Research

Erridge complained that his department was hampered not only by lack of resources, but also by a shortage of experienced people qualified to do the necessary research. Of course, lack of resources was a universal problem, but the lack of experienced people was due in the first instance to understandable clinical bias in medical school training. "Only time will tell," he commented, "whether more teaching of community medicine at undergraduate level will materially alter the attitudes of newly qualified doctors and persuade more able candidates into this branch." Nevertheless, despite these handicaps he and his colleagues are undertaking several research projects, ranging from an experimental multiphasic screening clinic—primarily of the middle-aged man—and a patient-attitude survey to health centre practice, to the prevalence of mental subnormality in the community.

Dr. Erridge spoke of the need to use existing staff as efficiently as possible. "It is said to be easier to establish a new lecturer's post than to get an extra clerk-typist, and my

experience bears this out." He thought that if there was suitable help to relieve the skilled staff of routine clerical and administrative chores there would be more time to plan research as well as to organize ways of raising more money. He himself had developed an interest in medicopolitics recently, partly by chance but also because he felt strongly that he was in no position to complain about the lack of voice for his particular specialty unless prepared to play an active part himself. His preliminary impression of medicopolitics—reflecting a managerial approach perhaps—was that the machinery of democratic representation was far too cumbersome to enable decisions to be taken quickly and effectively.

Asked about his professional status in the new career he had chosen, Erridge replied that there was probably a subtle change in the attitude of some of his clinical colleagues when he transferred from practice to a public health department. However, he thought that now he was regarded on a par with his clinical colleagues, a situation he saw as encouraging for the future of a branch of medicine which he so firmly championed.

New Appliances

Adjustable Cervical Spinal Bridge

Mr. PHILLIP HARRIS, consultant neurosurgeon, Royal Infirmary, Edinburgh, writes: An adjustable bridge for attachment to the longitudinal side members of a turning frame has been devised to facilitate the reduction of certain dislocations and fracture-dislocations of the cervical spine and to help maintain the position of an unstable cervical spine (Fig. 1). The

FIG. 1.—Adjustable cervical bridge.

bridge is secured to the frame and is so made that it can be attached to turning frames of different widths, so that the pressure pad under the patient's neck is always centrally disposed.

The purpose of the bridge is to act as a fulcrum (a controlled force) under the dislocated or fracture-dislocated portion of the spine, so that the skull traction (the applied force), using calipers and weights with a pulley (Harris and Wu, 1965), can more easily and reliably produce reduction of the dislocation. It is possible to adjust the height of the central vertical bar of the bridge (with its rubber pad) to achieve optimal correction of the spinal deformity, as shown by radiographic studies. The bar is then locked in place (Fig. 2).

Once spinal reduction has been obtained the bridge may be left in place; for example, during an anterior cervical operation, to excise bone and intervertebral disc fragments, and for interbody bony fusion. In addition, during any anterior

cervical spinal operation—for example, for cervical spondylosis—the bridge can be a valuable, firm support to the neck.

The support may remain in place for days or weeks, to maintain the spine in the optimal position to allow bony fusion to occur, or it can be removed as soon as the dis-

FIG. 2.—Bridge in place on the turning frame.

located spine has been reduced. It has proved to be practical and safe in use.

I am indebted to Dr. William R. Marsh, who drew the plans for the bridge and made the prototypes. Patents are assigned to the National Research Development Corporation, Kingsgate House, 66-74 Victoria Street, London S.W.1.

Reference

Harris, P., and Wu, P. H. T. (1965), *Paraplegia*, 2, 278.