EDITORIAL

THE HISTORY OF THE ARMY MEDICAL DEPARTMENT

This long awaited work by Lieutenant-General Sir Neil Cantlie was issued to the public on the 28th June 1974 and is the subject of a full review in this journal. We have read it twice and can assure our readers that they will not be disappointed as it is a book which once read one keeps and returns to again. Its importance cannot be over-stressed.

EARLY GUNSHOT WOUNDS

Probably because of Sir Neil Cantlie’s History our thoughts have strayed backwards over the centuries and have come to rest on early gun-shot wounds.

When firearms first appeared on the battle field the wounds which they caused provided many problems for the Military surgeon to solve. Many accounts of early gun-shot wounds and their treatment exist and the subject has been dealt with by many medical historians and yet none of them so far as we are aware have touched upon the basic reason why they differed so completely from previous wounds. We accordingly put forward the following explanation which we have not seen presented before, possibly it is so obvious that it has been overlooked.

Prior to the use of firearms in war all missile wounds were caused by shafted weapons (with the exception of the sling and sling-shots which play a negligible part in war and can be ignored) e.g. the javelin, arrow, cross-bow bolt or quarrel etc. The task of a surgeon dealing with a soldier wounded by one of these shafted missiles was simplified in two ways viz:

a. The shaft provided in many instances an extractor (for by no means all javelins, arrow or cross-bow quarrel had barbed heads) and

b. When the head was barbed or otherwise incapable of being pulled out, the shaft provided the surgeon with a guide to the exact location of the missile.

On the other hand a soldier with a gun-shot wound had no built in extractor, no location guide and further because of the round shape of the bullet the chances of bits of clothing etc being carried into the wound was far greater than by a wound inflicted with a sharp pointed cutting javelin or arrow head. Also because of the much greater velocity of a bullet the average degree of penetration would have been deeper. The effects of these factors in wound infections speak for themselves.

What may puzzle the average medical historian who has little knowledge of firearms is the alarm caused by burns from gunpowder, their frequency and the references to these lesions and their treatment in early works on military surgery. The explanation is simple. Until about the end of the 17th Century the method of discharging both cannon and hand firearms was by means of a slow match (the wheel-lock was too expensive for general use and can be ignored). Further, until the time of Gustavus Adolphus (in the Thirty Year’s War) powder was carried in flasks and in barrels and not made up as individual charges in cartridges. When one considers a musketeer loading his musket from a powder flask with his slow match already alight one can only marvel that any musketeer survived at all! No wonder that accidental explosions and burns were of such a frequent occurrence. It is not without significance that the term “hoist with
his own petard” dates from this early period. A petard was a small bomb which consisted of powder in a flask. It was designed to be used for blowing in doors, gates and wooden pallisades. The intrepid petardier ran forward to the gate or pallisade, fastened his petard to the gate/pallisade by means of a screw or spike then lit its fuse and fled. If he was lucky he escaped but far too often the intrepid petardier went skywards with the door/pallisade!

The above views are based on a lifetime’s interest in military firearms (our own collection of British Infantry Longarms 1700-1914 is now on permanent loan in the National Army Museum) and we would be happy to pursue this subject with any of our readers—in the correspondence columns.

Appointments to the Queen

Brigadier S. E. Large, M.B.E., M.D., F.R.C.P., D.P.H., p.s.c., late Royal Army Medical Corps, has been appointed Honorary Physician to The Queen, with effect from 9 May 1974, in succession to Brigadier J. J. Voller, who has retired.

Brigadier D. G. Milne, M.B., F.F.C.M., late Royal Army Medical Corps, has been appointed Honorary Surgeon to The Queen, with effect from 9 April 1974, in succession to Major-General H. C. Jeffrey, who has retired.

Brigadier R. M. Vanreeneen, M.B., F.R.C.P., F.R.C.Path., D.T.M.&H., late Royal Army Medical Corps, has been appointed Honorary Surgeon to The Queen, with effect from 30 April 1974, in succession to Brigadier J. B. M. Milne, who has retired.

Colonel R. Price, T.D., M.B., Ch.B., R.A.M.C., T.A.V.R., has been appointed Honorary Physician to The Queen, with effect from 1 April 1974, in succession to Colonel R. West, who has retired.

Honorary Consultants

Dr. D. B. Grant, M.D., M.R.C.P., has been appointed Honorary Consultant in Paediatrics to the Army, with effect from 1 April 1974, in succession to Dr. G. W. Newns, who has retired.

Dr. Grant also succeeds Dr. Newns as Dean, Institute of Child Health, University of London, 30 Guildford Street, London WC1N 1EH.

Professor R. J. Linden, M.B., Ph.D., D.Sc., M.R.C.P., has been appointed Honorary Consultant in Applied Physiology to the Army, with effect from 15 May 1974, in succession to Dr. O. G. Edholm, who has retired.

Dr. J. D. Matthews, B.A., M.B., Ch.B., F.R.C.P., has been appointed Honorary Consultant Physician to the Army in Scotland, with effect from 11 April 1974, in succession to Dr. H. J. S. Matthew, who has retired.