muscle itself that was affected. Acute osteomyelitis was not the cause as the bone was not involved in any of the cases. The condition described as acute suppurative myositis was thought unlikely because of the absence of prodromal symptoms, the failure to find any causative organisms, and it seemed beyond the realm of possibility that we should have six cases of such a rare disease. It was only when the last three cases were admitted in quick succession that we became suspicious that a noxious agent might have been injected. With this in mind the patients were carefully questioned. They were all new recruits and three of them made statements that another soldier had told them that he could prevent them from going to Egypt by injecting their muscles, and that they must report to the hospital the next day with a feasible story.

At the court-martial that followed two of the patients stated that the substance injected was crude paraffin; the third professed ignorance and the prisoner innocence. As one of the patients stated that he was drunk while the injection was being made, proof was only forthcoming on two out of the three charges, and the sentence was six months' imprisonment and ignominious discharge from the service.

The cases were of interest not only from the problem of diagnosis, but also because they show the severe toxic effects of the injection of crude paraffin leading to muscle necrosis.

My thanks are due to Dr. M. Alms, F.R.C.S., Orthopaedic Surgeon, for his great assistance in treating the patients; to Dr. F. Darne, F.R.C.S., and Captain E. R. Huehns, R.A.M.C., for helpful advice and criticism; and to Major R. W. Doy, R.A.M.C., Officer Commanding, Station Hospital, Mauritius, for permission to publish the cases.

SOME THOUGHTS ON THE RECRUITMENT OF MEDICAL OFFICERS

BY

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Royal Army Medical Corps

At a time when things do not seem to be going too well for the Corps, many people within it must be wondering what are the causes and remedies, and it is not unlikely that a number are debating the question of quitting or staying on in the hope that our more obvious deficiencies will be made good.

Of equal or greater importance to the problem of attracting recruits is the one of satisfying those already in the Corps; the snags of a service career are
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not fully appreciated by the former on joining and therefore any noted by the latter should be eliminated where possible for the benefit of posterity. Unfortunately, the vast majority of improvements which could be carried out are beyond Corps control, but they are discussed as their introduction is considered necessary and urgent:

1. Hospitals.—The need for the replacement of our temporary and outdated permanent hospitals is so obvious and well known that it hardly requires mention. Yet in spite of the rearmament programmes of two World Wars, not a single permanent hospital was built in Great Britain. Let us hope that the current rearmament programme will produce some permanent hospitals and not just a series of plans for their construction. The temporary type of hospital, e.g., Waringfield, however well run, is so unsatisfactory in design and structure that a short spell of service in one of them helps the N.S. officer to make up his mind very quickly that the Corps is no place for him to spend a career; to expect him to think otherwise is tantamount to asking him to accept a lower standard of working conditions than has been his wont. It is appreciated that the N.H.S. also has need of new construction, but their problems are not the same as ours—in particular they do not suffer from a shortage of recruits.

2. Pay.—It is difficult to understand why R.A.M.C. pay rates should be so closely related to those of the infantry and other arms. The cost of medical education, now extending over a period of almost seven years, has to be considered along with the free eighteen months’ training period of Sandhurst cadets who actually receive pay while undergoing training. In the United States Army regular medical and dental officers receive 100 dollars (£35) per month over the basic pay and allowances, the latter being tax free. Recently a Senatorial sub-committee was appointed to consider the necessity for continuing this policy, and it was interesting to note that one member of the Armed Forces Medical Policy Council stated in evidence that the additional 100 were necessary as a matter of equity and not simply as a recruitment inducement; he added that although sixteen years had elapsed since he qualified as a doctor, he was still paying back a sum of $35 per month to defray the debt he incurred for his medical training; many people must be similarly placed in Britain today. It has also been estimated that were two individuals to embark on a career in the U.S. Army, one as a doctor and the other as an infantry officer, the latter would have received about $40,000 more than the former by the time thirty years had elapsed since they began their respective trainings, assuming that each had drawn only the basic pay and allowances appropriate to their rank and service. It was on the basis of this argument that the figure of $100 was decided upon.

Great discrepancies exist between our pay rates and those of the N.H.S., and these have been further accentuated by virtue of the recent Danckwerts Award. Furthermore, our more senior specialists have no opportunity of receiving a Merit Award, which places them in a most invidious position vis-a-vis their civilian colleagues; the result is that a Brigadier grosses less than
half that of a civilian specialist who draws a maximum Merit Award. It is not to be wondered at when the younger specialists leave the Corps, although there are other reasons why they should. In these difficult times it is considered that our pay rates should slightly exceed those prevailing in the N.H.S. in both general and specialist categories. The highest bidder is undoubtedly going to come off best; in these days people have to be paid to take risks and to swallow or sublimate the inconveniences of a service career. Risk-taking is just not encouraged in this era of over-insurance.

3. Allowances.—Until very recently R.A.M.C. officers were specifically excluded from the regulation permitting officers with Staff College qualifications to receive Qualification Pay. For a Lieutenant-Colonel, R.A.M.C., to be able to draw Entertainment Allowance he must command a hospital of not less than 400 beds, plus the staff to run them, i.e., about 600 all ranks or more, as a minimum. An infantry or other combatant officer of the same rank requires to command only 400 all ranks. The R.A.M.C. officer has therefore to command 50 per cent. more troops to qualify for this allowance. Clearly he is being discriminated against, as he was for many years in the matter of Qualification Pay. It would appear that officers in command of any hospital or field unit should receive Entertainment Allowance, as entertainment plays an important part in the smooth running of a unit, especially if it is located in a remote place and if Q.A.R.A.N.C. officers are on the strength. Personal entertainment by the Commanding Officer and his wife cannot be replaced by Mess entertainment entirely.

4. Pensions.—The U.S. Army gives retired officers retired pay at the rate of 2\frac{1}{2} per cent. per year of service for twenty years or over, calculated at the highest substantive rank attained. An officer retiring after thirty years’ service therefore draws 30 \times 2\frac{1}{2} or 75 per cent. of the basic pay rate of the rank attained. This is much more generous than the terms offered to us. It is also interesting to note that in the event of death while serving, a sum of $10,000 is paid to the dependant in addition to a widow’s pension. Some form of insurance has been talked about for many years, on a similar basis, and is surely clearly indicated. Both widows’ pensions and officers’ retired pay are in urgent need of a boost, and after this has been done it would appear reasonable to relate them to the cost of living index.

5. Specialists.—One of the more evident shortcomings of our present organization is the necessity for a large number of specialists to give up practising their art at their prime in order to take up administrative appointments, just at the time when they are rendering their maximum therapeutic good to the community. A metaphorical pistol is gently held at the head and the words “Administer or retire” are uttered. Many foresee this untimely end to their professional careers, and retire earlier rather than later so that they can gain a foothold in the N.H.S. while still young enough to do so. This is without doubt a gross waste of highly trained and experienced medical personnel.
The solution is therefore to offer a thirty-year career as a specialist so that he can attain at least the rank of full colonel by time promotion and perhaps selection for higher consultant vacancies. Many people must fight shy at the thought of the possibility of a sudden end to their professional careers in the R.A.M.C. and so choose something different. It is appreciated that in time of war anyone with Regular Army experience must be expected to do administrative tasks, but surely this could largely be avoided in peace time if certain changes were made. One such change could be the adoption of a different conception of the method of filling appointments. In short, our present system dictates that an officer must hold a certain rank to hold a certain administrative (or some other) appointment. Tradition dictates that the A.D.M.S. of a Division or Armoured Division must be a Colonel. It might solve many problems at little inconvenience to others if he could be a Lieutenant-Colonel, Colonel or Brigadier, depending on who was available. This might be extended up and down the chain of command in the field and in all static headquarters and units. By this means, as the choice of administrative officers for a certain appointment would be wider, the call on specialists for such appointments should be reduced. It might be argued that this would cause inconvenience to other arms and services; this might be so, but R.A.M.C. officers have to be treated differently in any case on account of their status under the Geneva Convention, so other small differences are of no account.

Another suggestion is that a representative committee should be appointed to review all specialties with a view to determining whether their current status and size are appropriate to present-day requirements. It is felt that all specialties should now be of equal status and offer equal opportunity for advancement as far as possible; also it may be that certain specialties are overloaded and that too much emphasis is being laid on them, to the detriment of others. Denial of equal opportunity, within normal military limits, can only lead to discontent and many retirements.

6. Temporary Promotion.—The present wholesale distribution of temporary rank has largely jeopardized the time-proven system of advancement by time and selection as in pre-war days. If this is allowed to continue many officers will spend the majority of their careers in one or more ranks above their substantive ranks. Under the current system, an officer may be faced with the unpleasant fact that his juniors, because they have backed the right horse, and as a result have acquired temporary rank, may be financially, socially and domestically better off, not because he himself is less able, but because he has taken up an essential but less remunerative type of work in the Corps. Also as temporary rank may, under certain circumstances, count towards retired pay in that rank, it may confer not only temporary but also permanent advantages. Furthermore, the frequency of its distribution could well be used by the Treasury as a reason for not raising Corps pay rates. It is considered that much temporary rank could be dispensed with in the Corps and that this step would lead to a much more stable organization. The surrender of temporary
promotion could be used as a powerful bargaining weapon for attaining substantial pay increases.

7. Dependants.—The variety of clinical material seen in our hospitals in the United Kingdom generally bears a poor comparison in experience value with that found in civil hospitals, owing to the fact that the vast majority of patients are of a narrow age group and of the male sex. The result is that specialists in our hospitals are naturally limited in their scope, with few exceptions. This, however, could be put right by the Government’s effecting a change in legislation to permit service dependants of any age or relationship and also retired personnel and their dependants to receive both in- and out-patient treatment as available from military resources, as is done in the U.S.A. It is interesting to note that at the Walter Reed Hospital, Washington, in 1951, four-fifths of all out-patient attendances were by civilians, i.e., mostly dependants, and of all patients admitted for treatment, almost exactly half were infants, other dependants or those in retired status. The U.S. military hospitals are now in a position to offer to their doctors quite as good experience in any branch of medicine as can be obtained outside, and this, together with their extensive training programmes for interns and residents, is helping to solve the recruitment problem.

8. Employment of Civilians.—In pre-war days R.A.M.C. tradesmen were usually men of relatively long engagement and in consequence acquired much experience in their work. Today the vast majority are N.S., and in the short time available cannot be expected to attain the same standards of learning or technique. Standards have fallen considerably in many ways since the war, and although certain medical standards are unlikely to be raised or even maintained without many additional Regular officers, it is felt that many technical and non-medical standards could be rapidly raised to a safe and economic level by the replacement by civilians of the majority of clerks, mess staff, cooks, cleaners, X-ray and other technicians, in all static units. This would, in addition, ensure continuity. The cost of such a scheme would probably be little or no more that at present when one considers that a private soldier costs about £300 per year all found. A further advantage would be that general duty orderlies attached for training in the various departments would have the benefit of receiving tuition from better qualified teachers.

9. Equipment.—If the highest standards are to be aimed at and attained, this can only be done by the provision of such medical equipment as is considered necessary by the specialists who use it, within reasonable limits. Such equipment must include such items as the dictaphone into which reports can be dictated for later typing off by stenographers, thus saving time and quill-driving. The hackneyed use of the word “economy” is no longer applicable, however severe this or the next series of crises may be, considering the vast expenditure which has been made on the National Health programme (including the Danckwerts Award) over the past few years. That section of the community
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serving in the Army deserves the same standard of treatment as, or better than, obtainable outside, and to give it we require all the modern tools.

Conclusion.—It is considered that a commission should be appointed by the Government on the lines of the Warren Fisher Commission, but with wider terms of reference, for the purpose of eliciting the reasons for the decline in recruitment and frequent premature retirement of R.A.M.C. officers, and with a view to making specific recommendations to deal with these problems. Such a commission might also deal with the thorny problems of integration with the N.H.S. and even with the other Armed Services; judging by the large number of articles on the subject of recruitment which have been published, there should be no shortage of evidence.

[This article was written in 1952, before there was any indication of the appointment of the Waverley Committee.—Ed.]

Editorial

REMEMBER!

One hundred years ago, in May, 1854, Britain reluctantly declared war upon Russia. The war in the East was the first for nearly forty years which had touched the life of the British people, and in that time not only had the Army suffered from the parsimony inseparable from peace, but "old men forget." The young men of the Peninsular and Waterloo were the old men of the Crimea. They had forgotten the lessons of youth, and the commonplaces of 1815 were the brilliant discoveries of 1854.

In no department of the Army was this more true than in the Medical Department. Here the practical applications of these discoveries have been so firmly built into our structure that it is difficult to believe that they were ever sternly and bitterly resented and resisted reforms. But the child of however learned a father must still begin at ABC, and we children, too, have our ABC: Administration, or the military aspects of our profession; Bodies, or perhaps more accurately, minds—call it morale, man-management, or what you will; and Clinical Medicine. No administrative advance or ability can be more important than the men in whose minds it germinates, or who are affected by it, the latter the larger and more important group.

On the clinical side, consider two quotations from the introduction to A Field Surgery Pocket Book (Revised, 1950): "The evolution of weapons of destruction has proceeded apace, and worse may be yet to come, but the same surgical problem has been repeated in every war and is likely to be the same in the next . . . ." "The policy of early adequate surgery was the lesson of the South African War [it was of the Peninsular], and some of the teachings of the old masters of 1917 were being rediscovered a quarter of a century later. It is the duty of those who go, to record the lessons learned, and of those who come to study them." It is as surgeons in the Crimean sense of military medical