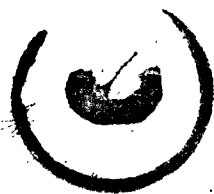


The
Deccan Medical Journal
vol-6

NO-2

April-1930



JL
Lm 216, 1/24
N30.6.2
160872

Price B. G. Rs. 1-8-0
Foreign 2sh Post Free.
Annual Subscription B. G. Rs. 5
From the Editor.

Vol. VI No. 2
April 1930.

THE
Deccan Medical Journal

PUBLISHED BY
The Hyderabad Medical Association

CONTENTS

RADIOGRAPHY:

By DR. S. A. JABBAR, M. B., B. S. Radiologist, Osmania
Hospital.

THE IMPORTANCE & THE CHIEF OBJECTS OF A MALARIAL
SURVEY & HOW TO DO IT—By. A. C. ABRAHAM,
L. M. S., D. T. M.

LEUCODERMA: TREATMENT WITH PSORALIA CORYLIFOLIA—
By J. C. GHOSE, B. SC., F. C. S.

A RARE CASE OF COLOBOMA OF LENS & IRIS.
By DR. S. A. RAHIM, B. A., M. B., D. O.

CLINICAL CASES—By V. R. GORAKSHAKAR, B. A., M. B.

SURGICAL NOTE TAKING—By S. A. RAHIM, B. A., M. B., D. O.

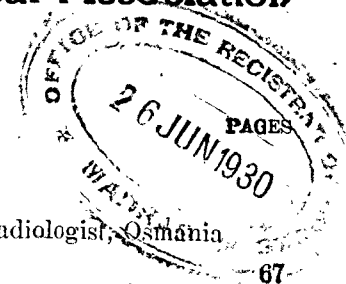
CORRESPONDENCE: A BILL REGARDING MEDICAL COUNCIL
FOR INDIA—By DR. U. RAM RAO.

EXTRACTS FROM TIMES OF INDIA & BRITISH MEDICAL
JOURNAL REGARDING THE INDIAN MEDICAL DEGREES
CONTROVERSY.

NEWS: APPOINTMENTS, TRANSFERS, ETC.

EDITOR

V. R. GORAKSHAKAR, B. A., M. B., Ch. B., (Edin.)
OSMANIA-GENERAL HOSPITAL,
HYDERABAD-DECCAN



The Bengal Immunity Co. Ltd.

ESTABLISHED 1919

The Premier Establishment for the Manufacture of
Sera, Vaccines, Injectuins and other
Organotherapeutic Products

Awarded Gold Medals at the All-India Medical Exhibitions

DIRECTORS:

Hon'ble Sir Nilratan Sircar, Kt. M.A.,
M.D.

Fai Harinath Ghosh, Bahadur M.D.

Hari Sankar Paul Esqr. of Messrs B. K.
Paul & Co.

Dr. K. Ghosh, D. T. M. & H., (Cantab).

Dr. Indu Bhushan Basu, M. D.

Captain Narendra Nath Dutta, M. B.,
Managing Director.

HON. WORKING COMMITTEE.

Dr. Bidhan Chandra Ray, M. D., M. R.
C. P., F. R. C. S. (Eng).

Dr. Harinath Ghosh, M.D., Rai Bahadur.

Dr. P. Nandy, M. D.

Dr. A. Chakravarty B. Sc., M. B.

Dr. Manindra Nath De M. B. (Cal),
M. R. C. P., (Lond.)

Dr. Dharendra Nath Banerjee M.B. (Cal)
M. D. (Berlin)

Dr. H. Ghose M. B.

Dr. D. R. Dhar M. B., T. M. (Cal).
M. R. C. P. (Lond).

Dr. B. B. Sen M. Sc., M. B.

Captain N. N. Dutta, M. B.

Dr. B. C. Das, B. Sc., M. B., Secretary.

Laboratory fitted up with most up-to-date apparatus. Works carried
on under the direct supervision of Medical Experts and hence products
absolutely genuine and reliable.

Vaccines prepared from highly virulent Strains

Our Sera—A Speciality

The only fresh and genuine Sera in the market

Anti-Dysenteric, Anti-Streptococcal, Tetanus and
Diphtheria Antitoxic and Normal Horse Sera

Liberal Commission allowed to Trade and Profession. For Terms,
List and Literature, please write to Managing Director,

153, Dharamtolla Street, Calcutta

Telegram: "INJECTULE,"

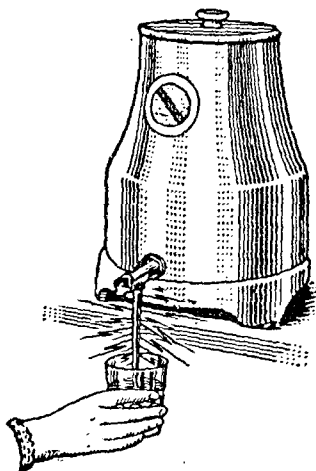
Verified
m



REVIGATOR OR RADIUM WATER JAR.

Thousands of sick people and thousands of others are now daily using the REVIGATOR WATER JAR. This Health Jar

Restores to ordinary drinking water an amount of RADIO-ACTIVITY in exactly Health Spring strength and serves as a PERPETUAL HEALTH SPRING in your home.



Is a tested product—having been tested by hundreds of thousands of satisfied users.

Is a tested product—having been clinically and scientifically tested by many Universities and Laboratories of high standing.

The Medical Authorities in charge of one of these Tests wrote :

“Our staff was frankly surprised, as over 97% showed a definite pathological improvement in 60 days’ use.”

Eminent Scientists and Doctors recommend Radio-Active water in many instances for the following ailments :

CONSTIPATION, ANAEMIA, HIGH BLOOD PRESSURE, RHEUMATISM, DIABETES, BLADDER, INFLAMMATION, STOMACH DISORDERS, GOUT, LUMBAGO, KIDNEY TROUBLES, NERVOUS DISORDERS, SKIN DISEASES, PYORRHOEA, NEURALGIA, GENERAL DEBILITY, ETC., ETC.

It is a very natural method of regaining glowing health. It makes life worth living.

RADIUM ORE REVIGATOR Co.,

San Francisco New York Chicago Los Angeles

Descriptive Literature and Price List on Request from

Sole Distributors :

HABIB AZIZ & CO.,

3741, Khutbiguda, HYDERABAD-DN.

ii

Radiography

BY

Dr. S. A. JABBAR, M. B. B. S.

MY chief aim in presenting this article is to show the necessity of cooperation of the colleagues in a Hospital and the importance of their understanding the difficulties appertaining to this branch of Medical Science.

There are a few fundamental factors that govern the production of Radiograph at least a hazy notion of which is necessary for understanding this article.

They are—1. The current and this is expressed as Milli-ampere.

2. The Electrical pressure and this is known as the Kilo-Volts.

3. The distance factor, i. e., the distance from the Target of the tube to the film.

4. The time factor, i. e., the time of exposure.

Let us now see how these factors govern the production of a radiograph and how they influence the Radiography and how they are themselves influenced.

The current that we pass through the tube and the voltage that we apply are both taken from the Electric Supply Mains brought into the Hospital

from the Street Main and the current that we pass through the tube varies according to the variation of the Supply Main. This will be clear from a little analogy. The wires bringing the current should be compared to a water pipe and the current to the water flowing in the pipe. For the flow of water in a pipe certain pressure is necessary and this pressure should be compared to the Voltage.

Now this pressure of water will govern the flow of water, i. e., the quantity of flow in unit time. If the pressure is great the quantity of water available will be proportionately increased and vice versa. Now imagine for a minute that from one main pipe there are about ten tapings and if all these taps were opened simultaneously there will be a momentary as well as a general, fall of water pressure which would react on the quantity of water received from each one of those taps.

The same applies to Electricity more or less. The cables coming into the X-Ray Department do so from the Common Main of the building and whenever the lifts, motor pump, etc., begin to work simultaneously with our starting to work the machine here, the current begins to vary both in Milli Amperage and Kilo-Voltage or the secondary aid.

When it is remembered that these are the most important factors that govern a Radiograph, it will be easy to understand that such variations will be calamitous in the production of Radiograph.

The other factors are fairly under our control, i. e. the distance factor and the exposure factor.

There is another factor that creeps in, i. e., the size of the patient or the part. For stout patients either all the primary four factors, namely the Milli Amperage, the Kilo-Voltage and the time of exposure and the distance have to be varied or at least the first two if the machine is capable of a bigger output.

Now for the production of X-Rays the chief factors necessary are the Kilo-Voltage which governs the Penetration and the Milli Amperage which governs the intensity. According to the thickness of the patient or the part the penetration has to be controlled and for Radiographic contrast and density the Milli Amperage has also to be controlled. When X-Rays pass through the body they are also scattered and this scattering if it is very much, practically ruins a Radiography and this also has to be controlled by lessening the exposure time, lowering the Kilo-Voltage increasing Milli amperage provided the machine is able to deliver greater current or by using various devices such as Tubular diaphragms, Potter Buckey Diaphragms etc. From the time we have received the Potter Buckey Diaphragm we have been able to produce first class Radiographs of the Hip joint and pelvis and generally of all bone work, which was almost impossible about a month ago.

We shall now take some concrete examples and try to illustrate our meaning. Let us take four parts of the body which let us imagine we are trying to Radiograph. Let them be the following :—

1. The wrist or the Ankle,

2. The chest,
3. The Stomach,
4. Kidneys.

Now taking a Radiograph of the wrist or the ankle is about the easiest and let us assume that we are using 10 Milli Amperes at 60,000 Volts (i. e.,) 60 K. V. and the distance between the Target and the film be 25" and the exposure time to be 10 seconds. This as a rule will give us a fairly good picture.

On the contrary if we try to give the same exposure with other factors remaining constant, for a chest, the Radiograph produced will not be satisfactory because the chest being thicker will absorb and scatter proportionately greater amount of X-Rays and the resulting Radiograph will be wanting in detail. So we will have to increase the time or use some other contrivance like the intensifying screen and thus lower the exposure, but if you want a Radiograph of diagnostic value we will have to remember that the Lungs are moving organs and if during exposure they move as they are sure to in 10 or 20 seconds, then the Radiograph would of necessity be of doubtful value unless the lesion in the chest is very gross or advanced. It will be impossible to detect T. B. at its earliest stage under the above circumstances. So naturally the question arises as to what should be done. The obvious answer is the exposure must be lessened to almost a fraction of a second. That would mean increasing the intensity of X-Ray and to increase the intensity more current will have to be taken and to produce more current a machine sufficiently strong should be procured.

Now let me see how we could produce a Radiograph of Diagnostic value of the stomach. This is much more difficult than the production of the Radiograph of the Chest because the Stomach is situated in the abdomen along with other viscera like the liver, Intestines, kidneys, spleen and pancreas, etc.

First to make it opaque to X-Rays we feed the patient with Barium Meal. But here we have to contend

1. Against peristalsis of the stomach.
2. The movement of the stomach due to Respiration.
3. The more the tissue the greater the scattered radiation and since rays have to penetrate the largest amount of tissue in this part of the body, the penetration has to be proportionately increased. And this increase in penetration brings about greater scattering which means a foggy Radiograph. To obviate these difficulties we have to lessen the exposure, which would be possible only if the Milli Amperage could be enormously increased. Otherwise we will have to make the best of a bad bargain and take our chances of getting a good Radiograph of Diagnostic value, once in a way which is very doubtful.

Then coming to the Kidney it should be admitted that it is about the most delicate work in Radiography because it should be remembered that here we are attempting the rather difficult work of differentiating between soft tissues.

The kidney outline has to be brought out distinctly from the Spinal muscles on which it is lying and which is of the same density as those muscles. Hence unless almost all the details of the surrounding structures are brought out it will not be possible to get a good Radiograph of the renal region. Trying to Radiograph a kidney with a machine and tube of small current capacity is like searching for an object in a big dark room with the help of the light of a match. Certainly this light cannot illuminate the room sufficiently well to enable one to distinguish one dark object from another in the same room. For Kidney work we need as much as 100 Milli Amperes and we have got equipment now which could give us about 10 Milli Amperes only.

There is another factor which has to be taken into consideration in connection with Kidney work i. e., the help of the Surgeon. Unless and until the surgeons are able to catheterize the ureter and fill the pelvis of the Kidney with Radioopaque Solution it is hardly fair to expect such fine diagnosis as that of finding a small calculus in the kidney or ureter. Hence it is absolutely necessary that the surgeons should understand that they should first catheterize the ureter of the patient and then bring him to the X-Ray Department, when even with the materials at our disposal, we can have a fairly respectable Radiograph of the renal regions.

Very much, certainly, can be done with the aid of Radiology but little can be achieved without the active cooperation of the departments such as the Surgeon's, the Physician's and the Pathologist's of the Hospital.

The Radiological Department can be brought up to do the best work only with the willing cooperation of all those that get their work done in this department. The Radiologist must be given information about the findings after operation on a case in which he has expressed an opinion. So also should the pathologist after examining a tumour or a specimen under the Microscope send a copy of his report to this department. Similarly should the Physician enlighten the Radiologist of the progress of a case for diagnosing which the Physician had taken the help of the Radiologist. For only in this manner can a Radiologist and his department build up their most precious experience, the fruits of which all our colleagues and the patients would reap. Finally it should not be forgotten that Radiology is not infallible. There are limits even to Radiology which every one should understand and recognize. Only in this way would we be in a position to give the best of our knowledge to the patient and all those that are concerned in his well being.

It will not be out of place here to express my gratitude and sense of appreciation for the understanding that Col. J. Norman Walker, our Director, had evidenced in the interest of this department and with his valuable help and sympathy we shall very soon bring up the department quite up to date, when the above enumerated difficulties would vanish and we shall certainly be second to none at least in India.

Col. Walker is already moving in the matter to give us an installation powerful enough to do all round radiography.

The Importance & the chief objects of a Malaria Survey and how to do it

BY

DR. A. C. ABRAHAM, L. M. S. D. T. M.,

*Certificate in Malariology, Malaria Officer I/c
Malaria Dept. H. E. H. The Nizam's Medical Dept.*

I N recent years there has been written a large amount of literature on the subject of malaria its survey and control. Since the Medical Department, H. E. H. the Nizam's Government, has been fortunate to obtain the sanction of the organization of a Malaria Department it is felt that a summary of the importance and chief objects of a Malaria Survey will be useful to those who may not have access to the literature. In presenting this article no claim to originality is made. Almost all the information included in it has been

drawn from the works of other observers. By Malaria Survey is meant a certain type of malaria investigation viz: one that sets out to elucidate the facts about malaria in some particular locality or area. Malaria is a protean disease transmitted and maintained under most diverse conditions, many of which are still imperfectly understood; indeed so varied are the circumstances affecting malaria with its triple-linked chain of Man, the Parasite and the Mosquito, as well as all the factors influencing the chain that in the present state of our knowledge malaria survey is almost always a true piece of research work. For the proper elucidation of the facts, without suitable technique the required facts cannot be ascertained and an inadequate elucidation of the facts may lead to advice being given that is not only useless but may be actually harmful as money may be wasted and anti-malaria work thereby brought into disrepute.

The importance of a Malaria Survey is felt when it is desired to know (1) what is the degree of the prevalence, the effects or the circumstances associated with malaria in some particular place area or country and always (2) where it is desired to take in regard to prevention or amelioration of malaria: (3) the extent to which malaria prevails in different parts of a country, its effects on the population, the circumstances under which it is unduly present and so on are the points on which any Government should have proper information. It is not however to Government only that knowledge regarding malaria is useful, but also where planting, mining, municipal extensions and improvements, Engineering works,

reclamation and Harbour works, Railway constructions, Canal schemes, sanitation of tea and rubber estates etc. are concerned. Malaria is of great importance in relation to irrigation, to those responsible for troops and malaria more than any other disease retards the development of tropical countries and keeps them in a state of backwardness and unhealthiness. Neither salubrity of towns nor prosperity of rural areas is possible in the presence of severe malaria and on the possibility of prevention of malaria will often depend the success of industrial and other enterprises. Preventive measures cannot be employed in such malarious circumstances without a malaria survey for any attempt without it will be a blind procedure inviting failure hence to take action apart from survey is to work in the dark and surveys must be regarded as eyes and ears of malaria work.

Now we may briefly consider what a malaria survey does:—

- (1) It ascertains the actual facts regarding malaria in a country or locality and without such a knowledge the degree of prevalence is a matter of opinion or conjecture:
- (2) It enables to know the general or specific nature of the measures most likely to be effective and helps the Malaria Officer to advise the responsible authorities accordingly.
- (3) It enables preventive action on lines advised to be effectively carried out for instance if destruction of breeding places is the method

to be undertaken, the engineers must be instructed or in the case of choice of sites for bungalows etc.

- (4) It helps to advance general knowledge both scientific and practical regarding malaria anopheline mosquitoes, parasites, etc.

A short summary how to conduct a malaria survey may not be out of place to mention here.

- (1) Take the help of the local authorities, Tahsildar or Munsif to fit up a temporary laboratory, for collecting children and also to obtain the statistics or any returns.
- (2) Then explore every part of the area, studying the physiography and topography: Note all the streams and storm channels—Study the subsoil water-table in relation to (a) dry porous areas (b) swampy tracts and sewage areas and the permanence of water in stream beds: Consider also the hydrographical features of rice-fields etc. and the forms of irrigation used in the rains and in the dry season if possible.
- (3) Collect larvae wherever they are found and the chief objects are:—
 - (a) It assists to know the species present in the area for species bred out may not always be those that have been caught as adults in the houses.
 - (b) What kinds of breeding places are producing anopheles.

- (c) To ascertain the degree to which different types of breeding place provide dangerous anopheles so that treatment or destruction of these sources may be considered.
- (4) Collect adult anopheles in dwelling houses cattle sheds wherever one can find them to know (a) presence or absence of breeding places; (b) source and direction of infiltration; (c) to study the bionomics e. g. with regard to length of life, direction and length of flight hibernation and aestivation, the relation to cattle kept under various conditions etc.; (d) for dissection of salivary glands and the midgut to determine what species of anopheles are carrying malaria in nature under the particular local conditions, to get a rate of percentage in each species infected with sporozoites in the salivary glands and oocysts in the wall of the midgut; And for scientific purpose to incriminate a species not yet known to transmit malaria in nature.
- (5) Proceed to take the spleen rate and parasite rate in order to know the degree of endemic malaria as the percentage of enlarged spleens in an adult population (adult spleen rate) does not give reliable indications of the prevalence of malaria, children aged 2 to 10 years are chosen and the percentage of enlarged spleens in the child population is known as *spleen rate* as compared to adult spleen rate of adults.

- (6) Collect any meteorological data especially rainfall, wet and dry bulb temperatures etc.
- (7) Collect as much information as possible with regard to economic conditions of people and to the history of malaria in the area, any increased incidence result of canal constructions or introduction of susceptible immigrants etc.
- (8) Gather informations from studying the dispensary books death registers etc., of the seasonal prevalence of malaria, any evidence of epidemic prevalence of malaria etc., throughout the survey every effort should be made to reach the fundamental facts regarding any unusual prevalence of malaria or unusual freedom from the same.

Before concluding this article a few words may be said regarding terms employed in malaria work in India.

Spleen rate means the percentage of those with palpable spleens between the ages of 2 and 10 years and the rate in adults being the adult spleen rate.

Parasite Index expresses the percentage of children in whose peripheral blood parasites are detected, no statement as to the amount of blood examined being given.

Epidemic Malaria is the term applied to sudden outbreaks of greatly enhanced malaria prevalence "autumnal epidemic" or "fulminant" form in which the disease behaves with regard to mortality like the great epidemic diseases plague, cholera, etc.

this form is chiefly confined to the dry tracts of the North-West of India.

INCIDENTAL MALARIA is the type of malaria which affects Europeans and other susceptible persons in an endemic area.

ENDEMIC MALARIA is the term expressed to mean that a certain degree of malaria infection is more or less static in a community or area.

The Central Committee for the study of Malaria in India have recommended the use of the following nomenclature in regard to varying degrees of endemic malaria in India.

1. Areas where the splenic index among children is not over 10 per cent are called Healthy areas.

2. Areas where the splenic index among children is between 10% and 25% are called areas of Moderate Endemicity.

3. Areas where the splenic index among children is between 25% and 50% are called areas of High Endemicity.

4. Areas where the splenic index among children is over 50% are called areas of Hyper Endemicity.

My best thanks are due to Col: J. Normon Walker, Director, Medical and Sanitation Dept: and the deputy, Director Major M. Ashraff for kindly obtaining me sanction for my deputation to The Ross-Field Experimental Station for Malaria at Karnal,

References :

1. Malaria, its investigation and control by the Col: Knowles and Mr. Senior White.

2. How to do a Malaria survey by Col: Christophers and Major Sinton and Major Covell.

3. The prevention of Malaria in the Federated Malay States by Watson. M.

4. Antimosquito-measures by Major Covell.

5. Health Bulletin No. 13. Malaria Bureau No. 5.

6. A critical review of the data recorded regarding the transmission of malaria by the different species of anopheles by Major Covell.

the oil with *patience* and *intelligence* is absolutely necessary, although there may be a few fortunate cases of rapid recovery from the use of the very first ounce of the oil as already reported to this School.

The facts to which particular attention is invited are :—

(1) *Psoralia Corylifolia* seeds are sweet scented—a fact indicated by its chief Sanskrit name *Sugandha* (lit “scented”), their agreeable aromatic odour resembling that of the *bael* fruit, whereas *Vernonia Authelmintica* seeds are not scented. There are other distinguishing features as well, namely,

<i>Psoralia Corylifolia</i>	<i>Vernonia Authelmintica</i>
N. O. Leguminosae	N. O. Compositae
<i>Leaves:</i> cordate, both sides conspicuously dotted with black dots.	<i>Leaves:</i> acuminate.
<i>Seeds:</i> dark—brown or brownish black, kidney shaped, flat, oblong, about 2 m. m. long, aromatic.	<i>Seeds:</i> black or dark brown covered with whitish scattered hairs, cylindrical, tapering toward the base, and marked with about ten paler longitudinal ribs.
<i>Oil:</i> thick, reddish-brown, with an agreeable odour. S. G. 0.910 at 100° F.	<i>Oil:</i> dark brown and strong smelling. S. G. 0.916 at 100° F.

(2) Confusion, and consequently inefficacy, arises from seeds of entirely different plants being known as *Bauchee* and inferior varieties of *Psoralia Corylifolia* are often used with unsatisfactory and negative results. Further, the action of *Psoralia Corylifolia* often needs to be accelerated by *subsidiary measures* according to the requirements of a case, and in all cases patients must either report progress or remain under observation for the treatment to be successful.

(3) In the event of the drug prescribed being of the required *strength* and *purity* as is the case with the oil issued by the School of Chemical Technology, Calcutta, the results observed are generally satisfactory, particularly when patients *strictly follow* instruction with *patience* and *intelligence*. The oil of *Psoralia Corylifolia* has an irritant action, its effect on leucoderma being specific. The skin becomes red, which varies in intensity according to individual tolerance and idiosyncrasy, the melano-blasts are stimulated leading to pigment formation and finally pigment is diffused into the de-pigmented leucodermic patches. Some patients get frightened at the first indication of irritation and discontinue applying the oil and some develop no irritation at all. In any case the patient should exercise intelligence and try to keep up the effect by either reducing or increasing the frequency of application, which normally consists of gently rubbing the oil over the affected part twice or thrice a day. It is sometimes necessary to dilute the oil with olive oil to suit individual tolerance and to apply an emollient as a soothing agent. With attention to these details progress

is generally assured, although it is not claimed that a specific cure for *leucoderma* has been arrived at in the sense in which Salvarsan is understood and used for syphilis.

Samples of oil from seeds of *Psoralia Corylifolia* were exhibited at the stall of the School of Chemical Technology during the Calcutta Exhibition of 1923 and from the way visitors to the stall were scared by pictures representing different stages of *leucoderma*, it appeared that both *leprosy* and *leucoderma* were looked down by all communities. Doubtless it will be doing a real service to science and to humanity if this school, which is very much interested in indigenous drugs investigation, is kept kindly informed of the results obtained by patients from the use of *Psoralia Corylifolia* oil as supplied by the School.

Leucoderma is called, though erroneously, "White Leprosy" in Hindu medicine, there being several varieties of leprosy under that system of treatment, and although this ancient system, as it stands at present, generally lacks in what we call scientific procedure and precision, it is still described by several European Scholars "as a marvel to the modern scientific investigator" and provides, in many instances, materials of considerable value, as well as facts of close observation. Several of them have been scientifically tested and found to be of real value, for instance, modern medical science has so far failed to find better remedies than those of Indian origin for the treatment of either nodular leprosy or leucoderma, the medicine used in either case being entirely Indian in origin and in conception, and the knowledge handed down from at least 1,500 B. C?

forms the basis of modern investigation not only in regard to leprosy, but also in several other directions.

In its last annual report the British Empire Leprosy Relief Association predicted that leprosy would be completely stamped out within the next ten years by means of treatment with oil extracted from the dried fruit of *Hydnocarpus* tree which grows on the Malabar Coast. It was announced that arrangements had been made for a deputation of doctors from all parts of India to undergo a course of training in the diagnosis and treatment of leprosy in Calcutta, thereby widely diffusing knowledge of the subject. A similar propaganda seems necessary for stamping out leucoderma by treatment with oil obtained from the seeds of *Psoralia Corylifolia*, the sufferers from this disease being presumably no less numerous and no less widely distributed than leprosy patients.

The remedy for leprosy is popularly known as *Chaulmoogra*. In his pamphlet issued on the subject in 1917 the writer first identified *Chaulmoogra* with *Hydnocarpus* from a chemical consideration of the oil extracted therefrom (*The Pioneer*, March 1st, 1928), all previous leprosy work having proceeded on *Gynocardia Odorata* and *Taraktogenos Kurzii*, as mentioned in the British Pharmacopœia (1898 and 1914) under *Chaulmoogra*. There is a similar misunderstanding in regard to *Bauchee* (*Psoralia Corylifolia*) which may definitely prove to be as efficacious for leucoderma treatment as *Chaulmoogra* (*Hydnocarpus Wightiana*) for leprosy. Both of these drugs are ancient Indian remedies and the misunderstanding arises from inaccurate identification.

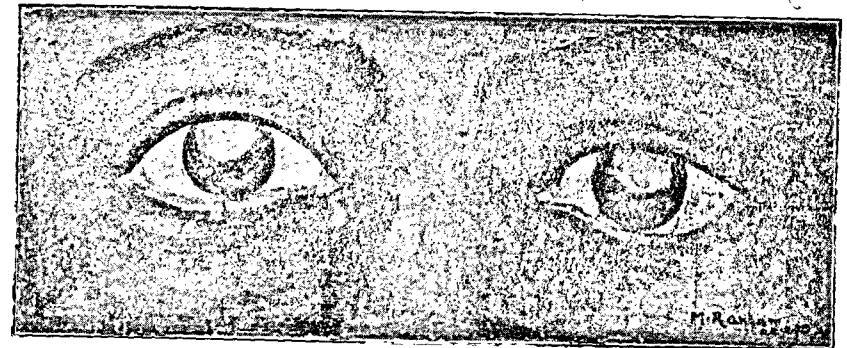
A Rare Case of Coloboma of Lens and Iris

BY

S. A. RAHIM, B. A., M. B. D. O.
Ophthalmic Surgeon.

Gulam Hussain a young man of 19 years got admitted into the Ophthalmic ward for loss of sight in both eyes. On examination there is only perception of light in his left eye. He says that he has lost his sight for the last two years but does not give any definite history of gradual failure of sight before that—a statement rather inconsistent with our physical findings.

The interesting feature of the case is that he has coloboma of iris and lens in their upper segment in both eyes. The lens is opaque and in parts has calcareous spots on it. It is tremulous (weak suspensory ligament) and its upper part is absent making it rather boat shaped in form. The iris is deficient at the top giving it the appearance of a little more than a crescent. It is pale blue in colour suggestive of



Clinical Cases

THE FOLLOWING SIX CASES WERE DEMONSTRATED AT A MEETING OF THE LOCAL BRANCH OF THE B. M. A.

BY

V. R. GORAKSHAKAR, B. A., M. B.,
1st Physician—Osmania Hospital.

I. A case of malaria affecting vision and speech with other nervous symptoms. This is a case worth recording. The patient—a student—aged 21 years came to the hospital complaining of fever, vomiting, headache, insomnia and toothache. The illness began four days before admission with rigor and fever. On examination he was found to have Diplopia but there did not seem to be weakness or paralysis of any of the muscles of eye ball. The Diplopia which was binocular was functional. There was affection of speech, scanning, slurring speech it was. It was dysarthria. There was no aphasia. He could not close his right eye independently of the left eye and there was some paralysis noticed on the right side of the face—lower half only. He could not raise his right cheek so well as he could the left cheek. The tongue when protruded slightly deviated towards left.

Pupils were sluggish to light. Intelligence was clear. The Gait was slightly ataxic with a broad base. Rhomburg's symptom was present. There was loss of knee jerk. Vomiting stopped under treatment but the patient had high fever the next day. Blood smear showed many malarial parasites of the Quartan type. Intravenous injection of quinine bi hydrochloride (10 grs.) was given; next day again injection of Sod. Cacodylate (grs. iii) was given. Diplopia disappeared after the quinine injection. A third injection of quinine was given on the 5th day after the admission. Diplopia never reappeared. Speech improved markedly. Pupils reacted to light well. Gait was not so very ataxic and the base was not so very broad as before. In-coordination was much less. There was no attack of fever. Retina was healthy from the beginning, but he was complaining of dimness of vision. Keen jerk could not be elicited but there has been a marked improvement as regards the Diplopia which has altogether disappeared and speech, which is almost normal. There is no history of venereal trouble.

We may put down this case as one of malaria of cerebral type. Parasites of the malignant type have a tendency to clump together in masses which block the cerebral arteries. In the case under report the parasites were of the Quartan type and these are not generally known to block the arteries. It is possible that there is a mixed infection in this case plasmodial and lavatarial. See similar two cases reported in the Deccan Medical Journal Vol. VI No. I.

Left eye: ext: Sq.

Right pupil dilated slightly.

Reaction Normal.

R. Fundus Normal.

L. „ Normal—but margin blurred.

In both of these cases the chief complaint is of tremors of the upper limbs. The tremors are somewhat fine and regular and purposive (In one of them there is the tendency to pill-rolling movement) such tremors we do find in paralysis agitans.

Expressionless Face.—

Both have a stare; in one marked. Blinking is absent in one markedly and in this the Parkinsonian Mask is well seen. In this latter case we have propulsion and retropulsion also—in looking up he loses balance. In the other case we have not got this characteristic symptom of Paralysis Agitans.

Interosseal position of hand: fingers flexed with overextension of 1st phalanx.—

Arms are abducted and bent at elbows—well seen in one of them.

Rigidity is well marked in one—it is not present in the other.

Peculiarity regarding rigidity (lead pipe) bent—remains so.—

The tremors—fine and regular—increase with rest—somewhat controlled, Voluntarily—absent during sleep.

Diminished by voluntary movement.

Hurried speech in both somewhat. Monotonous, due to rigidity of laryngeal muscles.

Swinging of arm in walking is lost.

Owing to rigidity of flexors body is bent forwards—centre of gravity brought forward—thus is explained the gait.

Gait.

Propulsion and retropulsion in one—forward stoop, shuffling due to spasticity in lower limbs. Festination.

Rapid movements are done with ease (touching nose) slow movements with difficulty (gripping hand).

There is the history of fever in both with diplopia. There is some strabismus. Knee jerks exaggerated in one, the non-characteristic case. Otherwise no change in reflexes as may be expected in Paralysis Agitans. No sensory phenomena. Not even the usual hyperaesthesia to heat—hot flushes etc.,

General aspect and attitude suggest Parikinson's and not alcohol neurasthaenia, or disseminated sclerosis.

Co-ordination is present. Muscular weakness slightly marked. Mental condition slightly effected, slight depression—not very intelligent both of them.

Discussion.

Affection of globus pallidus (inner 2/3 of Lent Nucl) causes rhythmic tremors and hypertonicity of muscles. Automatic (blinking of eyes) and automatic associated movements (swinging of hands

while walking) are disturbed. Affection of caudate N and Putamen (outer 1/3 of L. Nucl) would have caused choreic and athetoid movements and some incoordination.

We may say then that there is in these cases a lesion of the striato-spinal system due probably to the fever they had and which fever was, on account of the ocular symptoms, probably of the nature of encephalitis lethargica. Age is against the typical paralysis agitans.

Parkinsonian Facies was first demonstrated by Buzzard in an acute case of Encephalitis Lethargica within a week or two of the onset. It may be a residual or late manifestation of Encephalitis Lethargica.

Eyebrows elevated Forehead Smooth.

The Parkinsonian Syndrome is characterized by.

1. rigidity.
2. absence of expression.
3. absence of slight and automatic movements.

Total effect however is not quite like paralysis agitans.

Tremors are slight or absent as in our cases.

Distribution of rigidity is more limited.

Mental changes are common.

Progress is more rapid but on the other hand recovery may take place—as we find in the 3rd case demonstrated to-day.

Catatonia :

Due to rigidity combined with mental change is not manifested in our cases.

Choreiform and athetoid movement may be present is affected in Encephalitis Lethargica.

Grey matter of basal ganglia Mid Brain, Pons,

Progressive Hepato Lenticular degeneration (Wilson's Disease) is a family disease.

Age 10 to 26, average 15.

Bilateral degeneration of small celled system of putamen with or followed by degeneration of large celled globus pallidus.

IV. ATAXIA.

to

V. Dilawar Hossain, 20 years, male, Mohamadan, Noorkhanka Bazaar, was admitted into the hospital on 7th October 1929, for inability to walk without help; hearing is impaired.

marriage 10 months. 10 Months ago patient had an attack of fever which subsided but left behind the affection of Motor power and inability to sit, stand or walk. On examination his gait was ataxic. Knee jerks elicited with difficulty, ankle clonus, Babinski's sign, plantar reflex not present. Cremasteric abdominal and thoracic reflexes present. He is deaf. He says he has developed this during the course of the illness. Gives a history of masturbation.

This is a case where the prominent symptom is the Ataxia of the lower limbs. He is not able to stand without support and when he walks with support the gait is ataxic—with a broad base and somewhat high stepping with stamping of the feet. He has to look at his feet and ground while walking. If he looks up or if his eyes are closed he reels even

loss of knee jerk—no sensory phenomena—no Argyle sembles the ataxia, of Tabes. There is, however, no loss of knee jerk—no sensory phenomena—no Argyl Robertson Pupil—no loss of control over bladder and rectum. There is no paralysis. Intelligence is good but he is deaf and there is a history of masturbation. No syphilis.

There is not the usual history of lightning pains we get in Tabes Dorsalis. No boring pains or girdle sensations. No nasal analgesia—no affection of sensibility to pinprick or deep sensibility to painful stimuli. Postural sensibility is affected we may say for there is the Rhomberg's sign. There is no trouble about micturition—no visceral crises—there nothing to suggest Tabes Dorsalis excepting the steady gait.

The unsteadiness in standing and walking suggest Cerebellar Ataxia.

There is no impairment of joint sense nor of kinetic sense.

There is no sensory impairment and this is in favour of cerebellar Ataxia but there is no Asynergia—no lack of postural muscular tonus (Heel-knee test). There is no cerebellar gait—muscular power is unimpaired and he cannot walk alone but there is a tabetic stamp and the gait is worse if he closes his eyes. Thus the ataxia is not characteristic of cerebellar affection. There is also no dysmetria (finger-nose test) no affection of the rapid movements of pronation and supination.

There are no intention tremors.

It is not Friedreich's for in this the ataxia is unaffected by closing eyes—in this case ataxia gets worse. There are no symptoms of Disseminated sclerosis. There is nothing to suggest Ataxia due to affection of the higher cerebral centres—no alcoholism, fatigue, occupation neuroses etc., nothing to suggest lesion of corp. striat. (Chorea, etc.,) Red Nucleus, cortical monoplegia or Hemiplegia etc., Extension and Flexion of lower limbs are good. Muscular power is good all over.

The only symptom is the inability to stand and to walk and the ataxic gait.

V. AMYOTROPHIC LATERAL SCLEROSIS WITH BULBAR PALSY.

Shaikh Davood, age 50 years, male, Mohamadan, married, admitted on 26th January 1930.

Patient complains of difficulty in using the limbs and in talking; duration one year. One year ago patient had a septic wound on the left leg as a result of which the extremity got swollen with fever. After this he began to feel the paralytic symptoms first of the lower extremity and then the left side of the face.

Gives a history of *Gonorrhoea*, *Syphilis* and *Alcohol*. Wife living and healthy.

General condition of the Patient.—Patient is an old man in a debilitated condition.

Nervous system.—There is spasticity of muscles, kneejerk, markedly exaggerated. Babinskis sign present. Ankle clonus also present.

Swallowing affected. Cannot talk well.

(AMYOTROPHIC LATERAL SCLEROSIS
WITH BULBAR PALSY.)

In this case the most prominent symptoms are the rigidity of the limbs and the affection of speech (Dysarthria—No Aphasia. There is also thenar and Hypothenar atrophy. Intelligence is slightly affected.

Spasticity—crossed legs—exaggerated knee—jerk—ankle—clonus—Babinski all suggest Lateral Sclerosis—Upper motor neurone affection. Sensations are all right. Atrophy of the hand muscles suggests affection of lower motor neurone. Speech affection suggests Bulbar lesion. We may take it to be a case of Amyotrophic Lateral Sclerosis with Bulbar Palsy. There is the history of syphilis.

What is the difficulty of articulation due to?

Paralysis or incoordination of certain groups of muscles in the lips, tongue, palate, pharynx or larynx may cause it.

Defect may be in:

1. Bulbo,- Muscular neurones (Pontine and medullary nuclei, Peripheral motor nerves and muscles)

or

2. Supranuclear affections in cortico-bulbar neurones between higher speech centres and bulbar nuclei

or

3. Ataxia of the organs of speech.
1. Paralysis of motor nerves or nuclei.

Hypoglossal.— Unilateral— we have not got here.

Facial palsy. We have not got here.

Labials: letters P. B. Good.

Palate—bilateral paralysis as in Diphtheria or syph.

Perforation would give nasal voice which is not present here (B as M, D as N, K as Ng.)

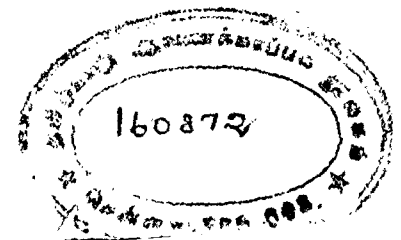
There is no regurgitation of liquids and so there is no total paralysis of palate. There is no paralysis of vocal cord—no hoarse voice; so no unilateral recurrent laryngeal paralysis.

Vagus is affected at point of exit from Medulla—soft palate is paralysed— this is absent here.

Disease of bulbar nuclei may cause the indistinct articulation as in Glosso—labio—laryngeal paralysis (Bulbar palsy). Here we have progressive weakness of the muscles of articulation. But in this case we don't find any tremors and atrophy of tongue and lips. No difficulty of saliva. Swallowing is a little affected. Coughing is normal. He says however that there is a drag on his tongue and it may be that here we have the beginning of bulbar palsy especially as there is also the amyotrophic Sclerosis.

In a myopathy called facio scapulo— humeral paralysis facial muscles are atrophied. We have not got that here (Rapid exhaustion of muscles on rapid repetition of movements).

2. Supra nuclear or cortico-bulbar affection.— Slurring of Alcoholism. In G. P. I. too similar.



Dysarthria of lenticular disease may be mentioned—it is due to spasticity of muscles of articulation.

In Bilateral Hemiplegia we have pseudo-bulbar paralysis; in this we have no tremor or atrophy of the muscles. In our case there is no bilateral Hemiplegia.

3. Is there Ataxia of the organs of speech?

In recent and acute cerebellar lesions we get this due to Asynergia of laryngeal and articulatory muscles. There are no other signs of cerebellar disease in this case.

In disseminated sclerosis we have staccato, scanning speech; we have not that here.

In Frederick's Ataxia we have thick, clumsy articulation.

Laryngeal Tabes—tongue keeps on rolling in the mouth, tremulous voice, articulation laboured.

We may conclude then that here we have some affection of bulbar nuclei commencing in association with the Amyotrophic later, sclerosis.

VI. PERIPHERAL NEURITIS: ALCOHOLIC.

Dharmiah, 30 years, male, Hindu, married, Tailor, Easamiah Bazaar, was admitted in the hospital on 21st January 1930, with a complaint of fever and pain in the joints, inability to stand up and walk in an extreme condition of lassitude with wrist-drop, loss of knee-jerk, no ankle-clonus, loss of motor power, inability to use the hands, incoordination and pain in all the muscles and tingling sensation slight

Dementia. Symptoms first started in lower extremities with weakness and paralysis in calf-muscles and then there was wasting which extended to upper extremities. He had control over Sphincters.

He is now able to walk.

The patient gives a history of *Alcohol* and *Gonorrhoea*.

This is of interest on account of the mental condition: *Dementia*.

Surgical Note taking

BY

S. A. RAHIM, B. A., M. B. D. O.

Surgeon, Osmania Hospital.

SCHEME NO. III.

DISEASE OF THE TONGUE.

Examination.

(a) Inspection:

- i. Its size, whether enlarged or small.
- ii. Its mobility, whether tongue moves out of the mouth freely, or if it is fixed one side or both sides.
- iii. Its surface, dry surface and note
 - a. its colour
 - b. the presence or absence of fur
 - c. the presence or absence of thickened epithelium.
 - d. the condition of the papillae
 - e. the presence of cyots, nodules, plaques, fissures or ulcers.
- iv. If an ulcer is present, note—
 - a. its depth and position in the tongue

- a.
 - b. its margins, reverted, rolled, sharp cut, undetermined.
 - c. its base—clean or sloughy
 - d. the surrounding area of mucous membrane
 - e. the nature of the discharge
 - f. the condition of the teeth
 - g. whether it appears to spread on to surrounding structures.

(b) Palpation.

- i. Examine the edges of an ulcer and feel for induration around.
- ii. Ascertain extent of spread of growth and if fixed to the jaw.
- iii. Examine the submental, sublingual, submaxillary and deep cervical glands on both sides.

SCHEME NO. IV.

DISEASE OF THE ABDOMEN.

I. Special points in the history.

(a) The pain.

- i. Mode of onset, sudden, gradually increasing, constant or irregular.
- ii. Time of onset in relation to food; exercise.
- iii. Its exact position.
- iv. Its character.
- v. Is it relieved by vomiting or not ?

(b) The vomiting.

- i. Time in relation to onset of pain; food.
- ii. If single or repeated.

- iii. Its nature.
- iv. Its character— a regurgitation; properlavage.
- (c) The Bowels.
 - i. constipation.
 - ii. diarrhoea.
 - iii. Alternating constipation and diarrhoea.
- (d) Micturition.
- (e) Menstrual history.

II. Examination.

- (a) Expose whole abdomen and lower part of chest.
- (b) Inspection.
 - i. Its general shape, distension, bulging.
 - ii. Movement on respiration.
 - iii. Visible tumour.
 - iv. Visible peristalsis.
 - v. Bruising or discoloration.
 - vi. Character of breathing.
 - vii. Note if alae rasi are working visibly.
- (c) Palpation examine for
 - i. Rigidity of abdominal muscles-general; localised.
 - ii. Tenderness.
 - iii. Tumour.
 - a. Does it extend into loin
 - b. Is it continuous with Liver
 - c. Is it freely moveable

- d. Can all its borders be felt
- e. Is it solid or fluid
- f. Is the spine normal.
- iv. Fluid.
 - v. All hernial orifices.
- (d) Percussion. To elicit the following points.
 - 1. The limits of hollow viscera e. g. stomach.
 - 2. The relation of a tumour to liver or spleen.
 - 3. The relation of a tumour to bowel.
 - 4. The presence of free fluid (which shifts when patient is moved).
 - 5. The presence or absence of liver dulness.
- (e) Always examine the lungs, especially in children.
- (f) Rectal examination for.
 - 1. Pelvic tenderness.
 - 2. Growth of rectum.
 - 3. Connection of abdominal tumour with per-vic organs.

SCHEME NO. V.

DISEASE OF ANUS AND RECTUM.

- I. Special points in history.
 - i. Pain—its nature, relation to defalcation and exact location.
 - ii. Tenesmus—if present.
 - iii. Bowels—if normal constipated or fluid.
 - iv. Discharge. Its relation to defaecation, its nature i. e. blood, pus or mucus.

- v. Past history e. g. syphilis, dysentery etc., Tuberculosis.

II. Examination.

(a) Inspection.

- i. Parts around anus—for redness, swelling ulceration or discharge.
- ii. The Anus—for stricture or relaxation, for swellings, external piles or protrusions.

(b) Palpation. Examine with gloved fingers.

i. The rectum for

- a. Fissures, ulcers, strictures or growths.
- b. Test extent and fixation of growth.
- c. Note whether examination causes pain.
- d. Note if finger is stained with blood or discharge.
- e. If there is a fistula, examine with a probe and determine its extent and communications.
- f. Examine for enlarged glands in hollow of sacrum.

ii. Prostate.

iii. The abdomen (especially for enlarged liver.)

iv. Record results by sigmoidoscopy etc.,

Correspondence

To

The Editor,

Deccan Medical Journal,

Hyderabad, Deccan.

Dear Sir,

I herein enclose a copy of the Bill, to establish a Medical Council in India which I intend introducing at the forthcoming session of the Council of State. There can be no two opinions as to its imminent need but the real difficulty now is "Who is to bell the cat?" As I have explained in my statement of objects and reasons appended to the Bill, the Government of India may not take the initiative at this stage, and so, I have come forward to perform that task once again. I hope with your kind support the Bill will have smooth sailing this time and will be passed into law before long.

An expression of your views on the Bill will be gratefully acknowledged.

Yours faithfully,

(Sd.) U. Rama Rau,

Member, Council of State.

16—12—29.

(TO BE INTRODUCED IN THE COUNCIL OF
STATE.)

▲
BILL

To Establish a Medical Council in India and to provide for the maintenance of a British Indian Medical Register.

Whereas it is expedient to establish a Medical Council in India and to provide for the maintenance of a register of qualified Medical Practitioners for the whole of British India: It is hereby enacted as follows :—

Short title, extent and commencement.

1 (1) This Act may be called the Indian Medical Council Act 193 .

Definitions.

(2) It extends to the whole of British India.

(3) It shall come into force on such date as the Governor-General in Council may, by notification in the Gazette of India, appoint.

2. In this Act, unless there is anything repugnant in the subject or context,

(a) the establishment of a uniform standard of India constituted under this Act ;

- (b) 'Medicine' includes surgery and obstetrics but does not include Veterinary medicine and surgery; and 'medical' includes 'surgical and obstetrical ;'
- (c) 'Provincial Medical Council' means a medical council constituted under an Act of a local Legislative to regulate the registration of Medical practitioners ;
- (d) 'Provincial Medical Register' means a register maintained under an Act of a local Legislature to regulate the registration of Medical practitioners; and
- (e) 'the Register' means the British Indian Medical Register of medical practitioners maintained under this Act.

Purposes of the Council.

3. The purposes of the Council shall be to promote and effect—

- (a) 'the Council' means the Medical Council of qualification in medicine for all Provinces such that the holders thereof shall be acceptable and empowered to practise throughout British India;
- (b) the establishment, maintenance, publication and revision of the British Indian Medical Register of medical practitioners;
- (c) the determination of the qualifications and conditions necessary for enrolment on the Register;
- (d) the scrutiny and approval of study and examinations undertaken by medical students,

and the inspection of the conduct of examinations;

- (e) the attainment of a status of the medical profession in British India which will ensure the recognition of its members in the United Kingdom and elsewhere and will enable practitioners whose names are borne on the register to acquire the right to registration under the Acts of Parliament called the Medical Acts and similar Acts in other countries; and
- (f) the regulation of conditions on which persons qualified to practise medicine in the United Kingdom and other countries may be enrolled on the Register.

Incorporation of the Council.

4. The Medical Council of India shall be a body incorporated by that name and shall have perpetual succession and an official seal, with power to hold property, both moveable and immovable and to contract and may sue and be sued in its corporate name.

5. The Council shall be composed of—
Composition of the Council.

- (a) the President, who shall be nominated by the Governor General in Council after the first election of members to the Council and thereafter, be elected by a majority of members of the Council under regulations made under this Act.
- (b) one member elected by each University in British India established by an Act of the

Indian Legislature or of a local Legislature and having a Medical Faculty;

- (c) one member from each province in which a Provincial Medical Register is maintained, elected from amongst themselves by private practitioners whose names are borne on the Provincial Medical Register and who hold qualifications granted or recognised by any Indian University or by any other University or medical institution which the Governor General in Council may specify in this behalf.
- (d) one member from each province in which a Provincial Medical Register is maintained, elected from amongst themselves, by private practitioners whose names are borne on the Provincial Medical Register and who hold qualifications other than those mentioned in clause (c) above.
- (e) one member from each province to be nominated by the Governor General in Council.

6. No member shall be eligible for election or nomination, as a member of the Council—

Restrictions on election and nomination.

- (1) under clause (b) of section 5, unless he is a member of the Medical Faculty of the University concerned;
- (2) under clauses (c), (d) and (e) of section 5, unless he resides in the province concerned and where a Provincial medical Register is maintained in that province, unless his name is borne thereon;

Provided that the restriction contained in Clause 3 shall not apply to elections or nominations to the Council, as first constituted under this Act.

7 (1) The term of office of members and the President, shall, subject to the provisions of sub-section (6) be four years.

Term of office, resignations and vacancies.

(2) Any member may at any time tender his resignation by a written notice to the President or to the Secretary of the Council; and upon the acceptance of such resignation by the Council, the Council shall forthwith give notice thereof, in the case of a nominated member to the Governor General in Council and in the case of an elected member, to the University which he represents or to the Local Government of the Province which he represents.

(3) Any person who is or has been a member may, if properly qualified, be re-elected or re-nominated; but no person may at the same time serve as a member in more than one capacity.

(4) Where the term of office of a member is about to expire, his successor may be elected or nominated at any time within three months before the expiration of such term; and where any vacancy exists for any reason, such vacancy may be filled at any time.

(5) Where there has been a failure to elect a properly qualified member or to cause the name of an elected member to be certified to the Secretary of the Council within a reasonable time, after his elec-

tion, then, after giving notice requiring the Local Government or the University as the case may be, to cause such election to be made or to certify the result of an election to the Council within one month from the date of such notice, the Council may, if the default is continued, itself elect a member.

(6) A member elected or nominated to fill a vacancy caused by death or resignation shall hold office in all respects as the person in whose place he is elected or nominated would have held office, and for the remainder of the term for which that person was elected or nominated.

(7) All members elected or nominated shall continue in office until all their successors are elected, or nominated or until the expiration of their term of office, if their successors are elected or nominated before the expiration of such term.

Officers and servants of the Council.

8. The Council, may, from time to time,—

- (a) elect from amongst its members, a Vice-President and an Executive Committee;
- (b) appoint a Registrar who may also, if deemed expedient, act as Secretary and Treasurer;
- (c) appoint or nominate such other officers and servants as the Council deems necessary to carry out the purposes of this Act;
- (d) require and take from the Registrar, or from any other officer or servant, such security for the due performance of his duty as the Council deems necessary; and
- (e) with the previous sanction of the Governor General in Council, for the remuneration

and allowances to be paid to the President, Vice-President, members, officers and servants of the Council.

Annual meeting.

9. (1) The Council shall hold its first meeting at such time and place as may be appointed by the Governor General in Council; and, thereafter, the Council shall meet at least once in each year at such time and place as may be appointed by the Council.

(2) Until otherwise provided by regulations, under this Act, ten members of the Council shall form a quorum and all the acts of the Council shall be decided by a majority of the members present.

Power to make regulations.

10. (1) The Council may make regulations generally to carry out the purposes of this Act, and, without prejudice to the generality of this power, such regulations may provide for.—

- (a) the election of the President ;
- (b) the management of the property of the Council ;
- (c) the summoning and holding of meetings of the Council, the times and places where such meetings are to be held, the conduct of business thereat and the number of members to constitute a quorum ;
- (d) the powers and duties of the President and the Vice-President ;
- (e) the tenure of office and the powers and duties of the Registered and other officers and servants ;

- (f) the election and appointment of an executive committee and of other committees for general or special purposes, the definition of the powers and duties, the summoning and holding of meetings and the conduct of business of such committees ;
- (g) prescribing the fees which may be levied for anything done under this Act by or on behalf of the Council ;
- (h) the establishment, maintenance and duties of medical inspectors ;
- (i) the terms upon which certificates from Universities and other medical institutions shall be received as evidence of qualification for registration and the exemption of candidates for registration from the prescribed qualifications either wholly or partially ;
- (j) the recognition of licenses granted by any, British, British Indian, Colonial or Foreign licensing body or authority ; the arranging and bringing into effect of schemes of reciprocity as to registration with any British, Colonial or foreign medical licensing body or authority; the terms under which medical practitioners shall be entitled to be enrolled on the Register in cases where such practitioners are duly registered or licensed under the medical Acts of the United Kingdom, or under the laws of any British possession other than British India, or under the laws of any foreign country where such British

possession or foreign country extends reciprocal advantage to British India; and

- (k) the procedure to be followed for the enrolment of persons on the Register and the particulars to be entered therein.

(2) No regulation made under this section shall have effect until it is approved by the Governor General in Council.

Registration.

11. (1) The Registrar, shall, subject to the control of the Council, maintain the British Indian Medical Register.

(2) Every person who complies with the regulations and other conditions requisite for registration as prescribed by or under this Act, shall, upon payment of the fees prescribed in that behalf, be entitled to be enrolled on the Register.

(3) Any person holding a medical qualification recognised or granted by an Indian University or a Board of Examiners appointed by a Local Government, who has been enrolled on a Provincial Medical Register prior to the date on which the Council shall have been first duly constituted under this Act, and has been engaged in the active practice of medicine in any province of British India, shall be entitled to be enrolled on the Register, subject to the provisions of this Act and the regulations made thereunder.

(4) The possession of a British Indian University degree or a diploma or of a certificate of enrolment on a Provincial Medical Register founded therein, obtained subsequent to the date on which the

Council shall first be duly constituted under this Act, shall not by itself entitle the possessor thereof to be enrolled on the Register.

(5) Medical Practitioners duly registered or licensed under the Acts of Parliament called the Medical Acts, and practitioners duly registered or licensed by any British, British Indian, Colonial or foreign licensing body or authority for whose registration provisions is made under any scheme of reciprocity arranged and brought into effect by the Council, shall be entitled to be enrolled on the register, subject to the provisions of this Act and the regulations made thereunder.

Privileges of registered practitioners.

12. Notwithstanding anything contained in any enactment, rule, regulation, by-law or order to the contrary,—

(1) no certificate required by or under any enactment to be obtained from a medical practitioner or medical officer shall be valid; unless signed by a practitioner enrolled on the Register ;

(2) no person who is not a practitioner enrolled on the Register shall be competent to hold any appointment as physician, surgeon or other medical officer in any hospital, asylum, infirmary, dispensary or lying-in-hospital not supported entirely by voluntary contributions or as a medical officer of health ;

Provided that the Governor General in Council may exempt any person or class of persons from the provisions of this section.

Correction of Register.

13. Any entry in the Register may be cancelled or corrected upon the ground of fraud, accident or mistake.

Registration and amendment of entries.

14. (1) Applications for registration or for the amendment of any entry in the Register shall be made to the Registrar and shall be disposed of by him in accordance with this Act and regulations made thereunder.

(2) Any person aggrieved by an order of the Registrar under sub-sec. (1) may apply to the Council.

(3) Notwithstanding anything contained in sub-sec. (1) where any practitioner applies to the Registrar for the amendment of an entry, which is adverse to him, the application shall be referred by the Registrar to the Council, and the Council shall hear and determine all such applications.

Erasure of names of persons guilty of improper conduct.

15. (1) If it appears to the Council that there is reasonable ground to believe that any practitioner enrolled on the Register has been convicted, either in His Majesty's possessions or elsewhere, of a criminal offence implying a defect of character which unfits him to be a medical practitioner, or that he has been guilty of conduct improper to a medical practitioner, then, whether such offence or improper conduct has been committed before or after the enrolment of such practitioner, the Council shall, after

three months' notice served personally or sent by post to the last known address of such person, hear and consider the matter, and, if satisfied that such person has been so convicted or has been guilty of such improper conduct, direct the Registrar to erase the name of such practitioner from the Register ;

Provided that, where a person enrolled on a Provincial Medical Register, and his enrolment has been cancelled for any of the causes aforesaid by the authority of the Provincial Medical Council of the province concerned, the Council shall, without further inquiry, direct the name of such person to be erased from the Register.

(2) The name of a person shall not be erased under this section because of his adopting or refraining from adopting the practice of any particular theory of medicine or surgery.

Appearance of parties.

16. In all proceedings before the Council under section 14 and section 15 the person making the application, complaint or appeal to the Council, and any practitioner whose conduct is the subject of the proceedings, shall be entitled to appear and be heard, either in person or by counsel.

Commissions of Inquiry.

17. (1) Whenever it is made to appear to the Governor General in Council that the Council is not complying with any of the provisions of this Act, the Governor General in Council may refer the particulars of the complaint to a Commission of Inquiry consisting of three persons, two of whom shall be appointed by the Governor General in Council, and

one by the Council; and such Commission shall proceed to inquire in a summary manner and to report to the Governor General in Council as to the truth of the matters charged in the complaint, and in case of any charge of default or of improper action being found by the Commission to have been established, the Commission shall recommend the remedies, if any, which are in its opinion necessary.

(2) The Governor General in Council may require the council to adopt the remedies so recommended within such time as, having regard to the report of the Commission, he may think fit; and if the Council fails to comply with any such requirement, the Governor General in Council, may amend the regulations of the Council, or make such provision or order or take such other steps as may seem necessary to give effect to the recommendation of the Commission.

(3) A Commission of Inquiry shall have power to administer oaths, to enforce the attendance of witnesses and the production of documents, and shall have all such other necessary powers for the purpose of any inquiry conducted by it as are exercised by a Civil Court under the Code of Civil Procedure, 1908.

STATEMENT OF OBJECTS AND REASONS.

A Bill 'to regulate Medical Education in India' was introduced by me, for the first time, in the Council of State in February '26 and though short-lived, it was very helpful in that the Government of India were enabled to collect a mass of opinions, in which to base their conclusions. The Government were convinced, after a careful perusal of those opinions, of the imminent need for setting up in India, a centre organization which will regulate standards of qualifications in Allopathic medicine but they were loath to proceed further with my Bill, which they considered to be both defective and drastic. Accordingly, I was persuaded to drop my Bill, which I did, in order to enable the Government to introduce their own Bill in the Legislative Assembly. Their attempt, however, had proved abortive on account of the interference of the Provincial Ministers. Meanwhile, the General Medical Council of Great Britain, have, pending the establishment of an All-India Medical Council, insisted on the appointment of a Commissioner of medical qualifications and standards, who would do the necessary inspection work on their behalf and report as to whether or not, the term of recognition of the Indian Medical degrees could be extended. This proposal did not find favour

with the Legislative Assembly. A serious *impasse* has thus been created and the only solution to this problem is the immediate constitution of an All-India Medical Council. There is a consensus of opinion, both among the Medical Profession in India and the lay public, as to the need for such a Council and the British Medical Council too, quite welcome it. It is doubtful if the Government of India would take the initiative in the matter at this stage and, overriding the decision of the Provincial Ministers, themselves introduce a Bill for the establishment of an All-India Medical Council. Hence this Bill, which I seek to reintroduce, with the necessary modifications in the light of the opinions already received on the subject. It is hoped, this time, it will have a safe sail, here and in the other house, and will be the means, not only, of avoiding a conflict with the British Medical Council in the future but also of establishing an uniformly high standard of medical education in this country.

The 15th December 1929.

U. RAMA RAU.

GOVERNMENT OF INDIA.
COUNCIL OF STATE.

A
BILL
TO

Establish a Medical Council in India and to provide for the maintenance of a British Indian Medical Register; and Annexure.

(The Honourable Dr. U. Rama Rau.)

FROM TIMES OF INDIA.

18—3—30.

Indian Medical Degrees.

We regret exceedingly the decision of the British General Medical Council "to refuse to recognise for the time being" the medical degrees of Indian Universities. We also regret the involved explanation with which the decision was announced in and by the *British Medical Journal*. A plain straightforward account of the difficulties leading to the decision might have been helpful. A rigmarole of argument about proud and sensitive Indian nationalism, about instinctive suspicions of British ideals of education and character and about "differing standards of civilisation in India" will only confuse British readers who do not know India. It puts the matter in the wrong way in so far Indian readers are concerned. As regards the role played throughout the discussions during the past year or two by the General Medical Council, it appears more like a bundle of half-frightened excuses than a frank straightforward exposition of facts. The chief trouble which this latest development will precipitate will be not in regard to the question of medical degrees, but the increased difficulties with which it will lead the general political situation. Just at the moment when everybody with

the welfare of India and of her relations with the rest of the British Empire at heart should be striving to clear away suspicion and promote friendly feeling, the Medical Council have cast political considerations to the winds and floundered in like a bull in a china shop.

Apart from these extraneous considerations the matter is a purely medical one, and should be regarded as such. The present unfortunate state of affairs would never have arisen if people of light and leading in India had from the outset dealt sensibly with the problem involved. The foundation of the trouble is that as the teaching staffs of the medical colleges in India have almost entirely been Indianised the British General Medical Council no longer feel the same assurance that those institutions are conducted according to the standards which they require. And what difference does it make to the General Medical Council? It makes no difference to them except that when they recognise a medical degree their recognition gives the degree-holder the right of medical practice all over the British Empire, and also secures recognition for him elsewhere. The Council must therefore satisfy themselves about the genuineness of the qualifications implied by the grant of the degree. Their loss of assurance in the present case is not the fruit of racial prejudice, but simply the result of their no longer having close acquaintance with the medical teachers concerned. A suggestion was made that in order to secure effective scientific oversight of Indian medical training in a manner acceptable to this country there should be instituted an Indian General Medical Council. The British

Council were quite content with this proposal; so were the modern Indian medical profession. It was the Indian Provincial Ministers who objected on an overdrawn plea of provincial autonomy when the proposal was forward by the Government of India. The Government of India, in order to bridge the gap while the problem was further discussed, proposed the appointment of a Commissioner whose inspection of the Indian Medical Colleges would keep the British Council satisfied about their standards. The British Council were again content, but the Legislative Assembly when the incidental financial proposals were submitted to it talked the matter out for political reasons.

That was last September. The British Medical Council fixed a time limit beyond which it would no longer continue to give recognition to Indian medical degrees unless a reasonable arrangement on lines already approved by the Government of India and the leaders of the Indian medical profession was concluded. The latest public discussion of the matter took place in the Legislative Assembly in its present session. Sir Frank Noyce speaking in behalf of Government said on that occasion:—

The position of the Government of India is that they are as anxious that India should possess Dominion status in this respect as is the Hon. mover of the resolution (Mr. Jayakar). It is their desire to see a statutory Medical Council established the position of which in relation to the (British) General Medical Council will be exactly the same as that of the Medical Councils which have been established in Australia, New Zealand and Canada.

They hope shortly to be in a position to place before this House their proposals in that respect. The Bill which was originally circulated for opinion has to be redrafted in some respects. That will be undertaken at the earliest available opportunity.

Sir Frank was able to add that the British Council had "expressed its desire to be in a position to treat with an All-India Council and to hand over all responsibility in regard to standards and qualifications necessary to ensure its recognition of Indian medical degrees." All that is needed is for India to get on with the business. We reiterate our regret that the General Medical Council were not more job-like, but the breakdown of their patience does not excuse the delay which has occurred in India. What has to be done is in principle agreed upon. Why then the dalliance?

Indian Medical Degrees.

(From the British Medical Journal).

The General Medical Council and Indian Qualification.

HISTORY OF A TEN-YEAR CONTROVERSY.

The General Medical Council, through its Executive Committee, has taken the important decision of refusing to recognize for the time being the medical degrees of the Indian Universities (Bombay, Calcutta, Lucknow, Madras and Punjab) as furnishing a sufficient guarantee of the possession of the requisite knowledge and skill for the efficient practice of medicine, surgery, and midwifery in this country. For some years past the recognition given to these degrees has been conditional and renewed for short periods; the recognition now lapses entirely.

This decision will not be unexpected by those who have studied the weighty addresses which Sir

Donald MacAlister delivers every session from the chair of the Council. During the last ten years those addresses have contained a recurring reference to the Indian universities and the continuance of the recognition of their degrees as entitling the holders to have their names inserted in the *British Medical Register*. When the present controversy began it did not seem likely to be protracted or enlarged. The General Medical Council, for its part, was desirous of helping the medical colleges in India to overcome some admitted deficiencies which were revealed in the years following the war, and the universities, for their part, gave evidence of a desire, in face of obvious difficulties, to bring up their standards to those required by the Council.

The Council has not only shown great patience in handling the situation, but twice during these ten years the chairman of its Examination Committee (Sir Norman Walker) has visited India at the invitation of the Government, and the Council also approved the appointment of an able and experienced officer of the Indian Medical Service as an inspector, upon whose reports the recognition of the university degrees has from time to time been conditionally continued. Neither Sir Norman Walker nor Colonel Needham, in their visits to the colleges, acted as a mere inspector; they conceived it as their function to consult with and advise the Indian educational authorities, always with a view to some more satisfactory arrangement than a conditional recognition from year to year. Of late, however, certain events in India have intensified the difficulties, and a spirit, not of apathy, but of resistance, has manifested it-

self, which, reflected in some words used in the Legislative Assembly last autumn, has had the effect of delaying a satisfactory settlement, if not of destroying its prospects altogether.

*The Position of the General Medical Council
in Respect to India.*

It will be useful to place clearly on record the precise interest of the General Medical Council in Indian degrees and diplomas. The General Medical Council has no jurisdiction in India, no right of intervention in Indian medical education so far as India itself is concerned. If no medical graduate of an Indian university proposed to practise in Great Britain or in any country with which Great Britain has reciprocity, or to apply for a commission in His Majesty's service, the Council would have nothing to say. If it were simply a question of suitable professional training for doctors practising in India under Indian conditions, the authorities there, with their special knowledge of local requirements, would be the best and indeed the only judges. India is autonomous, and the Council has no power to intervene. But when East meets West (as it does continually), and the Council is called upon to recognize an Indian qualification as equivalent to a British one for registration in Great Britain, its statutory duty under the Medical Act of 1886 is to inquire into the conditions under which the qualification has been obtained and the measure in which these conditions fulfil the requirements, not of India, but of Great Britain. The President of the Council has made the point as clear as language can make it. "Our pri-

mary interest", he said, at the November session, 1928, "is that recognized Indian medical degrees shall guarantee a standard of proficiency sufficient for practice in this country. It is this interest, which we cannot forego, that alone justifies our intervention in Indian medical education." The Council is the body whose recognition of Indian medical diplomas for registration is by law equivalent to a guarantee of their sufficiency for effective practice of medicine, surgery, and midwifery beyond the limits of India.

As with most other debates, the roots of this controversy extend far beyond the immediate point at issue. Many factors enter into the situation, the most assertive at the moment being Indian nationalism, proud, sensitive, instinctively suspicious of British ideals of education and character. Indian customs, like that of purdah, which has limited the opportunities of obstetric instruction (where the trouble began), have to be taken into account. Then there is the necessity, which the Indian is under, of pursuing his studies in a foreign tongue, so that while his acquaintance with English textbooks may be word-perfect, he suffers often throughout his curriculum from inability to follow entirely the conversational English of the clinic and the examination room. The further fact has to be reckoned with—the fact out of which, the present Prime Minister once said, the difficulties of government in India arise—that India is a continent of peoples whose civilization is advancing at different rates of progress. Even the climate, which makes it harder in India than in England to work throughout the three academic terms a year, is not to be disregarded.

The Rise of Indian Medical Education.

Until recent years medical education in India was directed by the Indian Medical Service. The surgeons of the East India Company, the body under which, up to the middle of the last century, Indian affairs were conducted, gave the first impulse to the medical education of the Indian student. At first it was little more than an apprenticeship in dispensing, but even a hundred years ago the medical student, as the term is understood in the West, began to emerge. Regular college instruction was provided, at first in chemistry, anatomy, and *materia medica*, and later, as the benefits of the plan became apparent, in all the subjects of the medical curriculum. The colleges which were established at Calcutta, Madras, and Bombay, and afterwards at Lucknow and Lahore, were all Government institutions, and in the closest relationship with the Indian Medical Service. The professors were presidency officers—not whole-time professors, but engaged in civil practice as well—and for a long period they were all Europeans.

It was in these circumstances, with the I. M. S. acting as sponsor for medical education in India, and spreading Western ideas of medicine, surgery, and sanitation, that, in 1892, the General Medical Council first recognized an Indian medical degree as entitling the holder to have his name on the British *Register*. No doubt the members of the Council sitting in London at that time knew little about the actual conditions of instruction and training in India, but they did know that the teachers and examiners

were all men who had been educated in British schools and were carrying the spirit and tradition of those schools into their Eastern environment. The fact that entrance to the I. M. S. could only be gained by passing an examination in London led to almost all the candidates for that service, both Indian and European, being holders of British qualifications.

The Indian Medical Service, following upon the recent Indian reforms, has undergone a drastic transformation. From certain points of view it is only the simulacrum of its former self. Another important change has been the devolution of medical administration, including the provision for medical education, from the central to the provincial Governments. The latter under the Government of India Act, 1919, have a large measure of independence. These changes have been followed, as was only to be expected, by a great diminution in the proportion of European teachers in the older colleges, while in two additional colleges established in recent years and affiliated to the Universities of Calcutta and Bombay respectively, the professorial staff includes no Europeans.

The curriculum in India differs at some points from the one followed in this country. The custom which obtains here of providing for registration of medical students subject to their passing a recognized preliminary examination in arts, and in addition a practical and theoretical examination in chemistry and physics, does not hold good in some of the Indian universities. In such universities the custom is, after matriculation, which is sometimes passed at the age of 14, to require students before admission

to a medical college to pass a university intermediate arts and science examination, or its equivalent, after two further years' study. As the matriculation standard in India is not accepted as the equivalent of the recognized preliminary examination required from intending medical students in this country, the single intermediate examination, which includes chemistry and physics, operates in lieu of the two separate examinations required from British students. The number of students passing the intermediate is greater than the number of vacancies in the medical colleges, and thus a further selection is necessary, a selection said not always to be based on educational grounds.

No student of the history of medicine in India would withhold praise for the excellent work which the Indian medical colleges have accomplished in the past. The best tribute to this work is the high honours which some Indian students have obtained in British examinations. During the war conditions changed for the worse, as they did in many other fields, owing to overcrowding and pressure. The immediate matter which opened up the present controversy was the revelation of a discrepancy between regulation and practice in midwifery instruction. Information on this point reached the General Medical Council in 1920. The subject was one in which it was always difficult in a country like India to arrange for practical instruction. The inadequacy of obstetrical training was at that time recognized, and recently commissioned officers of the I. M. S. who had graduated at colleges where the training was obviously inadequate were required to go for

an intensive course to Madras, where opportunities were more abundant.

The Council, on learning that matters were not as they should be in midwifery, addressed a letter of inquiry to the universities, and after receiving the replies the Executive Committee—which in these questions acts with plenary powers as if it were the Council itself—resolved that unless it received by a given date information that the arrangements and requirements with regard to midwifery had been brought into satisfactory accordance with the Council's resolutions, the recognition hitherto granted to the degrees must terminate. The universities pleaded—a plea which was endorsed by the Secretary of State (the late Mr. E. S. Montagu)—for an extension of time to reform the midwifery and gynaecological part of their curriculum. A temporary arrangement was arrived at—namely, that the Council should nominate one of its members to the Government of India as a visitor to the Indian universities. The result was that early in 1922 Sir Norman Walker, a man with exceptional experience of educational administration, left for India.

Sir Norman Walker's visit created in India an impression of good will. The Indian universities were satisfied that means must be found for resolving the perplexities regarding the standard of obstetrical knowledge. Some of them expressly accepted his suggestions for the improvement of the teaching of midwifery. He dealt, equally sympathetically, with inadequacies in other respects which had become apparent.

A Special Inspector Nominated.

One very important outcome of Sir Norman Walker's report on his return was the proposal that the Government of India should be invited to appoint an officer as special inspector of the universities. The choice fell upon Colonel R. A. Needham, who had had twenty years' experience in the I. M. S., and was at the time Deputy Director-General. The Secretary of State approved the proposal, and Colonel Needham commenced his duties forthwith and submitted his first reports in 1923. Although called an inspector, he had wider functions—namely, to endeavour to co-ordinate the standards in all essential branches of medical training at the different colleges, and to report to the General Medical Council regularly on the maintenance or improvement of the standard, so that recognition might be continued from year to year. Colonel Needham's reports, which were most carefully framed, were highly valued by the Executive Committee. He made reference to defects as he saw them, such as congestion in the colleges, or inadequacies of teaching, or deficiencies in the examination, but he was also careful to acknowledge every effort at improvement, both for what it was and what it promised. Some of the colleges were evidently concerned, apart from the question of external recognition, to provide better facilities for study in midwifery, to extend the curriculum in general (which varied in different parts of India between thirteen and eighteen academic terms), and to extend the too limited period of hospital study after the examination in anatomy and physiology.

An unfortunate episode was the refusal of Calcutta University in June, 1924, to admit the inspector to be present at its final examination. The university was warned that in the absence of a report the conditional recognition would automatically terminate. No report was forthcoming, and the recognition of the Calcutta degrees lapsed in November, 1924. After that date, for four years, the degrees granted by Calcutta did not confer a title to registration in this country. Calcutta made some approaches to the Council in 1925, but the Executive Committee was unable, on the information afforded, to resume recognition, and so matters continued until 1928, when Calcutta applied for recognition of its degrees, and stated that it had revised its regulations. Inspections were consequently resumed, and in the absence of Colonel Needham on leave, Colonel Megaw, I. M. S., was commissioned to visit and report, with the result that the recognition of the Calcutta degrees was accorded, as with the other universities, conditionally, and for a limited period.

Meanwhile, at the end of 1926, on the proposal of the then Secretary of State (Lord Birkenhead), Sir Norman Walker paid a second visit to India. His object was to see the courses of study and the examinations at the universities, to remove difficulties as far as possible, and to have regard to the new situation, now rapidly developing, whereby fresh universities and colleges, including faculties of medicine, were in process of formation in many parts of the Indian Empire. The years 1922—27 saw a large increase in the number of colleges in India, and scattered as they were from Bombay to Rangoon,

and from Lahore to Madras, they rendered the conditions of regular visitation and inspection by the direct agency of the Council almost out of the question.

Sir Norman Walker's report on this second visit (fully summarized in the *British Medical Journal*, ii, 1927, p. 312) is perhaps the most comprehensive of recent documents on the subject of Indian medical education. It contains many valuable suggestions, and the picture it gives is, on the whole, reassuring. Sir Norman Walker found excellent maternity hospitals at Madras and Bombay, and the prospects of such at Calcutta and Lahore. He praised the hospital departments in many particulars, especially in respect to ophthalmology. But he pointed out certain defects, such as the isolation of the examinations, the fact that the examiners were all more or less connected with the college or district in which the examination was held, whereas in this country examiners from other universities are brought in; and another point emphasized was the need for maintaining uniformity in examinations from year to year by the appointment of examiners for a certain term.

An All-India Council Mooted.

The principal matter which grew out of Sir Norman Walker's report, however, was the need for new steps to be taken in India itself for the setting up of a responsible and co-ordinating central authority. The existence of conditional recognition from year to year on the report of an inspector to a body sitting in London was unsatisfactory alike to those who

sought recognition and those who bestowed it. However able the inspectors, and whatever good will was shown to the colleges, it could only be a temporary expedient. The time had come when India itself should give some guarantee of uniformity of standards through an authoritative body with which the Council in London could consult.

The suggestion took the form of an All-India Council, whose relation to the various colleges would be not unlike the relation of the General Medical Council to the examining bodies in this country. It is worth while to turn from India for a moment to consider what that relation is. The universities are independent and autonomous, and may impose what conditions they like as to the granting of their medical degrees. But the General Medical Council—by virtue of its right to require information about the course of study and examination for qualification, to inspect the final examination, and to report defects to the Privy Council, which may suspend the right of registration of qualifications granted by the university in default—acts as a co-ordinating and controlling influence. As a matter of fact, conditions being what they are in this country, this disciplinary possibility is quite in the background, and the Council, which itself is composed largely of representatives of the teaching and examining bodies, exercises a benevolent role by the suggestions which it makes from time to time for improvement in the curriculum and by circulating among all the bodies the views and practice of each. There may be no exact analogy in other professions for the position of the General Medical Council in this respect, but it must

be remembered that, while it is important to conserve the independence of the universities, the public interest is involved in medicine to a greater extent than in other faculties, and therefore a minimum standard must be exacted from all.

The medical colleges in India from the first were isolated units, organized by and dependent on the Government, and staffed by Government medical officers. When a university was founded in their presidency or province they became colleges of the university, still retaining, however, in great measure their independence. So long as the work of the colleges integrated with that of the Indian Medical Service a certain amount of co-ordination was possible. But with the coming of provincial Governments into control of the administration, including university appointments, the colleges lapsed into a greater insularity than ever. Provincial medical councils have been set up, but these do not concern themselves with the maintenance of standards of medical degrees granted by provincial universities, and from the mere facts of geography they could not serve as a means of maintaining uniformity of standards throughout India. At present there is no co-ordinating body in India, and for the General Medical Council to endeavour to act as such would in the nature of the case be ineffective. The system which has obtained for the last seven or eight years has been temporary, and has now become unworkable.

A Temporary Commissionership of Standards.

An All-India Medical Council therefore seemed to offer the way out, one that did not trench on Indian

prestige and at the same time satisfied the General Medical Council as furnishing a body with which it could discuss questions of recognition. It was acknowledged, however, that the setting up of such a body must take time. What was to happen meanwhile ? Was there to be a hiatus in the recognition of the degrees or an attempt to continue the increasingly difficult procedure of inspection under the aegis of the Council ? To bridge the gap it was proposed to set up a Commissioner of Medical Qualifications and Standards, an official whose appointment would be by the Government of India, who would have his headquarters at Delhi, and who with his staff would continue and expand the work already done by the Council's inspector. The reports of such a commissioner would be accepted by the General Medical Council as were those of its own visitor. The control and provincial Governments agreed to this course, and at the end of 1928 it seemed that this vexed question of Indian qualifications was at last approaching a settlement. A bill for the establishment of an All-India Medical Council had been introduced into the central Legislature. The bill provided that this body should exercise supervision over the standard of professional teaching and examination throughout India, having special regard to the external and central or non-provincial aspects of medical qualifications. The appointment of a central commissioner had been approved by the Government of India, for one year in the first instance, and the Secretary of State had suggested that it was desirable to offer the appointment to Colonel Needham—a nomination with which the General Medical Council

was heartily in accord, having had experience of Colonel Needham's qualifications, and knowing how desirable it was that the commissioner should be familiar with British standards. The pay of the officer was even fixed. On the strength of all this the Council continued provisionally the recognition of the degrees of Bombay, Calcutta, Madras, Lucknow, and Lahore for a further period, postponing the consideration of recognition of those of Patna and Rangoon until it received the reports from the new commissioner.

The Impasse Created by the Legislative Assembly.

Shortly before he was due to sail so as to reach India in time for examinations to be held at the end of 1929, Colonel Needham received an intimation from the India Office cancelling his appointment. The reason for this was the action taken in the Legislative Assembly. The Finance Committee of the Legislature had given some warning of what might follow by rejecting the credit for the appointment of the commissioner. The Government, however, brought the matter before the Assembly, and there the suggested arrangement for the commissionership was opposed by the Nationalist and Congress parties on the ground that the creation of the post was of no urgency, but might very well be postponed until the following session. The objection really amounts to this: that India, while not averse from All-India Medical Council, regards the proposal for filling the necessary interregnum by the temporary appointment of a commissioner as reflecting on Indian

prestige. Many of the arguments used by Nationalist members were captious. One objection was that the officer proposed for the appointment belonged to the Indian Medical Service (although the I. M. S. has mothered Indian medical education); another, made by a Hindu leader, was that the proposal involved disrespect to the Indian universities, which, the speaker said, he would rather close than see submitted to this indignity; and there was much talk of dictators and British tyranny. The position of the central and local Governments, which, aware of the gravity of the case, supported the proposal, was put forward, but after a prolonged discussion the opposition was still dissatisfied, and the motion was "talked out". An effort was made to secure the continuation of the debate on the following day, but this was refused by the President of the Assembly, and the session came to an end without any decision being taken.

In view of what had happened the Government of India asked that Colonel Needham should not sail, and the Secretary of State could do no other than comply. It was stated that at the next session, early in the present year, the matter would again be brought forward, but in the meanwhile not only has the proposal for a Government commissioner broken down, but the formation of an All-India Council is stayed. The responsibility for this grave result cannot be placed on the General Medical Council. In his reply to the Secretary of State on these perplexed and perplexing matters," the President of the General Medical Council stated that the Executive Committee had postponed its final decision until its

meeting in February, but he added that the inevitable absence of authoritative reports on the actual standards of study and examination for Indian medical qualifications was of serious import. The committee would be deprived, by the action taken in India, of the guarantees of sufficiency necessary under the Medical Act of 1886, on the basis of which alone it could be in a position to continue recognition of Indian medical degrees. "When the Government of India," said the President further, "is in a position to supply such guarantees by means of satisfactory reports from a Commissioner of Medical Standards and Qualifications, or from a legally constituted All-India Medical Council, the Executive Committee . . . will give applications from Indian universities, transmitted by the Government of India, its careful and sympathetic consideration."

New Proposals from India.

In January the Secretary of State informed the General Medical Council that the Government of India was of opinion that it was not possible to reopen the question of the appointment of a commissioner in view of the strong opposition in the Assembly, and also in view of the opinion of the quinquennial Indian universities conference, which had met at Delhi in October. This conference, while favourable to the establishment of an All-India Medical Council, regarded the appointment of a commissioner as not in accordance with the best interests of medical education in India, and as wholly opposed, not only to practice elsewhere, but to the whole trend of Indian public opinion, medical and legislative.

The universities conference did, however, make the suggestion that, pending the creation of the India Medical Council, a board consisting of representatives of the Government of India and of the medical faculties of the universities should be set up as a temporary measure for determining and supervising medical qualifications and standards. The Viceroy's department, in transmitting this suggestion, regarded it as a sound one, and proposed that the board should have as its president the Director-General of the Indian Medical Service, and as members one representative from each of the faculties. It was further proposed, by the Government, that the board should appoint three inspectors, specialists respectively in medicine, surgery, and midwifery, who would report on standards of medical education and examination, and on whose reports the board would decide whether guarantees should be given to the General Medical Council that the possession of the degree of a particular university ensured the minimum qualifications required for British registration.

The Secretary of State, in forwarding these new proposals, said that it was assumed that the three inspectors would possess British qualifications, and it seemed likely that their reports, being reports of specialists in the subjects of the final examination, would be more authoritative than those of a single commissioner. Mr. Wedgwood Benn hoped that the measures proposed would be acceptable to the Council. The President could only reply that the decision of the Executive Committee at its meeting at the end of February could not be anticipated, and that the questions of the composition of the proposed tempor-

ary board and its independence and sufficiency would have to be discussed.

Meanwhile the main proposal for the eventual establishment of an All-India Medical Council has not enjoyed an uninterrupted development. An informal council of Ministers of the provincial Governments, misunderstanding the proposal as an encroachment on their control of the medical services—which, as stated, have lately been decentralized and placed in their hands—disapproved of the bill for the creation of the council, and therefore the Government of India decided for the time being to proceed no further. A later message from the Viceroy's department to the Secretary of State, dated January 6th, stated, however, "Local Governments now agree that only solution of present difficulties is to be found in the establishment of All-India Medical Council. We are most anxious to proceed with legislation with the least possible delay, but in view of intricacy of the subject and necessity of alterations in the bill, as originally drafted, to meet criticisms and suggestions received from various quarters on which it will probably be necessary to consult local Governments, it will not be possible to introduce legislative measure this session."

Some of the universities, notably Lucknow and Bombay, have expressed concern at the prospect of their medical graduates ceasing to be recognized as possessing a registrable qualification. "We find it difficult to think," writes the vice-chancellor of Lucknow, "that when the King George's Medical College has, in equipment and courses, been brought

to a standard satisfactory to your inspectors who have come from year to year, the students who pass out now should be given a qualification of less value than the students who passed out in former years, especially when it is our constant endeavour to continue making further improvements."

The General Medical Council's Decision: Indian Degrees not to be Recognized.

The Executive Committee of the General Medical Council met on February 24th, and after a consideration of all the facts and representations passed a series of important resolutions, the first of which reads as follows:

That in the absence of authoritative information respecting the medical qualifications and standards of the Indian Universities of Bombay, Calcutta, Lucknow, Madras, and Punjab, the Executive Committee of the Council, in fulfilment of its duty under the Medical Act, 1886, Section 13, is unable for the time being to recognize the medical degrees of these universities as, 'furnishing a sufficient guarantee of the possession of the requisite knowledge and skill for the efficient practice of medicine, surgery, and midwifery' in this country; and that accordingly the conditional recognition hitherto granted to these degrees has now lapsed.

With regard to the Indian proposal to set up a temporary board, the Committee resolved :

That the proposal . . . has been carefully considered by the Executive Committee; but it is unable to accept the proposal as furnishing a satisfactory

method of supplying the Council with authoritative information on medical qualifications and standards in India, and with the necessary guarantees of sufficiency.

In a late message the Government of India proposed to appoint temporary inspectors of the qualifying examinations of the Universities of Rangoon and Patna. Here again the Executive Committee has found it undesirable to renew the practice of approving the appointment of separate *ad hoc* inspectors, which it had already found inadequate for the purpose of ascertaining the sufficiency of the standards for Indian medical degrees, actually required and enforced by the universities.

To separate representations from Bombay and Lucknow it was resolved simply to reply forwarding a copy of the above resolutions. There, apparently, the matter has for the time being come to an end.

News

APPOINTMENTS, TRANSFERS, Etc.

THIR TO MEHIR 1338 FASLI.

CIVIL SURGEONS.

A. R. Huften	Mahboobnagar	Retired Karim Abbas, Offg.
C. F. Chinoy	Aurangabad	Special Plague Officer, Hyder- abad
Mirza Hasan Ali Beg	Chaderghat	to Aurangabad
P. N. Naidu	Asifabad	Patancheru A. S., R. K. Garde, as Offg.
Mithra Pala	Mint Hospital	Chaderghat Offg. Civil Surgeon
R. K. Garde	Raichur	Asifabad Offg. Civil Surgeon

ASSISTANT SURGEONS.

Mohd. Abdur Rasheed	Narayanpet	Retired
S. Raghavandra Rao	Narayanpet	Plague Duty
L. B. Pkatalls	Liyal	Narayanpet

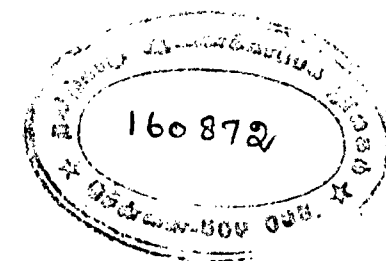
Mohd. Abdul Basith	New appointed O.H. Sanctioned	Osmania Hospital
Mrs. Watts	Victoria Z, Hosp	"
Khairunnisa Begam	New appointed	"
Riasathali Khan Shiek Ahmed	Narayanpeth	Osmania Stores Retired
Ghulam Ghouse	Salem	Karvan
O. C. Sitaramiah	Asifabad	Seren (Promoted)
Abdul Ali Khan	Asifabad	Osmania Hospital
A. C. Gabriel	Osmania Hosp.	Adilabad (Promo- ted)
M. H. Desh- ponde	Nandedosp	Mint Hospital
Syed Abdur Rahman	Shorapur	Died
Damodram Naidu	Central Jail Warangal	Shorapur (Promo- ted)
M. V. Rejaili	Patancheru	Central Jail Gul- barga
C. Masichallan	Kannad	Mushirabad (Pro- moted)
Marim Abbas	Mushirabad	Mahboobnagar Offg. Civil Sur- geon

SUB ASSISTANT SURGEONS.

Latchman Govind Dan- davathi	Kinwat	Asifabad
W. S. Joshi	Asifabad	Kinwat
Alam Ali Khan	Gangavati	Osmania Hospital

Kamidullah Khan	Suriapet	
Mohd. Khamruddin	Baroen Balda	Chitapur
Bhim Singh	Lingsagur	Baroen Balda
Hunmabadkar	Newly appointed	Lingsugur
Dicambar Latchman	Newly appointed	Gangavati
Chintaminai Rao	Gajvail	Sillod
Miss Fransica	Newly appointed	Beed
V. D. Paramasiyam	Mahboobabad	Osmania Hospital
B. S. Narayan	Travelling Dispy. Warangal	Mahboobabad
Ahmedullah	Newly appointed	Travelling, Warangal
Mohd. Ghani Siddiqi	Khemmam	Asifabad Tour
V. S. Modhen Rao	Warangal	Khammam (Promoted)
B. Memkchador	Newly appointed	Warangal
J. Jagunath Rao		Raichur
B. S. Ramalingam	Raichur	Kalvakurti
G. G. Kelkar	Ambad	Dismissed
Gopal Vithal	Devarkunda	Ambad
Venkat Vardhan	Newly appointed	Devarkunda
Abdus Sattar	Osmania Hospital (Permanent)	
A. Natesan Pillai	Newly appointed	Osmania Hospital

W. S. Narasimgha Rao	Nanded	Lingal (Promoted)
Barsiker T. B.	Khuldabad	Central Jail Warangal
V. R. Desai	Jenwada	Kannad
P. S. Rao	Khuldabad	Janwada
Vaidya	Newly appointed	Khuldabad
B. B. Kulkarni	Kodangal	Osmania Hospital
N. V. Narasimha Rao	Plague Duty	Kodangal
T. J. Kamble	Kodangal	Plague Duty
T. V. Dias	Parbhani	V. Z. Hospital
Mrs. Clarke	Nanded	Parbhani
B. L. Narasimha Rao	Newly appointed	Plague Duty
K. M. Rudrappa	"	"
A. Mohan Ramgam	"	"
Mrs.	"	Aliabad Dispy.
Miss Bherde	"	Plague Duty Nalgonda



160872
112062

The Hyderabad Medical Association.

THE membership is open to all persons holding medical and Surgical qualifications according to the Western System and the chief object of the Association is to promote Medical and Surgical knowledge by reading of papers, demonstration of cases and discussions, in monthly meetings.

The Office of the Association is in the Osmania Medical College, Afzulgunj, and the meetings are ordinarily held in the Osmania General Hospital.

President—R. N. COORLAWALA, F. R. C. S.,
(ENG.), D. P. H., ETC.

Vice-President—MAJOR MOHAMED ASHRAFF, M. B., CH. B.

Secretary and Treasurer—MAJOR FARHAT ALI, B. A., M. B., CH. B.

Editor of the Journal—V. R. GORAKSHAKAR, B. A., M. B., CH. B.

Managing Committee—The above Office-bearers and

KHURSHEID HUSSAIN, M. B., CH. B.

H. J. CHINOY, L. R. C. P. & S.,

LATEEF SAYEED, M. B., CH. B.,

CAPT. K. N. WAGHARAY, M. B., B. S.,

B. S. RAJ, L. R. C. P. & S.,

MISS K. S. KANGA, L. R. C. P. & S.

Every member has to pay an annual subscription of O. S. Rs. 12.

Only the Sub-Assistant Surgeons will pay half the above rate but the subscription will, in any case, be payable for the whole year in advance and every member will receive free a copy of the Quarterly Journal of the Association.

The Deccan Medical Journal.

PUBLISHED quarterly by the Hyderabad Medical Association. The only journal of its kind in His Exalted Highness the Nizam's Dominions and consequently the best medium of advertisement for Chemical, Pharmaceutical and Surgical Manufacturers. Articles of special interest to the profession from experts appear in every issue.

Editorial Committee :—

Editor—V. R. GORAKSHAKAR, B. A., M. B.,
CH. B.

Assistant Editor—S. RAGHAVENDER RAO,
L. C. P. S.

The members of the Committee—The above and

CAPT. K. N. WAGHARAY, M. B., B. S.,
S. E. DAVID, M. R. C. P., L. M.,
MISS A. SHAW, M. B., B. S., D. T. M. & H.

<i>Rates of advertisement:—</i>	Rs.	a.	p.
Full page ordinary	15	0	0
Half page ordinary	8	0	0
Quarter page ordinary	5	0	0
Back cover inside	25	per cent.	extra.
Back cover outside	50	per cent.	extra.
Front cover inside	60	per cent.	extra.
For four issues prepaid	10	per cent.	discount
For two issues prepaid	5	do	do

For further particulars apply to

THE EDITOR,

THE DECCAN MEDICAL JOURNAL,
Osmania General Hospital,
HYDERABAD-DECCAN.

In the Treatment of the Affections of the Upper Respiratory Tract

correction of the internal systemic abnormalities is aided by local applications. By supplying continuous, moist heat over a considerable period, together with the osmotic, antiseptic and synergistic action of its components

Antiphlogistine

when applied to the affected area, increases the blood and lymph circulation, promotes the comfort of the patient and aids in the restoration of normal function.

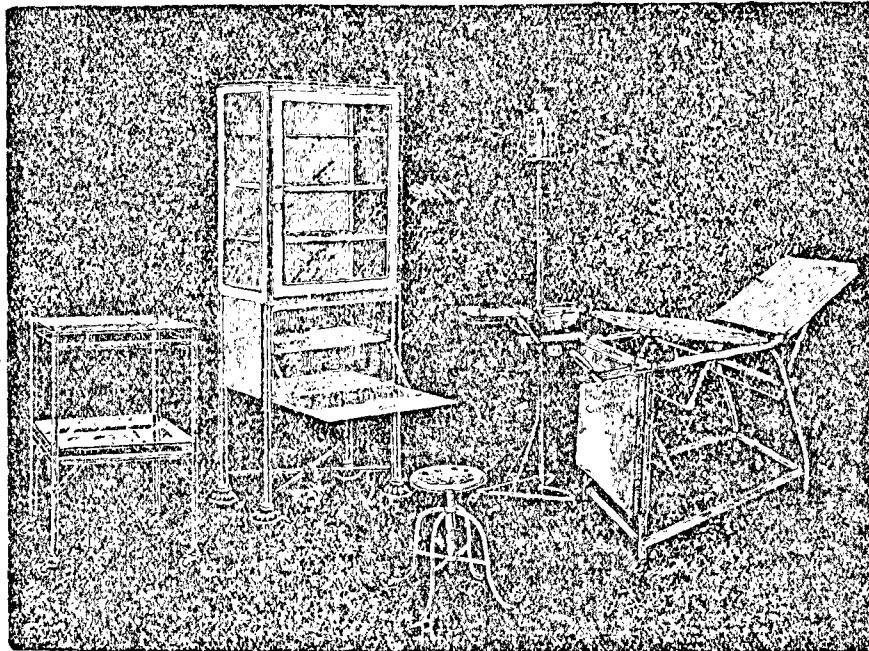
Antiphlogistine does not supplant other forms of therapy but, rather, should be coördinated with them.

Write for sample and literature, quoted from standard sources.



THE DENVER CHEMICAL MANUFACTURING COMPANY
163 Varick Street, New York, N. Y.

QUALITY of DISTINCTION



THE FOREMOST HOUSE IN INDIA
FOR
Aseptic Furniture & Steel Boxes, etc.

ASEPTIC CABINETS, OPERATION TABLES,
DRESSING WAGONS, WARD LOCKERS,
STOOLS, HIGH PRESSURE AND STEAM
STERILIZERS, BEDSTEADS, BED SCREENS,
LOTION AND IRRIGATOR STANDS, GLASS
AND ENAMELLED WARE, SURGICAL
INSTRUMENTS, ETC., ETC.

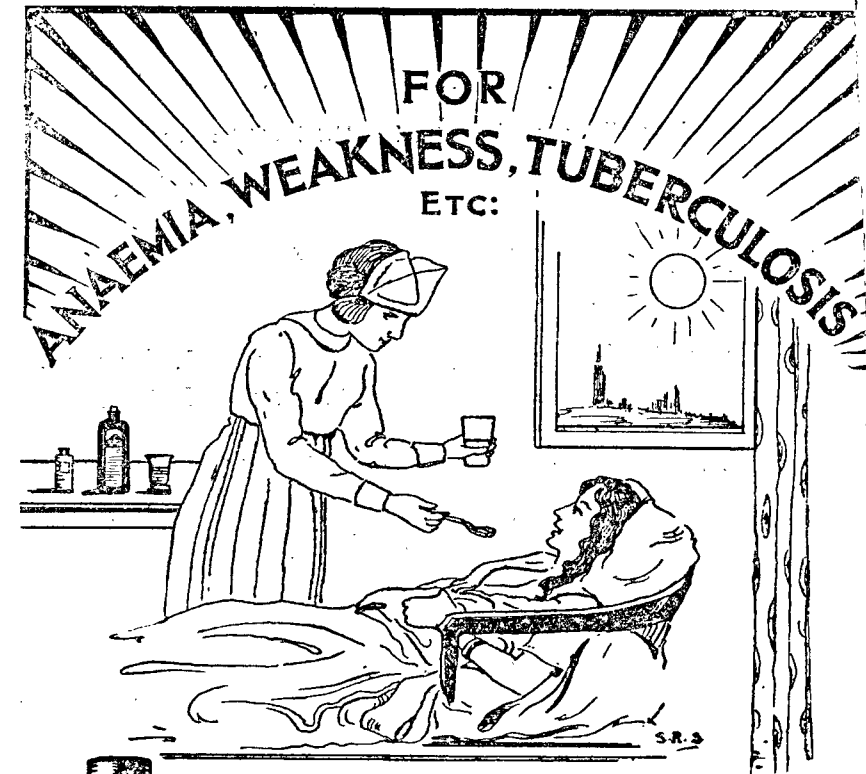
AND ALSO
STEEL OFFICE AND DRESS BOXES

CATALOGUES FREE ON DEMAND

ALLIBHOY VALLIJEE & SONS

By Appointment **ALVI WORKS** 26 GOLD AND
to H. M. the King. **MULTAN CANTT., PUNJAB** SILVER MEDALS.

Telegrams : 'DESPATCH' BOX



CURE YOURSELF
BY THE MOST REMARKABLE DISCOVERY:
DR. ROUSSEL'S
HEMOSTYL

A SCIENTIFIC FRENCH PREPARATION, HIGHLY RECOMMENDED & LARGELY PRESCRIBED BY ALL LEADING DOCTORS THROUGHOUT THE WORLD. AGREEABLE TO THE TASTE PARTICULARLY EFFICACIOUS FOR DEBILITY FOLLOWING MALARIA, INFLUENZA, CHILDBIRTH, Etc & ALL RUNDOWN CONDITIONS

AGENTS FOR INDIA.

KAHN & KAHN

Jehangir Wadia Buildings, Esplanade Road, BOMBAY.
14, Clive Street CALCUTTA
Stockists at Madras :—
Messrs. Sri Krishna Bros. Post Box. 166, MADRAS.

Please Note :—The genuine package bears the RED LABEL,

"Hemostyl Specially Prepared for Tropical Countries."

BEWARE of IMITATIONS without such Labels.

"TREPARSOL"
New French Discovery. SURE CURE for
SYPHILIS & AMOEBIASIS

In Tablets
No Injection Necessary

Sole Agents for India.—

KAHN & KAHN,
Jehangir Wadia Building, P. O. Box. 105, Bombay.
14, Clive Street, P. O. Box. 315, Calcutta.

Stockists at Madras:—

Messrs. Sri Krishna Brothers, Post Box 166, Madras.

The Patna Journal of Medicine

(The Journal of the Patna Medical Association).

Edited by

H. HYDERALIKHAN, F. R. C. S. E.,
BANKIPORE, PATNA.

ONE OF THE MOST UP-TO-DATE JOURNALS
IN INDIA.

Articles by Experts.

January 1927—Special Endocrinology Number.

July 1927—Special Educational Number.

Price Re. 1/4. Annual Rs. 4/6.

Post free from the Editor.

T H E
"M. L. B." SPECIALITIES.
Making the WORKS in HOECHST
world-known.

SALVARSAN—COMPOUNDS

JEOSALVARSAN, Ehrlich's original 914, the most reliable anti-syphilitic for the intra-venous route. In also Double Ampoules the most convenient preparation on the market.

MYOSALVARSAN, the popular SALVARSAN-COMPOUND for the intramuscular route.

JEOSILVERSALVARSAN, **SODIUM-SALVARSAN**, **SULFOXYLSALVARSAN** with their different advantages.

NOVOCAIN.

The first synthetic, non-toxic-cocain-substitute, which opened the whole field of

LOCAL-ANAESTHESIA
No License Required!

PYRAMIDON.

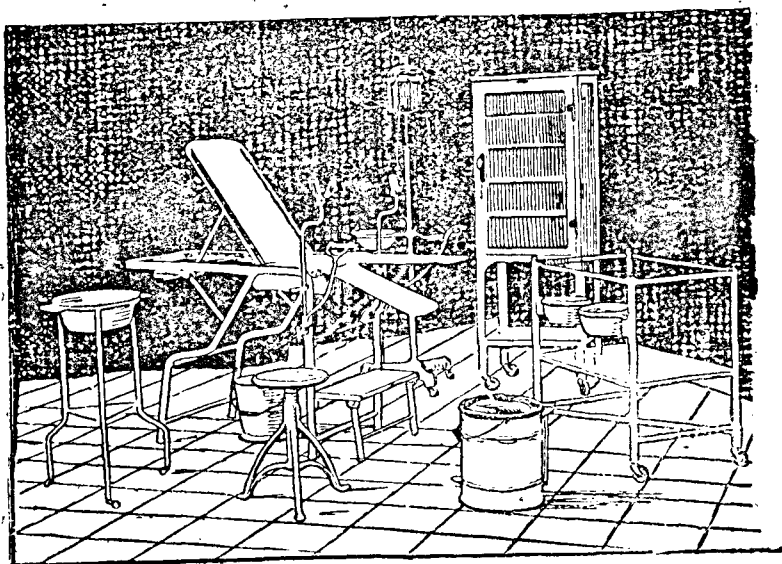
The oldest analgesic and anti-pyretic. Dependable, quick and mild in action. The antipyretic of choice for children.

Literature and full particulars on application.

HAVERO TRADING Co., Ltd.,
CALCUTTA.

Pharmaceutical Dept. "Bayer-Meister Lucius"
P. O. Box 2122,
15, Clive St., Calcutta.

Can be had from us at the most Competitive Prices



Printed by D. T. Rao, LL. B., Bar-at-law at the Vani Press, Bezawada—1930.

[illegible]