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MILITARY SANITATION.

THE action of Mr. Brodrick and Sir Frederick Treves, in directing attention through the *Times* to the chronic and continuing inefficiency of our military medical system as a means of protecting armies in the field against disease, and to the contrast which it offers to that which has been brought into operation by our allies the Japanese, is of a kind which ought to be adequately supported alike in Parliament and by external public opinion. Mr. Brodrick rightly claims that, by reforms introduced under his administration, the Medical Department of the Army has been rescued from the unpopularity in the profession by which it was previously weighed down, and that it now attracts candidates of a high class, in numbers considerably exceeding the vacancies to be provided for. The expenditure on the Medical Vote, which in 1898 was £295,000, is now £490,000; the medical officers have risen from 832 to 1,002; and the Medical College will shortly be in full work for the instruction of officers. The "humanitarian problem of tending the sick and wounded has been faced; but the regulations of the British service as to disease prevention remain substantially what they were 100 years ago." Two diseases alone, dysentery and enteric fever, caused 74,000 admissions to hospital and 9,200 deaths in South Africa; and both these diseases are in medical opinion largely preventible by a system which would provide for the isolation of those affected, by a scientific system of excreta disposal, and a satisfactory water supply. The difficulty of obtaining these things, according to Mr. Brodrick, depends upon the fact that the army surgeon, although a health officer, has no sanitary staff. He is responsible, but he can give no orders. He can only act through a commanding officer, often junior to him, who has no technical knowledge. The remedy suggested is that the combatant officers should be taught, and taught by the medical officers, "the elements of military hygiene"; and that every cadet at Sandhurst or Woolwich should be examined on passing out "in a problem which he could grasp as easily as tactics or strategy." In other words Mr. Brodrick proposes to replace the existing ignorance of the combatant officers by the self-conceit of

smatterers, and to afflict the unfortunate army surgeon with colleagues or superiors who, instead of merely ignoring his recommendations, as they do at present, would fancy themselves qualified to criticise them.

Sir Frederick Treves, as might be expected from his professional knowledge, while he agrees with Mr. Brodrick as to the vital importance of the problem, takes quite a different view of the manner in which alone it could be solved. He sees clearly that the first thing needful is to place the Medical Department in a position to enforce its recommendations, and that the next is to give sufficient instruction to the fighting elements to enable them intelligently to second the efforts made for their preservation. He quotes with approval Surgeon-Major Seaman's statement that "Japan organised her medical department on broad generous lines, and gave its representatives the rank and power their great responsibilities merit, recognising that they had to deal with a foe that kills 80 per cent. of the total mortality. She even had the temerity (strange as it may seem to an English or American Army official) to grade her medical men as high as the officers of the line who combat the enemy that kills only 20 per cent." Sir Frederick goes on to mention the reforms which seem to him to be necessary; and his description of them affords an amusing contrast to Mr. Brodrick's proposal to inflict sanitary instruction on the already hard-worked cadets at Woolwich and Sandhurst. He declares that the head of the Army Medical Department should be a medical man, and not, as at present, the Adjutant-General; and that the Director-General should be responsible for the efficiency and economical administration of the department in all its branches, with control of the money voted for the medical service. Next, and manifestly most important of all, that the Army medical officer should be vested with such authority and provided with such *personnel* as will enable him to carry out those sanitary arrangements in the field which experience has proved to be absolutely essential to secure the minimum loss of life from disease. Last of all, he asks that the combatant officer should have as a part of his qualifications some knowledge of hygiene as applied to campaigning and barrack

life; and that a like knowledge, of a more elementary character, should be possessed by the private soldier.

It is impossible to read these communications, and still more impossible to read them between the lines, without perceiving that the difficulties to which they point have their origin in the same condition to which Dr. Johnson once imputed a mistake of his own—that is to say, “pure ignorance.” The class of people who furnish members of Parliament, and officers of State, and “combatant” officers of the Army, have grown up, generally speaking, in an atmosphere from which all effective knowledge of physical science has been excluded, and in which questions regarded as debatable have been usually settled by some form of compromise. They would probably admit that the 74,000 admissions to hospital and the 9,200 deaths from preventable disease in South Africa were to be regretted; and they would plead, with helpless imbecility, that the re-

commendations of the Medical Department had been carried out to some extent, and as far as was compatible with the traditions of the service, or with the views of a regimental commanding officer who regarded sanitary precautions as “sheer nonsense.” It is here, indeed, that we have the crux of the whole question. It is not sufficient that there should be, somewhere in a subordinate branch of the Army, the knowledge by which epidemics of disease can be prevented; but this knowledge, in order to render it effective, must be placed in a position of authority, such that its depositaries are able to enforce the observance of the precautions which they recommend. This, and nothing less than this, is what has been done by Japan; it has been done effectively in campaigns of previously unexampled magnitude, and has been not only compatible with, but largely contributory to, the attainment of military successes to which no parallels can be found in history.

LOCAL ANÆSTHESIA IN GENERAL SURGERY.

THE subject of local anæsthesia in general surgery has not attracted much attention in England, although a few surgeons have advocated its advantages very strongly. The reason is not far to seek, at any rate in London, where there exists a group of trained men who are skilful anæsthetists, and devote their entire time to the administration of anæsthetics. In the Latin countries it has not hitherto been found possible to obtain the services of special anæsthetists, and the value of the skilled production of insensibility during a surgical operation is not yet sufficiently appreciated by the public to make it possible for medical men to specialise in this branch. It happens, therefore, that in Great Britain most of the junior members of the profession have been taught the method of producing general anæsthesia, and are not afraid of administering gas, ether, and chloroform, whilst in France, in Spain, in Portugal, and in Italy local anæsthesia has come into very considerable use.

Dr. Struthers, of Edinburgh, has recently published a very valuable, interesting, and well written book entitled “Notes on Local Anæsthesia in General Surgery,” showing that we have erred in adhering too exclusively to general anæsthesia in many cases where shock, discomfort, and even danger might have been avoided by resorting to cocaine, eucaine, or stovaine. Opinions differ widely, as he points out, concerning the extent to which local anæsthesia may be employed legitimately in the interests of the patient. Some require a general anæsthetic even for the most trivial operations; others prefer local anæsthesia, for they dread

the chloroform more than the operation. Speaking generally, it may be said that the operations, which may be done suitably under local anæsthesia, are those in which the field of operation is comparatively limited and superficial, and in which its limits can be outlined with tolerable certainty before the operation is begun. Operations in deeply seated tissues, on tumours, etc., of uncertain extent and wide attachments are unsuitable for local anæsthesia, and if it is used in such cases a not uncommon result is the infliction of severe pain on the patient or the performance of an incomplete, and therefore bad, operation. In estimating the possibilities attending the use of local anæsthesia, too, it must be borne in mind that the sensibility of the tissues in the body varies greatly. The subcutaneous fat, muscles, tendons, and fasciæ are very much less sensitive to pain than the skin, and are in fact almost insensitive. Periosteum is highly sensitive, but bone denuded of periosteum is insensitive, so that ribs bared of periosteum may be painlessly excised in operating for empyema, and exostoses may be chiselled off when the periosteum has been rendered analgesic by a cocaine-adrenaline solution.

The methods of producing local anæsthesia, whether by infiltration, by regional, or by spinal anæsthesia, are by no means perfect. They are attended by some grave disadvantages, as is very frankly pointed out by Dr. Struthers, and they have some dangers peculiar to themselves. They are only applicable to certain cases, but Dr. Struthers makes out a good case of their use, and gives in detail the precautions which must be taken to obtain the best results.