cardio-vascular work at U.S.A. General Hospital No. 9” July 29, 1918, RG 112, Series UD 8, Box 943, Folder: 730.6: Cardio-Vascular, US National Archives.
exercises to test cardiac rehabilitation in the unit and to determine what level of disability each patient had.  

Actual treatment for heart disease was marginal, however. Men at Lakewood with cardiac disorders such as valvular heart disease showed few signs of improvement, and were typically discharged with no coherent plan for long-term treatment. George Burnett, for example, suffered from myocarditis – inflammation of the lining of the heart – and was prescribed rest, regulated exercise, and a special diet, though no long-term treatment plan. Another problem with cardiovascular patients was that persistent complaints and symptoms such as racing or heavy heartbeat led physicians to classify patients as either cardiac or neuroses. And physicians might even overlap the classifications. “Irritable heart,” for example, first appeared after physician Jacob Mendez Da Costa observed chest pains, palpitations, fatigue, and other symptoms in young troops in the American Civil War. Da Costa’s studies resurfaced during the Great War, and the Surgeon General renamed the condition “neurocirculatory asthenia,” which joined uncertain military neuro-psychiatric classifications during the war years.

Heartbeat fluctuations were a potential symptom of many neuro-psychiatric conditions, which made diagnosing genuine cardiac conditions particularly difficult in the war years. Psychiatrist Norman Fenton, for example, observed this in his studies of neuro-psychiatric wounded veterans in 1919 and again in 1924. Based on questionnaires of hundreds of former patients he treated while in France, Fenton charted the social readjustment in men he treated in shell shock wards during the war. One major category he examined was veterans diagnosed with

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452 The Commanding Officer of General Hospital No. 9 to the Surgeon General, “Patients in Hospital Two Months or More” January 31, 1919, RG 112, Series UD 8, Box 942, Folder 705: Report of Overseas Cases, US National Archives.
anxiety neurosis. Many former patients had difficulty adjusting to economic and social life well into the 1920s. Mirrored in other reports, one veteran with anxiety who was admitted to a hospital in Philadelphia recalled constant nervousness, heart palpitations, weakness, and dizziness. Anxiety neurosis and other neuro-psychiatric illnesses that stemmed from war service regularly manifested in heart conditions that rehabilitation could not always adequately address. Heart conditions, therefore, were difficult to define and address given both the lack of diagnostic specificity and insufficient military planning for long-term treatment. This left many soldiers chronically ill with no visible war wounds.

Despite their efforts to organize a center for chronic illness, the Army Medical Department needed hospital space for what they considered more serious battle wounds and therefore changed direction. Nowhere was the need for hospital space more evident than with diabetic soldiers. The US Army recruited Frederick Allen of the Rockefeller Institute to organize diabetic work in Lakewood in July 1918, and Allen brought together dieticians, technicians, and laboratory helpers. In his preliminary survey, Allen reported that, among American troops in 1917, there were 100 admissions for diabetes, 26 discharges, 16 deaths, and a combined total of over 2,000 days spent in hospitals for treatment. The Surgeon General’s Office looked ahead, and argued that, with the influx of soldiers into the military in 1918, the Diabetic Service would undoubtedly be large.


\[^{456}\] D. Ferguson, “Some Clinical Types of Functional Heart Disease,” *United States Naval Medical Bulletin* 28, no. 1 (January 1930), 95.


\[^{459}\] Jack C. Gittings to the Commanding Officer, “Organization of the Diabetic Service in this Hospital,” August 8, 1918, RG 112, Series UD-8, Box 943, Folder 730.7: Diabetes, US National Archives.
Allen and the Surgeon General debated whether diabetic soldiers needed, or if the Army could even provide, extended hospital services instead of being immediately discharged to civilian life. The Surgeon General argued that soldiers should remain no more than a few weeks and be worked into a “rational system of treatment” that included education about living with diabetes. Diabetic soldiers, therefore, were not to be kept long and discharged with little in the way of post-hospital observation. By November, for example, the hospital had treated close to 20 cases. Three men were recommended for discharge, three were given disability discharges, and six “could be discharged without seriously endangering their lives,” while “one of them… will never observe diet when left to his own desires.”

Jack Gittings, a medical officer at Lakewood, identified the structural deficiencies in American health care when relying on individual effort in postwar health treatment. He argued that the absence of after care would mean any Army hospital education given to patients, or health advancements for diabetics, would be almost useless due, in part, to soldiers’ lack of education and financial stability to obtain or continue treatment. One possible avenue, Gittings argued, was to arrange services through the Red Cross or another organization to continue care. Without this, he writes, “The choice is essentially between making some provision for their after treatment and letting them die.” The difficulty in planning was not only due to the overwhelming nature of war planning, but also the lack of effective treatment. Most cases of diabetes between 1915 and 1922 were treated with a “starvation diet,” or, a plan not meant to effectively manage the disease, but instead to relieve symptoms by restricting calories to

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460 The Acting Surgeon General to the Commanding Officer, “Policy concerning treatment of Diabetes,” September 18, 1918, RG 112, Series UD-8, Box 943, Folder 730.7: Diabetes, US National Archives
461 Jack Gittings to the Commanding Officer, November 6, 1918, RG 112, Series UD-8, Box 943, Folder 730.7: Diabetes, US National Archives.
462 Jack Gittings to the Commanding Officer, November 6, 1918, RG 112, Series UD-8, Box 943, Folder 730.7: Diabetes, US National Archives.
dangerous levels.\textsuperscript{463} In the pre-insulin period there were few avenues for treatment, which left Army medicine particularly vulnerable to criticism.

Despite the bleak realities of treatment, a larger number of soldier-patients under care might have led to therapeutic discoveries, but the Surgeon General’s Office seemed particularly interested in reserving beds for other war wounds. Jack Gittings and Frederick Allen recognized the need for a more robust social welfare system for diabetic veterans, who did not fit neatly in early-twentieth-century ideas about disability, hinged partially on visibility and cure. The men could not be easily “fixed” with an artificial limb or a reconstructed jaw. Allen argued emphatically that war service was as much to blame for aggravating illness as it was in causing physical wounds. “There can be no doubt,” he writes, “that the strain, heavy eating, etc., of active service may aggravate an existing diabetes or bring out a latent tendency; and second, that the absence of treatment under field conditions may be responsible for damage fully on par with disability from wounds.\textsuperscript{464} According to the medical policymakers within the military, however, there was little that could be done for this class of patients.

The Surgeon General’s Office made this glaringly clear in its response to Allen and Gittings, who sought a more comprehensive plan for the men. The Commanding Officer of Lakewood, Charles Mason, sought direction from military authorities amid the growing cost of the Diabetic Service, as he wrote that it has accomplished “nothing except to keep these patients alive.\textsuperscript{465} The Surgeon General affirmed the policy of merely a few weeks of educational

\textsuperscript{463} Allan Mazur, “Why Were ‘Starvation Diets’ Promoted for Diabetes in the Pre-Insulin Period?” Nutrition Journal 10, no. 23 (March 11, 2011).
\textsuperscript{464} Captain F.M. Allen to the Commanding Officer, November 20, 1918, RG 112, Series UD-8, Box 943, Folder 730.7: Diabetes, US National Archives.
\textsuperscript{465} Charles F. Mason to the Surgeon General, “Policy concerning treatment of diabetes,” November 7, 1918, RG 112, Series UD-8, Box 943, Folder 730.7: Diabetes, US National Archives.
treatment, and therefore kept “hospital beds for more legitimate purposes.” And in response to Allen’s passionate appeal for long-term services, the Surgeon General’s Office suggested, “If the wellfare [sic] of this class of invalids would be better served by Captain Allen in civilian capacity rather than as a medical officer, this Office sees no reason why he should not be given his discharge.”

Frederick Allen hit a metaphorical wall against the lack of long-term treatment plans for chronically ill patients, whether in civilian or military hospitals or outpatient clinics. The temporary nature of US Army General Hospitals after the war, and the lack of medicinal treatment, hampered the state’s ability to put in place long-term treatment programs for diabetic soldiers. Additionally, the Army gave no order to send all diabetic patients to Lakewood from other military hospitals, a decision that further prevented the ability to study and treat the men. This path was in stark contrast to the Army’s explicit policy for all hospitals to send deaf patients to Cape May, New Jersey for special treatment, even though their numbers were similar to diabetic patients. In their policy decisions and correspondence, the Army Medical Department and Surgeon General’s Office classified certain invisible chronic medical conditions as less worthy of scrutiny and treatment. While there was no cure for diabetes and their resources were limited, it is clear that the US Army did not want to be seen as a welfare agency, in which they would treat long-term illness or help those without resources to care for themselves.

The Orthopedic Service fared little better in its quest to treat soldier-patients with arthritis. By November 1918, the service at Lakewood desired more staff due to overwork and

466 Surgeon General’s Office to Colonel Charles Mason, December 11, 1918, RG 112, Series UD-8, Box 943, Folder 730.7: Diabetes, US National Archives.
467 Surgeon General’s Office to Colonel Charles Mason, December 11, 1918, RG 112, Series UD-8, Box 943, Folder 730.7: Diabetes, US National Archives.
the increased numbers of men returning from Europe who needed treatment.\textsuperscript{468} No additional staff arrived. It was the labor shortage that led Captain Cleary of the Lakewood hospital to declare that the neglect of sufficient staff will be “recorded upon the bodies of many of our wounded soldiers, so long as they shall live.”\textsuperscript{469} The proportionately smaller attention the Army gave to arthritic patients does little to reflect the reality of rheumatic diseases in the war. Around 3,000 AEF soldiers per month developed rheumatic diseases during the war, totaling around 93,000 men. By 1931 the Veterans’ Administration was paying over $10,000,000 per year in disability compensation to around 35,000 veterans with arthritis.\textsuperscript{470}

Despite the large number, First World War arthritic patients did not benefit from early and comprehensive treatment due in part to the temporary nature of the military hospitals and the general lack of treatment options. And visual aversions to more culturally convincing wounds such as facial injuries and amputations generated more attention from the media. Additionally, the inability of modern medicine to sufficiently grasp the complexity of chronic illness or invisible wounds would not have reflected very well on doctors, who were eager to prove their medical abilities to the state and society. This was a problem they did not have to confront with facial wounds.

The setbacks in chronic illness centers after the war mirrored developments elsewhere in the broader postwar medical apparatus. In hospitals, soldiers who did not serve overseas, or who had ailments difficult to trace to military service, encountered skepticism from doctors, a

\textsuperscript{468} The Surgeon General to the Commanding Officer, “Orthopaedic Service at Base Hospital #9,” November 12, 1918, RG 112, Series UD-8, Box 943, Folder 730.8: Orthopedic, US National Archives.
\textsuperscript{469} E.W. Cleary to the Commanding Officer, “Inadequate Staff,” November 15, 1918, RG 112, Series UD-8, Box 943, Folder 730.8: Orthopedic, US National Archives.
\textsuperscript{470} Philip S. Hench and Edward W. Boland, “The Management of Chronic Arthritis and Other Rheumatic Diseases Among Soldiers of the United States Army,” \textit{Annals of Rheumatic Diseases} 5, no. 4 (June 1946), 106.
situation intensified because of vague definitions of disability.\textsuperscript{471} For example, Elam Shirk traced his back pain that lasted into the 1920s to his military service in the war. Yet, the Veterans’ Bureau claimed that he was not “handicapped.”\textsuperscript{472} Many veterans also came home to a public that assumed disabled veterans would have visible wounds, rather than damaged lungs or chronic pain.\textsuperscript{473} One of the largest groups of veterans who came under scrutiny for allegedly feigning their illness were veterans with neurological wounds.\textsuperscript{474} Chronic illness, therefore, proved elusive to a military medical apparatus and a Progressive Era ideology that positioned disability as a temporary setback, and one that could be seen and cured.\textsuperscript{475} Wounds that were not obviously visible proved particularly challenging for the patient, the state, and society to regulate.

\textit{Just As Good As... Before the War: The Promises of Making Facial Wounds Invisible}

Facial wounds were highly visible, but the rhetoric about them did not attempt to confront the costs of war. Instead, predominant discourse emphasized how surgery could re-make the man as if he had never gone to war in the first place. Soldiers in the Great War suffered devastating wounds from shrapnel and bullets that often destroyed the face or jaw or, in other cases, left teeth missing or horrific scarring from burns. Iowa native George Bolt, for example, was in a dugout on the morning of May 17, 1918 with four other soldiers when a large shell burst through the ceiling, exploded, and killed everyone except Bolt. On impact, the shell ignited a storage area of flares that filled the dugout with flames, scarred his face, and burned both ears.

\textsuperscript{471} Jessica L. Adler, \textit{Burdens of War: Creating the United States Veterans Health System} (Baltimore: Johns Hopkins University Press, 2017), 44.
\textsuperscript{472} Adler, \textit{Burdens of War}, 192.
\textsuperscript{474} Rose, \textit{No Right to Be Idle}, 204.
\textsuperscript{475} Adler, \textit{Burdens of War}, 4.
and hands off. He spent close to two years undergoing successive surgeries in the US Army hospitals in Cape May, New Jersey, and Jefferson Barracks, Missouri.


While the newspaper stories sometimes included the graphic nature of men’s wounds, more often they told redemptive reconstruction stories centered on the marvels of modern medicine. John Hiatt of Lexington, North Carolina was given this sort of media coverage after a shell destroyed his jaw, teeth, and nose, and took away practically “all the man’s features.” But

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all was well in the end. He allegedly wore “an entirely new face” that was “just as good as the one he had before the war.” While rhetorically graphic, stories such as these minimized the disfigurement at the expense of highlighting the wonders of surgery.

Stories of facial wounds captivated civilian audiences. Writers evoked facial mutilation in journalism, poems, memoirs, and fiction in the war years. But the stories were also accompanied by public visual anxiety, or a “collective looking-away,” as stories reminded civilians of children who fled their fathers, or nurses who struggled to look at the patients. Several types of observers followed the processes of reconstruction in the aftermath of these wounds. It was not just civilians who were fascinated and horrified by mutilated faces, but artists and surgeons also photographically documented each stage of recovery through the many surgeries, and in the process created a new consciousness of seeing. As rehabilitation aimed to re-make productive citizens, facially wounded patients occupied a precarious zone between war and recovery that complicated the visual representations of successful healing that one saw in the portrayals of blinded veterans. American media privileged the easier visuals – for the public – of uncomplicated wounds. It is partially for this reason that stories focused more attention on the promises of medicine rather than the actual damage of the facial wound.

Maxillofacial surgery in the war years relied on a team of dentists, surgeons, and artists to remake the faces of men. Over 2,000 American soldiers suffered face and jaw wounds in the

war, and among them 600 needed further treatment in hospitals in the United States. The primary locations for facial reconstruction were at the US Army General Hospitals in Cape May, New Jersey and St. Louis - later at Jefferson Barracks. Patients were under “visual quarantine,” and kept in an building separated from the rest of the hospital, connected only by a wooden ramp. But the wooden ramp was a bridge “not of sighs” as one local writer argued, but of “joy and light and laughter, for over it men pass, their jaws shot away, every tooth gone, noses and cheeks cruelly torn, a sight to make angels weep; and back again they may come in time, restored to a normal type… the gift of speech enabled by processes which the lay mind would think impossible.”

Building “K” at the St. Louis hospital connected to the main buildings by a wooden ramp. Courtesy of the US National Archives.

484 Kember, “Face Value,” 43.
485 Kember, “Face Value,” 44.
487 RG 112, Series UD 8, Box 1159, Folder: Historical Data, US National Archives.
Maxillofacial surgery at US Army General Hospital No. 40 in St. Louis was organized under Lieutenant Colonel Vilray P. Blair. He supervised 18 facial surgeons and an equal number of dental surgeons, as well as artists and sculptors. Patients usually endured eight to ten surgical procedures over a period of months or sometimes years. The surgeons grafted cartilage and skin from other parts of the body and remolded it to the contours of the face.\textsuperscript{488} Despite the surgeons’ expertise, much of the work would not have been possible without the skill of women artists both in and out of the operating room.

American women played a major role in hospitals alongside the medical men. Mary Gilmer, for example, was the official War Department artist and worked at the hospital in St. Louis. Originally a portrait painter, Gilmer made drawings of soldiers’ wounds at every step of the operation to document the process.\textsuperscript{489} Her model faces of each soldier also allowed both the surgeon and the patient to see how the face would turn out in the end.\textsuperscript{490} Another sculptor who featured prominently in American facial reconstruction was Mary Elizabeth Cook. An artist from Columbus, Ohio, Cook worked at Fort McHenry and then at Columbus Barracks where she “deftly wielded the sculptor’s knives and chisel, making wax models and plaster casts” that the surgeons consulted as they re-made the men’s faces. Cook made hundreds of plaster casts and wax models in the war years. Her own words illustrated the work she did: “I endeavored to make my models to resemble the men as closely as possible until they were satisfied that the models resembled them before they were wounded. Then I made plaster casts of the men in their wounded condition, thus giving the surgeon two working models – one of each man as he was and one of his as he should be.” Cook often worked from pre-war photos. When she did not have

\textsuperscript{488} “Making Faces,” 20.
\textsuperscript{490} Martyn, “Woman Portrait Painter,” 15.
them, she consulted each wounded man, who guided her molding in accordance with what they could remember of their pre-war face.491

The rhetoric about plastic surgery emphasized miraculous transformations at the hands of the surgeons and artists at the hospital, which contributed to a celebrity-like status for the knife wielders. Articles conveyed to audiences that men were re-made as good as new. One author emphasized that surgeons were “molding broken humanity back again into the image of its Maker.”492 With modern surgical skill, the rhetoric implied, war wounds carried less weight because men could be re-made. The war, therefore, allowed surgeons to increase their standing in society, as aesthetic surgery gained importance as a field of medicine. Aesthetic surgery first appeared in the sixteenth century, partially as a response to facial disfigurement from syphilis. The field disappeared for a time until it gained importance again around the turn of the nineteenth century. Yet, by the turn of the twentieth century much of the surgery was rooted in the division between procedures meant to correct issues like breathing trouble, and “aesthetic” or beauty surgery, which was negatively connected to quack medicine because of its lack of therapeutic value.493 After completing nose and ear reconstructions, for example, German surgeon Jacques Joseph challenged the widespread resistance to aesthetic surgery with his 1898 argument that the psychological aspect of surgery was as important as its physical success, and a person whose looks caused social or economic harm suffered as much as a person with a life-altering disease.494 But aesthetic surgery ultimately benefitted from the Great War, however,

since the treatment of facial wounds through reconstructive surgery allowed practitioners to attach themselves to mainstream medical practice.

One means of enabling the public and the medical profession to visualize the importance of the growing field of aesthetic surgery – and by implication, rehabilitation – was to showcase the work that was done in the maxillofacial wards. In September 1919, the maxillofacial department at Jefferson Barracks invited curious civilians to see a public exhibit of casts, photographs, and drawings that depicted each stage of the facial reconstruction process. The public exhibit of facial wounds highlighted surgical progress and the importance of Army reconstruction. The article told readers that anyone who doubted what Uncle Sam was doing for the men should see the exhibit. Yet officials also were wary of an exhibit that could objectify the wounded men through the imagery. A newspaper, for example, wanted to publish photographs from the exhibit, but the commanding officer argued against it out of consideration for the patients’ feelings.Officials and newspaper outlets regulated the public nature of a very public wound in their quest to highlight the progress of modern surgery and the promises of making wounds invisible.

Many stories on American soldiers and facial wounds highlighted the heightened profile of plastic surgery, but also emphasized gendered anxieties related to the facial wound that mirrored other rhetoric about making good. Viola Fryday, for example, saw her partner Corporal Edgar Westlake leave for the front, where a piece of shell destroyed his nose. After he returned she was shocked at his appearance, to which he responded that he would not make her marry him with a face like that. Only after reconstruction did they marry. Another article cited a soldier

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496 “Exchanges Rib for Wife and New Nose: Soldier Disfigured by Wound Shocks His Fiancée,” The Sentinel, April 14, 1919, 1.
who joked that he had better luck getting girls with his new nose than with his original one. In the war years, white middle class physical beauty usually emphasized male faces with crisp angled lines, and faces were “often perceived as representing an individual’s ‘natural’ state.” Physical beauty, according to both mainstream advertising and messages about wounded soldiers, was important for finding love. But the articles also emphasized that as part of that love, it was the veterans’ responsibility to go through the rounds of often-painful surgery necessary to achieve the physical beauty.

Other articles emphasized the responsibility women had in helping men to make good, to stay with their loved ones after their facial disfigurement. Roy Canby’s story gained wide publicity in 1919. Canby returned from service with one side of his face scarred from mustard gas. Upon return, his girlfriend Gertrude left him, which led him to attempt suicide. She was fixated on the man she saw, that “when I see him I hate him” and she “won’t have a man whose face looks like it had been branded with a small waffle iron.” Gertrude also emphasized a change in personality, that when he returned he no longer loved to have fun and took life too seriously. Newspaper analyses of the situation overwhelmingly argued that Gertrude was in the wrong. Roy Canby, according to the articles, had been recognized as a hero. But his reward for everything “lies only in the love of a heartless girl who has jilted him because of his battle scars.” Gertrude, accordingly, lacked “everything that makes a woman fine and good and noble.” After facial disfigurement it was the man’s responsibility to utilize modern surgery for reconstruction and to

make public sight easier, but it was also women’s responsibility to stand by the man who sacrificed his appearance in war.

Gendered anxieties about facial disfigurement and the visibility of war wounds were particularly prevalent in Holworthy Hall’s 1919 novel *The Man Nobody Knew*. Hall introduced the public to Richard Morgan, a fictional American soldier who enlisted to fight in the French Foreign Legion during the Great War. Disaffected from his home of Syracuse, New York, and the woman there who broke off their engagement, Morgan fought in the war to prove his worth to society. He was reported dead, but instead he was facially disfigured, recuperating in a French hospital where nobody knew who he was. Despondent, he found hope after hearing that surgeons could make his face like the way it was before the war, as long as he provided a pre-war photograph of himself. Rather than lend a pre-war photograph, Morgan gave surgeons a postcard that depicted an attractive figure of Jesus. He obtained his new face and went home to re-claim his lost love.\(^{500}\)

One major theme of the novel was not only Richard Morgan’s physical reconstruction, but also his moral one. His pre-war life in Syracuse was troubled. He was careless and quick-tempered, and lived on the good reputation of his successful father.\(^{501}\) When Morgan arrived in France, he stripped himself of his former identity and took the name “Pierre Dutout,” as he hoped to start over and leave the life he detested in the past.\(^{502}\) After his wound, lying in the hospital bed, nobody knew his identity. He was known only as “the individual.”\(^{503}\) After Morgan emerged from surgery with his new face, which “suggested both the fire of immaturity, and the

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drain of experience” – possessing both qualities of youth and age – he began to call himself Henry Hilliard.⁵⁰⁴

Hilliard returned to Syracuse with a newfound fortune after he met a New York City capitalist who wanted to exploit the upstate city’s market. The capitalist recruited the attractive young man to help with his quest. Hilliard held onto part of Richard Morgan’s personality, however. He hoped that, if he helped the capitalist exploit his former city, he could get back at those who had treated him so poorly. But when he saw his former lover, Carol Durant, pieces of Richard Morgan fell away and he began to take on the personality of the new and facially improved Hilliard. He donated his newfound fortune to charity and then found himself “uplifted.”⁵⁰⁵ After weeks of forming a new relationship with Carol Durant, Hilliard finally came clean about his identity. Durant embraced Hilliard’s new loving personality and the two clung to their love for one another.⁵⁰⁶

*The Man Nobody Knew* reflected themes prevalent in other stories of facial disfigurement, and the emphasis many sources placed on the sense of sight in rehabilitation odysseys. Through his facial reconstruction, Henry Hilliard transformed his personality. He went from an immoral young man who did not work hard, to a man who embraced love and integrity. He made good. Rhetorical features such as this were replicated elsewhere, and reflected ideas central to Cesare Lombroso’s nineteenth-century theory of criminology, which linked physical appearance to deficient morality.⁵⁰⁷ Films such as *Skin Deep*, which was based on the life of a New York gangster in 1922 whose face was scarred by his crimes, served to further link facial

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⁵⁰⁶ Hall, *The Man Nobody Knew*.
⁵⁰⁷ Mary Gibson and Nicole Hahn Rafter, *Criminal Man* (Durham: Duke University Press, 2006); Kember, “Face Value,” 51.
disfigurement with morality.\textsuperscript{508} Therefore, \textit{The Man Nobody Knew} linked already-prevalent themes of visual appearance and morality to war wounds. In Hilliard’s – or Morgan’s – case, facial disfigurement from the war, and the subsequent surgery, gave him the opportunity to turn his life around from being a public drain to being an industrious and loving individual. Making good in this way was a central theme of postwar rehabilitation as a system.

\textit{The Man Nobody Knew} also reflected some of the themes present in articles about facially wounded veterans. Facial disfigurement related to gendered anxieties about relationships between men and women. Facialy wounded veterans such as Corporal Westlake and Roy Canby managed gendered anxieties about their mutilated faces about how love could continue despite the absence of facial markers of identity as they had been before the war. \textit{The Man Nobody Knew} mobilized these social anxieties into the form of a novel, as Hilliard’s saga to regain his lost love was one of the central components of his after-the-war story. In stories on facial disfigurement the wounding remained in the background. The war, and even the wound, was secondary. While the stories were about their new faces and what it enabled them to do, the wound story itself was displaced almost entirely from the text, and this diverted attention from criticism of war.

More explicitly, \textit{The Man Nobody Knew} also made plain for the public the promises of modern medicine to erase the devastating and visual wounds of modern war. Not only could Hilliard have his face restored in an almost uncomplicated way, he was even able to choose whatever face he wanted. The wonders of surgery, the story went, could make invisible the wounds of war that otherwise would have remained present for the public to see. Themes such as these were not isolated to fiction. One newspaper article that touted surgical techniques during the war argued, “Have you always been a little dissatisfied with the shape of your nose? Then, go to war for Uncle Sam, get it shot off, let his surgeons supply you with a new nose and have it

\textsuperscript{508} Kimber, “Face Value,” 51.
made to your liking. By the same process, if your chin isn’t all that is [sic] should be or the size of your mouth does not please you, you can have these features remodeled with about the same certainty that you can tear down part of your house and have it rebuilt to your specifications.509

Far from being a purposefully ironic appeal, stories like this – particularly in the immediate aftermath of the Great War – regularly inflated the benefits of modern surgery to correct facial disfigurement from war wounds to even pimples. For example, Dr. William Balsinger, a Chicago facial surgeon who had worked on disfigured veterans, promoted his surgical skill, and rode the wave of prestige granted to plastic surgery during the war years.510

Among other claims, he promised that “any woman can in a few minutes change her old complexion for a new one of startling beauty” by simply using his services.511 Balsinger also centered much of his work on plastic surgery of the nose. He promised to make “beauties out of ugly ducklings,” where an operation was as easy as “putting on a new suit of clothes.”512 In 1923 and 1924 Balsinger gained widespread attention for constructing a new ear for a wounded soldier who had his shot away in France.513

The sensational stories of Dr. William Balsinger’s medical exploits, as well as the lesser-known articles about maxillofacial work at places such as Walter Reed and in St. Louis, and even Hollworthy Hall’s The Man Nobody Knew sidestepped the wounds of war for the benefit of good stories. Readers did not have to confront what weapons did to human bodies. Civilians therefore did not see, for example, the many American men who returned with their faces permanently

513 “They Now Put Young Faces on Old People, Victoria Advocate, October 14, 1923, 6; “Veteran of World War Given Brand New Ear,” The Tipton Daily Tribune, February 16, 1924, 7.
scarred, such as Private James Berry, who was wounded in 1918 in the Argonne Forest. US Army doctors operated on him in St. Louis, but no amount of positive stories about modern medicine could make invisible the fact that almost half of his jaw had been ripped off.

Plastic surgery benefitted from the war in medical methods and public perception. The promises of erasure were important within the broader context of rehabilitation, a movement that sought to hide wounds and mobilize the senses of wounded soldiers to help them re-integrate into civilian life and make good. But the public also needed to rehabilitate, or move on from the war. For civilians, not seeing wounds allowed them to move beyond the turbulent war years as well. For the veteran, surgery promised to divert attention from his facial disfigurement. It promised to benefit all involved. Without visible wounds or continued physical and emotional suffering, the war need not be debated. Everyone, in the end, had made good.

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Conclusion: They Ache Just The Same

A poem titled, “Invisible Wounds,” appeared in the *Boston Post* on July 9, 1920, by Folger McKinsey. “Did you think that all wounds must be wounds you can see?” it asks. “There are wounds of the heart, that so hidden may be…” McKinsey’s poem focuses on invisible scars that men bore on their return from the Great War, and finished with, “They ache just the same as wounds that you see.” These words reflected the tensions that shaped Americans’ visual perceptions of wounds or war-related illnesses. Newspaper articles on the war conditioned many Americans to think about war-related disability something evident through sight. The dichotomy between patients with maxillofacial wounds and those with the various chronic and oftentimes invisible illnesses that stemmed from the First World War is stark. While medical officers did not necessarily rely solely on visual evidence in regulating patient treatment, an obvious wound such as an amputation made a patient’s process of obtaining medical treatment and making good more straightforward. Those veterans, after all, were not compelled to prove they were disabled.

Maxillofacial patients had among the most visible wounds of returning veterans. The wound was so visible that patients were shielded from the gaze of their fellow patients in different parts of the hospital. But they were not complicated wounds, the contemporary literature suggested, despite the highly intricate and painful healing processes. Because of modern science, the man could instead be re-made as good as before the war. This assumption reflected the public’s gaze on the veteran’s body as an important factor in rehabilitation. His disability was a visible and constant reminder of a politically uncomfortable war. In the postwar period when Americans sought a return to normalcy, modern medicine argued that it could give the public that return to normalcy in part by remaking men’s broken faces. Seeing war wounds

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was therefore problematic in society’s rehabilitation from war, or in their quest to make good by moving on.

While surgeons promised to make facial wounds invisible, Army physicians contended with the problem of the invisibly wounded or sick patient. Medical mobilization for facial wounds was relatively quick and decisive. Indecision and lack of services hampered the programs for arthritis, cardiovascular disease, and diabetes. In a period when modern medicine was growing and attempting to prove its worth to society and the state, failing to adequately treat soldier-patients with these ailments likely would not have been met with the same esteem toward the medical industry as the promise of Maxillofacial surgery. But the juxtaposition of the widespread publicity surrounding the promises of healing broken faces and the problems of treating and re-integrating chronically and invisibly ill or wounded patients is not dissimilar from the cultural production of uncomplicated blinded veterans, who were mobilized to motivate other disabled men to make good. In both instances, individuals, society, and the state regulated the sense of sight, and emphasized the visual markers of disability, or an assumed lack of disability, as a means of easing the transition from war to peace.

Conclusion

From October 2014 to February 2015, Manchester Art Gallery in the United Kingdom showcased an exhibit called, “The Sensory War” featuring prominent artists from the Great War such as CRW Nevinson, Paul Nash, and Otto Dix, and many others. It explored “how artists have communicated the impact of military conflict on the body, mind, environment and human senses between 1914 and 2014.”519 “The Sensory War” took the story of war and the senses into the twenty-first century, and demonstrated the lasting importance of the senses in wartime and healing, and the complex meanings the senses can convey in modern societies that often remain detached from war’s human consequences. In collaboration with “The Sensory War” exhibit, Ana Carden-Coyne, David Morris, and Tim Wilcox write, “The First World War involved a profound re-configuration of sensory experience and perception through the invention of devastating military technologies,” and “its legacy has continued and evolved through even more radical forms of destruction over the last hundred years.”520 If the Great War was the war that brought the world into the modern era of technological destruction, it also introduced new medical technologies, new ways of experiencing and understanding wounds through the senses, and new ways of attempting to make good through rehabilitation.

As thousands of wounded or sick American soldiers returned to the United States after the Great War, individual soldier-patients, the state, and society mobilized the senses as tools to regulate the meanings of war, its costs, and how the wounded and society could make good. Progressive Era ideas about social welfare made it the individual’s responsibility to readjust, or make good in postwar life. In the process, the senses became tools for healing. But healing often

meant different things to the individual soldier than it did to the state or society. And managing the meanings of disability and normality took shape during the years of the Great War through soldier-patient sensory experiences within hospitals.

When deaf veterans returned, military authorities politicized speech, and argued that successful rehabilitation entailed adhering to normative speech patterns. Veterans entered the US Army Section of Defects of Hearing and Speech, and trained in lip-reading. In the process they suppressed American Sign Language, which owed much to the success of the eugenic crusade to eliminate the outward signs of deafness in American society. There, too, speech therapists worked to treat non-normative speech patterns such as stutters, and therefore helped institutionalize critical ideas about communication within the military program. There, patients had little power in the top-down construction of their healing. To be healed meant to speak and understand clear spoken English.

Other patients in US Army rehabilitation relied on the sense of touch in order to re-integrate into postwar social roles. Feeling braille signaled a veteran’s transition between the wounded world and his new life as a blinded man. Other patients relied on touch for vocational training, which included feeling farm machinery and animals. But the sense of touch harbored far more indirect social cues as well. For many men who returned with a war wound, feeling engaged ideas of sexuality, as hospitals used dances to re-introduce men to gendered and sexualized atmospheres. But not all touch was positive. Medical staff often looked at men with venereal diseases in the genito-urinary wards with scorn, and attempted to limit their exposure to women and other men in the hospital. Touch, therefore, was a crucial site of medical power regulation after the war.
Touch and hearing were by no means the only senses that played a role in rehabilitation experiences. Throughout postwar hospitals, the sense of taste lent many patients the ability to control their circumstances and challenge the state over their care. Food quality was almost universally poor in the wards and dining rooms, due in part to lack of equipment and insufficiently trained personnel. In response, patients pressured the state, and held it accountable for their healing and overall experience in rehabilitation. Men also used ingestion to defy what many widely read publications promoted as the ideal and moral veteran. These men broke with hospital regulations to find and drink alcohol wherever they could. The sense of taste and the act of ingestion, therefore, allowed some degree of freedom within an imposing system of rehabilitation.

While hearing, touch, and taste emerged as tools of rehabilitation within hospitals, the sense of sight contributed to complex management of the meaning of rehabilitation between the soldier-patient and society outside the hospitals. Many blinded veterans returned from France with complex neurological and multi-sensory wounds. Despite this fact, cultural representations positioned blinded veterans with singular and uncomplicated wounds. Writers argued that these men had easily re-integrated back into society and made good through their own individual hard work, and the stories held them up as standards of success for other soldier-patients to emulate. Cultural representations politicized the images civilians and patients saw by displacing the wounds from the stories of war.

Sight took on other meanings as well. As thousands of soldiers returned from France, the state inadequately cared for many patients with invisible wounds or illnesses. Military medical planners argued that beds could not be reserved for diabetics, arthritics, or cardio-vascular patients as easy as they could for what they considered more legitimate, visible wounds. The
Army therefore placed sight, or the visibility of a particular war-related medical issue, in a central place in its medical planning. At the same time they struggled with the problem of invisible wounds and illnesses, the Army placed faith in the promise of making wounds invisible through modern plastic surgery. Soldiers who returned from war with their faces destroyed, as articles told the public, could expect their wounds to be erased and their faces made better than they were before the war. The postwar years included complex management of the politics of remembering war, and the visibility of war wounds. These are issues the United States faces in the wars of the twenty-first century as well.

On his second tour of duty in 2011 in Afghanistan, Brad Snyder stepped on an improvised explosive device (IED), and the explosion destroyed his sight. Following his wound, Snyder moved to Baltimore to train as a competitive swimmer at Loyola University, the site where blinded veterans of the Great War swam as part of their rehabilitation. Swimming gave men blinded in the war a way to use their senses, in the freedom of the pool, to move and exercise. 521 100 years later, Snyder’s entrance into the pool signals the timeless existence of sensory adaptation to the sensory wounds of war. Since his war wound, he has swam for the US Paralympic Team and won over ten medals, the first of which was nearly a year after his initial injury.

Bradley Snyder’s re-integration into postwar life as a blinded veteran in some ways mirrors his predecessors. He mobilized his senses, in the face of the loss of one of them, in some of the same ways. For example, just as the blinded veterans of 1918 were greeted with a tactile watch upon their arrival at Evergreen, Snyder, too, uses an accessible watch. “I love talking

about my watch,” he writes. “It’s a tactile timepiece that replaces traditional hour and minute hands with magnetic, rotating ball bearings so that blind folks like myself can literally tell the time through touch. It’s superbly designed and very sharp-looking, so it appeals to those with vision too.” Snyder also writes on the occasional feelings of isolation, due in part to society casting him as a spectacle or inspiration because of his disability and his accomplishments. But, he argues, “I’m not alone in being alone… Through talking, we find humanity.”

It was through talking that Snyder challenged prevailing ideas about overcoming his disability and making good in ways similar to ideas that emerged during and after the Great War. When ruminating about his successful swimming career, for example, Snyder argued, “My success in the Paralympics is not an example of how I ‘sprung back’ to my original form,” as many contemporaries had noted. “That’s because there is no such thing as an original form.” Snyder’s experiences, therefore, speak to the timelessness of war wounds, sensory adaptation, and even isolation in the aftermath of modern warfare that can often emerge from or be exacerbated by the social pressures of rehabilitation. The senses have long been tools in postwar journeys to “make good” along the lines born in the Great War. But veterans are usually active in constructing their own versions of what “making good” actually entails. Despite the news stories that have typically cast disabled veterans, including Snyder, as inspirational or overcoming barriers — depictions that have almost inevitably ignored the imagining of the wound — veterans have fought to shape their own experiences and have their voices heard. By investigating the acute meanings inscribed into the senses or into war wounds, or simply by listening, individuals and societies can better understand, and think critically about, the human costs of war.

524 Brad Snyder and Tom Sileo, Fire in My Eyes: An American Warrior’s Journey from Being Blinded on the Battlefield to Gold Medal Victory (Boston: Da Capo Press, 2016), 226.
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