Hence exercising the joint towards *full* extension is less satisfactory than maintaining it as still as possible in *slight* extension.

Support

A Plaster Jacket.—This is a method in great vogue at the moment, but I believe it is seldom worth the discomfort it entails. It is usually employed wrongly—that is, in the hope of securing reduction rather than of maintaining it. It is a mistaken policy to put a patient with an annular protrusion into plaster, for I have reduced such displacements by one manipulation after as long as six months' vain immobilization. By contrast, pulpy herniations do sometimes reduce themselves slowly in plaster, but these are the simple ones that do so much more quickly when treated by sustained traction or recumbency. The results of treating sciatica with and without a plaster jacket do not appear significantly different. It is a palliative measure useful for relieving acute symptoms. Moreover, I have found that patients with gall-stones, peptic ulcer, or merely prone to indigestion usually cannot tolerate plaster; neurasthenic patients with disk lesions demand the removal of the cast within a few days. It is thus only in the exceptional case that plaster is required. One untenable reason for immobilization has been expressed: that rest in plaster allows the broken cartilage to unite. Intra-articular cartilage has no blood supply, therefore it cannot heal at a spinal joint any more than at the knee-joint. The real indication for a plaster jacket is—as for a fracture—the maintenance of reduction in cases of marked instability until a bespoke corset is ready. If a good corset cannot be obtained in a few days, and the patient keeps having recurrences, a plaster jacket may be kept on until the corset is ready.

A Corset.—Whereas a plaster jacket cannot be worn for longer than some months, and thus cannot provide lasting protection against recurrence, corsets, renewed each year or two, can be worn indefinitely, thus affording permanent security. If the two steels are accurately moulded to the lumbar curve, lordosis is maintained and the joints steadied. Moreover, if the patient bends too far forwards or sags as he sits, the front of the corset presses unpleasantly against his lower ribs—a salutary reminder.

Repeated crippling attacks of internal derangement, in spite of adequate precautions once more raise the question of laminectomy.

Figs. 3 and 4, which appeared originally in the author's book *Osteopathy and Manipulation*, are reproduced by kind permission of the publishers, Messrs. Crosby Lockwood and Sons, Ltd.

The total number of administrations of analgesia given by midwives in the domiciliary midwifery service in London during the first six months of the present year was 4,929, or 66% of all the confinements which the midwives attended. This applies to all classes of midwives, those of the L.C.C. and of the District Nursing Association and the hospital district midwives. It is stated that the opportunity of receiving analgesia is given in all cases. The confinements where it is not recorded as having been administered consist mainly of those attended by doctors (concerning which no information is available of the analgesia or anaesthetic administered), women who do not wish to receive analgesia, women who are medically unfit for its administration, and confinements where labour is precipitate. All the 123 L.C.C. midwives, the 30 midwives employed by district nursing associations, and the 84 employed by hospitals on district work are qualified to administer analgesia. The percentage of confinements in which analgesia is administered has risen steadily. For L.C.C. midwives alone, the percentage of confinements in which analgesia was administered was 34 in 1948, and 68 in the first six months of 1950.

MARS AND AESCULAPIUS

A NEW ZEALAND MEMORIAL ORATION

BY

Sir ARTHUR PORRITT, M.Ch., F.R.C.S.

[During his recent visit to New Zealand, his native country, Sir Arthur Porritt delivered an oration at the biennial meeting of the New Zealand Branch of the British Medical Association. The oration was the first to be given in memory of members of the New Zealand Medical Corps who lost their lives in the two world wars. We print below an abridged version of an address which must have given special pleasure to its audience.]

This address must perforce to some extent be personal, but it is my aim to draw from these personal reminiscences deductions which may help to provide such practical and constructive answers to some of our national, professional, and individual problems as one feels would have been endorsed by those whom we are remembering to-day. In the main they were not dramatic heroes, they were not military geniuses, nor were they giants of the medical and scientific world. They were good New Zealanders, good doctors, and our friends, welded together in an inflexible purpose by the furnace of war.

Hence my title—Mars, the god of war, and Aesculapius, the god of medicine. Mars was always represented as a powerful, eager, virile youth (not the helmeted blood-stained brute of modern cartoons), and Aesculapius as an old bearded man, slightly bent, and leaning on a staff around which was entwined a serpent, the emblem of wisdom. The legendary end of Aesculapius is sad and yet prophetic. As a result of a complaint laid by Pluto that mortals were dying too slowly (presumably thanks to the good offices of Aesculapius), and that therefore Hades was being depopulated, Zeus slew him with a thunderbolt. It is comforting to remember, however, that, at the request of Apollo, Zeus subsequently placed Aesculapius amongst the stars for ever and ever, thus symbolizing medicine in perpetuity. . . .

It is from two angles, therefore, that I wish to speak of those of our friends who have gone on—as New Zealanders and as doctors—broadly, though not entirely, in relation to the two cataclysms through which most of us have passed during the last few decades. When one thinks of these last fifty years—Edwardian comfort and complacency, the rude awakening of 1914–18, the spurious artificial prosperity and depression of the inter-war period, the second holocaust, and the years of inevitable reaction, with the stark realities of moral and economic failure lurking just round the corner—is it any wonder that those who have lived five generations in one should feel some measure of instability, should find it difficult to assess their values, should perhaps feel older than their age, and should search consciously or unconsciously for some firm rock of faith to which to cling?

I feel that those we honour to-day had found such a rock. They were New Zealanders. Let us not shut our eyes to the fact that with a short history of little more than one hundred years we have a great tradition. . . . In this young country few of us have got beyond the third generation of New Zealanders, but our grandfathers and fathers were of rugged stock—independent, God-fearing, self-reliant—the real pioneers. Their legacy of virility and stout-hearted adventure has been intensified by the lovely country of our birth. . . . Most of us know far too little of this country of ours—its history, its economic assets, its

development, its wealth of beauty in scenery and flowers and birds. It should be impressed on every New Zealand child that so far as his circumstances allow he should aim to know his own country inside out before he travels from its shores.

The New Zealand Soldier

[Sir Arthur Porritt went on to speak of three groups of New Zealanders who had helped to put the country "on the map" during the last 30 or 40 years—the New Zealand Divisions in two world wars, New Zealand athletes and sportsmen, and certain noteworthy individuals, such as Lord Rutherford in science, Sir William Marris in diplomacy, and Sir Harold Gillies and Sir Archibald McIndoe in medicine. Of the New Zealand soldier he said:]

New Zealand had produced some doughty fighters in the Boer war, but it was the 1914–18 war which first really brought them to the fore as a national military entity. Their deeds of derring-do in the Middle East, in Gallipoli, in France, carried out with a dash which would have been almost bravado had they not been accompanied by a steely discipline and precision such as might have been expected more from seasoned regulars than from casual volunteers, their morale, comradeship, and friendship became by-words in the British armies. Their record has proved to be one which even another and greater war and thirty intervening years have not dimmed in perspective.

[Here, before passing to some personal reminiscences of the Second New Zealand Division, Sir Arthur Porritt mentioned that one of the original band who went with the First Expeditionary Force to Samoa in 1914 and ultimately returned to New Zealand in 1919—a doctor and a soldier—was to his great delight present on this occasion: the orator's father (Dr. E. E. Porritt, F.R.C.S., of Wanganui, N.Z.).]

During two years' service with the British Army in the Middle East in 1941–2 I personally saw much of the Second New Zealand Division from a medical angle. The medical officers of that division and its attendant military hospitals were my contemporaries and friends of Otago days. I do not think there was a New Zealand hospital in the Middle East that I did not find excuse to visit at some time during that period.

At work in a British unit and generally unrecognized as a New Zealander, it was a great joy to me to hear the constant and repeated praise of the New Zealand Division, not only as a fighting force but as individuals. . . . It was always a great delight to me to have New Zealand patients in the six to seven hundred—sometimes a thousand—surgical beds of my division, and I like to think that to those patients it was a consolation to find a New Zealander in charge. At one time after Greece and Crete we had well over 500 New Zealanders in at the same time. Nor did the liaison stop there. One of my best surgical specialists was a New Zealander, and so was the British consulting surgeon to the Middle East—a well-known character to most of you—General "Jock" Monro. I feel it is not my province to trace that historical pilgrimage from Alamein to Tripoli, to Sicily, and on to Italy in detail, but I should be lacking in my bounden duty if I did not underline the enormously stimulating effect the New Zealand Division obtained from its quite unique leadership. Here was a New Zealander of New Zealanders, whose inspiring personal example, apart altogether from his military genius, was almost enough by itself to ensure the success of any formation. As a soldier, as a sportsman, as an individual, Sir Bernard Freyberg has certainly done his fair share in putting New Zealand "on the map."

[After referring to the popular welcome of the New Zealand soldier in the home country, Sir Arthur Porritt mentioned the sportsmen and athletes of New Zealand. New Zealand had

just had the honour of staging the first post-war and "biggest ever" Empire Games, which had been an unparalleled success.]

Here in the development of a thousand friendships through a common interest in sport lies one strengthened link in the chain of the Empire. Furthermore, to those of us who are doctors these games should embody the ideal of national physical fitness. In New Zealand the standard is already high. Let us strive not only to maintain but to raise it. A life without health is less than a life, a nation without health is at best second-best, an empire without health is on the way out. The future of medicine undoubtedly lies not in curing diseases but in maintaining health.

[In mentioning some New Zealand achievements in sport he spoke of the exploits of Jack Lovelock—"an Aesculapian like ourselves." "I can see him now in that gigantic stadium in Berlin . . . a seeming pygmy among giants, but with superb track sense and an inflexible determination to succeed, run the best eight milers off their feet to register New Zealand's first athletic Olympic victory in record time."]

Expatriate New Zealanders

[Reference to some famous New Zealanders in the world of affairs brought him to one controversial point which should not be glossed over.]

They are all expatriate New Zealanders. How does it come about that their great work has been done elsewhere? In many cases it is sheer force of circumstances; in others the lack of facilities sufficient to allow them adequately to exhibit their skill and ability to the full. In neither of these eventualities need New Zealand accept any blame, for blame there is none, on either side. Nor need she bemoan her loss, for such men do infinitely more to enhance her prestige in the world at large by remaining outside her shores than, with the inevitably limited facilities available, by staying in New Zealand.

Let us admit frankly, however, that this by no means answers the whole question, and it would seem a matter of no small importance in New Zealand's present stage of development to restrict to a very definite minimum this export of brains she badly needs. This is a matter for politicians, educationalists, and industrialists alike. Too many good young New Zealanders in varied fields of activity go or are sent abroad to widen their experience and extend their knowledge, and, having done so, find to their great disappointment that New Zealand makes no attempt to encourage their return, and that if they do come back reasonable opportunities are unobtainable. This state of affairs can and should be remedied. Spending of money—even State money—on worthy objects can often in the long run be an economy, and what more worthy object than a young New Zealander specially trained in his own particular sphere who wishes to devote his talents to his own country?

[He then spoke of New Zealand doctors, nearly all of them, like himself, graduates of Otago University.]

New Zealand graduates in pre-war days were accepted at face value—known to be well-trained, skilful doctors. They still are, but not perhaps to quite the same extent. Reasons for this lie on both sides of the world. Within the limits of the clinical material available a New Zealand graduate can bear comparison with the best, and probably win. Such were the doctors with whom the New Zealand Division was blessed. Add to their professional background the possibilities of a wide experience of travel and of the closer co-operation and opportunities for friendship and understanding which come automatically with military service, and you will appreciate what a chosen band they were.

Under their very eyes, through their own hands, the stimulus of war was being applied to medicine. Mars, with one hand reaping that terrible harvest of human lives, was with the other prodding Aesculapius along to prodigious feats. Just as the first world war established orthopaedic surgery as an entity, so has the second opened up vast possibilities in the surgery of the chest, of the brain, of the blood vessels. Three handmaidens of surgery contributing to this result are the dramatic improvement in anaesthetic methods, the immensely increased use of the life-saving blood transfusion, and the advent of first the sulphonamide drugs and then penicillin and the antibiotics. Many of us came to divide our medical war into three stages—the pre-sulphonamide, the sulphonamide, and the penicillin.

In the first, the stage of the B.E.F. in France in 1939–40, sepsis in war wounds and septicaemia were still rife; in the second, the stage of the Middle East campaigns, the sulphonamides had to a very large extent prevented generalized infections, but every local wound was potentially if not actually septic; in the third, the stage of Normandy, of Italy, of the Far East, penicillin made septic wounds the exception rather than the rule.

[The orator described other wartime advances in medicine—the advent of drugs which had almost abolished dysentery and typhoid in armies fighting in hot climates; the improvement of mechanization whereby surgery was gradually taken right forward to the wounded man in small units; the arrival of the nursing sister in these forward surgical units, bringing with her that human touch essential to preserve the flickering flame of life in severely wounded men.]

The Service Doctor

But it was not only in these direct ways that stimulus and interest came to the Service doctor. More than ever before he became invaluable as a “back-room boy,” studying and elucidating problems which had a great if incalculable effect upon many of the major campaigns. By this I mean such problems as the efficient protection of life and limb in tanks and armoured vehicles; the variety of food and clothing to provide the correct level of sustenance and cover in a dozen different climates; the study of remedies to prevent sea-sickness in assault landings; the investigation of effects of variation in atmospheric pressure and speed on pilots and submarine personnel; and many other fascinating problems in which it was found that clinical knowledge, physiological data, and scientific fact were of prime importance.

Just one other point perhaps remains to be considered. In the war we were working in a regimented State-controlled service. Were the results efficient? Were the personnel satisfied and happy in their work? In all fairness the answers must be, by and large, that they were. Why, then, does a civilian State service go so largely against the grain?

Admittedly the circumstances are different. However much we would like it to be so in these difficult times of peace, we know that the sense of urgency to achieve cohesion of purpose at any personal sacrifice is not of anything like the same potency. Let us remember, too, that in the Services both doctor and patient were being clothed, fed, transported, and generally cared for free of individual cost. Let us not forget that in all medical services it was only when the cast-iron bureaucracy of administration, excellent as it admittedly was, had been made reasonably malleable by the unquenchable clinical flame of those large numbers of our professional colleagues temporarily under arms that a really co-ordinated and

efficient service resulted. There were many hard lessons learned on both sides, but it was worth it. No machinery, however good, will run a profession. The economic as well as the efficient administration of any medical service depends upon its ability to encompass the personal idiosyncrasies of both patient and doctor within reasonable limits. Because the profession, being doctors, realized the many difficulties of achieving this end, they would appear to have lost the “kudos” for the conception of a comprehensive medical service for all; but it was a medical idea and ideal long before it became one of the more important planks in a political platform.

What the ideal State medical service should achieve is that no individual is denied the facilities medicine has to offer. By “facilities” I mean institutions—hospitals, sanatoria, health centres—also instruments and drugs. These are the inanimate objects that can be nationalized to the great advantage of all, particularly if good medical advice is taken on how it should be done. It is not the idea of the State schemes which is at fault; it is the precipitate, relatively thoughtless implementation of them that has led to so many unfortunate complications. . . .

I believe strongly that there is a great deal of good in most of these schemes, but such good will be watered down just to the extent to which any particular scheme inhibits the incentive, the initiative, or the independence of either partner—the doctor or the patient. It is not the politician of to-day who will suffer from an ill-conceived scheme, but the patient of the future. Such a possibility we, as medical men, must prevent at all costs. As a profession, from the very nature of our work we are, and have proved ourselves to be, poor hands at producing a united and concerted effort. A man who, night and day, is facing up to the responsibility of dealing with the individual physical and psychological problems of his fellow men is, generally speaking, not adept at formulating overall plans to cope even with a large series of circumstances and conditions, and far less a large series of people.

But at least each of us can take out of the back cupboard his moral values and see to what extent they allow him to support this scheme or part of a scheme or strongly oppose another. I am sure that we all now have to make this individual effort if we are to ensure the best treatment for our present and future patients, safeguard a generation of the profession still unborn, and be as good doctors as God and Otago University may make us. . . .

[Reverting, as he concluded, to his main theme, a tribute to the men of the N.Z.M.C. who lost their lives in war, Sir Arthur Porritt said:]

Time in his comforting and effortless way is steadily deadening that sense of personal and professional loss we felt when these good men departed. He has pushed Mars back—well back, we trust—into the shadows of the past, but he has led out a rejuvenated Aesculapius into the limelight—one might say the floodlight—of to-day and the future.

The second annual report of the Scottish Society of the History of Medicine says that an increasing number of North of England members are being enrolled. Three meetings were held during the year: a discussion on the teaching of the history of medicine; a paper on the history of British dentistry since 1685; and a full day devoted to papers by two distinguished American visitors on the history of Johns Hopkins University and on the life and work of John Morgan, founder of the first medical school in America (Philadelphia, 1765), followed by a pilgrimage to places of medical interest round Edinburgh.