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The Medical Practitioner

A Monthly Medical Journal

EDITED BY

Dr. M. S. Krishnamurthi Ayyar, M.B. & C.M.,
Retired Sanitary Commissioner, Travancore State,
AND
Dr. V. Rama Kamath,
Member, Madras Medical Council.

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Scientific articles and notes of interest to the profession are solicited. Contributors of original articles will receive a copy of the journal in which they are published.

Communications on all matters connected with the journal, literary and business should be addressed to the Managing Editor, 147, Purasawalkam High Road, Vepery, Madras, as he alone is responsible for the conduct of the journal. Annual subscription to the journal is Rs. 1-8-0 including postage, payable in advance. Papers and articles forwarded for publication should be either typed or written legibly on only one side of the paper. They are understood to be offered to "The Medical Practitioner" alone and any breach of this rule will be followed by non-publication. When any such of the article appears in "The Medical Practitioners" the copyright automatically becomes the joint property of the author or authors and of the publishers. Papers and articles sent will be sent back to the contributors, if so desired, and postage sent for the purpose. The Editors of "The Medical Practitioner" cannot advise correspondents with regard to prescriptions, diagnosis, etc., nor can they recommend individual practitioner by name as such action would constitute a breach of professional etiquette.

THE

Medical Practitioner

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NEW YEAR GREETINGS.

We offer our sincere greetings to our subscribers, readers, advertisers and the public for the new year. The activities of "The Medical Practitioner" during the last year have not been without effect. The humiliating order requiring countersignature on medical certificates granted by private medical practitioners has been withdrawn. The system of appointing honoraries ha been extended to moffusal hospitals. The practice of opening rural dispensaries in places where a member of the independent medical profession is already settled, has been disallowed by the Government. These are amongst other things about which the journal has been agitating; still there remains much to be done to bring the medical relief of the general public to the level obtaining in other civilised countries both in the interests of the public and of the medical profession. The duty of affording medical relief to the general public should rest mainly on private medical practitioners and we shall continue our efforts to achieve this end. We are fortunate in having at present as the head of the medical department Major General C. A. Sprawson who has shown by his action and public utterances, his sympathy with the independent medical profession in its attempt to rise to its legitimate position in the matter of affording medical relief to the general public. The popularity of "The Medical Practitioner" both among the medical men, private and paid, and the lay men, is shown by the increase in the number of subscribers among whom there are, besides the independent practitioners, servicemen including members of I. M. S. and lay men amongst whom a judge of the Madras High Court may be mentioned; but still, to improve the usefulness of the journal and to run it without loss a large number of subscribers are required. The subscription has been fixed at the lowest minimum possible, so that every medical practitioner, however low his income may be, can find it possible to pay 2 annas every month for the journal.

We offer our thanks to our subscribers, readers, advertisers and the public for the sympathetic co-operation they have shown and wish them all again a happy new year.

MEDICAL SERVICES IN BOMBAY PRESIDENCY

Recruitment to the teaching cadre seems to be as unsatisfactory in Bombay as it is in Madras. It will be ever so, as long as the teaching institutions are under the control of one autocrat who has no continuity of interest except for a brief period, ranging from 3 to 5 years and sometimes not even a couple of years. The present system of appointing Surgeons-General from outside the provinces has made matters worse though as we have said before such appointments have salutary effects from administration point of view especially at a time when the right of private practice enjoyed by those in service has been misused and a local senior-most medical officer next in rank to the Surgeon-General has usually ties of attachment with some men in service. As in Madras so also in Bombay a few years ago the Surgeon-General was appointed from among the senior-most I. M. S. in the province. He was usually the Principal of the Provincial Medical College and the Senior Medical Officer of the hospital attached to the College and the latter officer was allowed only consultation practice which was never misused as is the case now both here and elsewhere.

Reverting to the old order of things in the matter of appointment of Surgeons-General, will be more beneficial in case those who are to be the future Surgeons-General are first made the Principals of the Provincial Medical Colleges and Senior Medical Officers of the hospital attached to the teaching institutions and debarred from private practice even of a consultative nature. A senior-most I. M. S. officer of local experience both in teaching and administration will, certainly do better service having continuity of interest which is highly essential for running teaching instituitions in an efficient way.

Having said so much regarding the person who is in charge of services both educative and administrative, we will next consider the state of affairs in Bombay of recruitment to educational service. We will concern ourselves regarding the whole time Professors in the Medical Colleges and Lecturers in Provincial Schools. Apparently there are three such professorships at the Grant Medical College, viz., the Professorship of Anatomy, Pathology and Pharmocology. The recruitment to these seems to be very unsatisfactory. No thought seems to have been bestowed in making these appointments. The chief quality in a Professor is the ability to teach and secondly, we repeat secondly, the necessary knowledge of the subject he teaches. A teacher has to be trained even if he has to teach a subject like Medicine, young graduates should first be given the opportunity of minor teaching appointments and the unsuitable amongst these should be carefully weeded out during their period of probation. Those that prove satisfactory should be given a chance to hold the post of lecturer ships in the Provincial Schools, which would give them an opportunity to show their merit. These lecturers in schools should be given opportunities to widen their experience at foreign teaching institutions. It is only those, that have proved successful in teaching at schools, should be promoted to professorships. We find in Bombay, professorships are held by persons having no previous teaching experience and a ripe age of 60 does not preclude one to be a professor at the Grant Medical College. There seems to be a tendency for old order of things when a member of the I.M.S., could teach Anatomy, Physiology and Ophthalmology in successive tenure of each professorship, having been a professor about six months in each subject. It should not be made possible for any eminent medical man to occupy the chair of a subject which was not one in which he made a research and research alone of whatever importance should not qualify one to hold a teaching appointment unless the candidate has had teaching experience also. There is a real danger in Bombay as in Madras which, if not checked soon, will seriously interfere with the discipline and everything else in educational institutions interfering to a certain extent even with examination results, though indirectly and that is,—the misuse of the right of private practice by those engaged in teaching institutions,—hospitals, colleges or schools. We have noticed in Bombay many of the whole timed officers employed in colleges or schools running nursing homes and private hospitals. This will necessarily cause a great laxity in attendance and will surely tell upon the work to be turned out in hospitals. This apart, the officers will have little or no energy to do the work entrusted to them after spending their morning hours at their private institutions. There is further a temptation of sending hospital patients to one's nursing home. It is quite possible that students instead of pleasing their teachers by studying their lessons well, may, by misguided zeal, try to please their professors by taking to them private patients. Such a tendency has a far-reaching demoralising effect apart from interfering seriously with the future medical education of our young men. We cannot be sure of the source of this infection in medical services—whether Bombay got it from Madras or Madras from Bombay. This malady seems to have spread more, after the medical department came under the control of the popular Ministers and we appeal to the Hon'ble Ministers in both the provinces to nip this infection as early as possible in the interest of efficient medical education and medical relief.

The professors in both the provinces are amply paid but the lecturerships in schools are not at all attractive in Bombay as in Madras. We learn that all the lecturers in schools in Bombay are deprived of private practice. The incumbents can hardly rise to the maximum pay of a civil surgeon of the Assistant Surgeon grade at present going under the pompous name of B.M.S. (Class II). We may mention by way of passing that there has come into existence a separate grade of medical officers who have been recruited from among private practitioners especially from amongst those that volunteered their services during the Great War. They are seen both in the hospital service as well as in teaching institutions and are not large in number, all told they may be within a dozen. They were started on Civil Surgeon's pay. There now seems to be a move to bring about a separate cadre of such officers recruiting them in larger numbers in this cadre. Though appointments in teaching institutions and hospitals serve the problem of unemployment to a certain extent, the Government either in Bombay or in other provinces should not lose sight of the fact that they have a serious responsibility in the matter of filling in these posts as they are concerned with the training of young men for one of the noblest profession if not the noblest. We shall repeat what we have said once before that experience in teaching more than the necessary knowledge of the subject should count in the matter of choice of lecturers and professors and all those employed in teaching institutions, hospitals colleges or schools should be debarred from private practice except consultation practice if found necessary. Last but not least in importance is a good character in those who are in charge of young men.

We shall next consider about the last two grades in medial services in Bombay, the Assistant Surgeons and the Sub-Asst. Surgeons. The former is known as Bombay Medical Service Class II and the latter the Subordinate Medical Service. Recruitment to both these services is not by competition or any known fair methods. Favouritism and influence seem to play more than merit and qualifications in the matter of choosing candidates for these two cadres. The system of recruitment adopted in Madras, though defective, is certainly far more satisfactory than that of Bombay. It is surprising why the candidates for these services are not chosen by open competition as is done in Madras regarding the recruitment of Assistant Surgeons which has now been entrusted to the Madras Services Commission. This body has been recently entrusted with the work of recruiting Sub-Assistant Surgeons also by selection. After recruitment, the prospects of the Assistant Surgeons are not bright as that obtaining in Madras where Assistant Surgeons reach automatically, a grade of Rs. 450 and some of them become civil surgeons as a matter of routine. In addition to this, many civil surgeons are entertained in the teaching cadre and we have to-day in Madras a large number of Assistant Surgeons who have risen to the grade of Civil Surgeons.

The Bombay province which has copied the vicious communal system from this province during the period of the Panagal Ministry when communalsim was at its best, did not copy what was best in the late Raja of Panagal. The late Raja's best achievements were with regard to Indianisation of medical services and we venture to say that other provincial Ministers have not done what the late Raja did, to improve the status and emoluments of the provincial medical services. The Hon'ble Minister of Bombay will do well to copy the policy now adopted in Madras and allay the discontentment in the members of the Bombay Medical Service Class II.

The lot of subordinate medical service seems to be most deplorable. This grade is the *bete noire* in all the provinces. We may say they represent the depressed classes in the medical department. Once a Sub-Assistant Surgeon always a Sub-Assistant Surgeon. He is in a water-tight compartment. There are a very few instances where some of the Sub-Assistant Surgeons are promoted to the grade of Assistant Surgeons due to extraordinary sympathies of the medical officers. Even with regard to this class of subordinates the state of affairs in Madras is much better though not as it should be. It is possible in Madras for a small number of Sub-Assistant Surgeons to be promoted to the grade of Assistant Surgeons without additional qualifications. The Madras Government permits Sub-Assistant Surgeons of 10 years' service to compete for the post of Assistant Surgeons, if they possess Indian University or British registrable qualifications and those with these additional qualifications are recruited as Assistant Surgeons without competition after 15 years' service. Is it too much for us to request the Bombay Government to treat these hard working subordinates who form the back-bone of medical services, more liberally ?

THE ADMINISTRATION REPORTS OF THE MEDICAL COLLEGES AND SCHOOLS IN THE PRESIDENCY OF MADRAS FOR THE YEAR 1929-1930.

There are at present in the Province 2 medical colleges one at Madras and the other at Vizagapatam and 2 medical schools for men one at Royapuram and the other at Tanjore and one medical school for women in Madras all run by the Government. The number of seats available in the 2 colleges is 137 and in the schools 174. The number of successful candidates passed out from the colleges was 100 and from the schools 150 making a total of 250. This number is too low for the requirements of the Province, if the medical need of the general public is to be met adequately. The committee appointed to go into the question of medical education in the Province has sent its report and has recommended therein to extend the course of training for the L.M.Ps. for 5 years and to fix the general educational qualification for admission into medical schools equal to that required for medical colleges. The report is under consideration of the Government and we hope from the speech made by the Surgeon-General in connection with the inauguration ceremony of the Students' Association at the Royapuram Medical School, that the training and status of the L.M.Ps, will gradually be raised to those of the graduates.

Expenditure: The expenditure in the Madras Medical College was over 6 lakhs of rupees that of Vizagapatam 3 lakhs and that of the three medical schools 3 lakhs, making in all 12 lakhs of rupees and from all these institutions 250 students came out successful which works at the rate of Rs. 4,800 to produce one successful candidate but the rate varies from Rs. 660 per student in the Madras Medical College to about Rs. 1,200 in the Vizagapatam Medical College and about Rs. 2,000 in medical schools. It will be seen that the cost of producing a successful student from the Vizagapatam Medical College is double that of the Madras Medical College. Though the Vizagapatam College is intended for the convenience of the students from the Andhra districts, out of 146 undergoing their courses in that college 56 come from non-Andhra districts and in the Madras Medical College out of 627 students 87 are from Andhra districts. Thus it is clear that Vizagapatam College does not serve the purpose for which it was opened. As recommended by the Medical Education Committee it may be abolished, if it is not possible to restrict admission of students from the Andhra districts into the Madras College.

Results of the Examination: The results in the final L. M. & S. and M. B. degrees are only 43 per cent in the Madras College and 36 per cent. in the Vizagapatam College. This is very low when compared with Medical Colleges in other parts of the world where the percentage of success is not less than 80 The reason for this low percentage of successes may be largely due to the selection made for admission into the colleges on communal basis and not on merit. As long as the appointments in the hospitals and some in Medical Colleges and schools are to become honorary in course of time, and in honorary appointments unlike in paid appointments communalism doesnot exist,

as is evident in the case of over 100 honorary appointments made till now, admission to medical schools and colleges should only be made on merits disclosed either from the marks obtained by the candidates in university examinations or by competetive examination specially held for the purpose. The money spent on educating more than 60 per cent. of the unsuccessful candidates is purely a waste and if this is avoided the cost of production of successful candidates will become less.

In the Seth Gordhandas Sunderdas Medical College, Bombay, a national institution run by honoraries which provides seats for 60 students, the expenditure comes only 2¼ lakhs and at this rate the expenditure at the Madras and Vizagapatam Colleges should be Rs. 5 lakhs instead of 9 lakhs.

The need for more medical men and how to get them : To satisfy the medical needs of the public both rural and urban areas of the province at the rate of 2 per 10,000 instead of 5 to 10 in other civilised countries of the world, the required number comes to about 12,000. To maintain this number, the number of admission into medical schools and colleges should be about 600 annually, counting that 500 of them will come out successful every year. As the standard of the L. M. Ps. is to be raised to that of the graduates, all the medical students except perhaps the women students should be educated jointly in one or more institutions and not separately in schools and colleges. The difference between school and college should be abolished. If it is found that it is not possible to provide accomodation for the 600 students in the existing colleges of Madras and Vizagapatam, a third one may be opened at Tanjore where the Raja Mirasdar's Headquarters Hospital affords ample opportunities for clinical work and the existing medical school abolished. The professors and teachers required in these colleges may be divided into two classes (1) those that teach Medicine, Surgery, Opthalmology etc. for which full time professors are not necessary and (2) those that teach Anatomy, Physiology and Bio-chemistry etc. for which whole time teachers are required. For the former classes the honorary physicians and surgeons attached to the hospitals may be appointed and they may be given, if necessary, a small allowance for teaching. For the latter full time medical men may be appointed with decent pay and they in addition to their work in the college should be given some research work and attached to research laboratories. In Bombay at the Seth Gordhandas Sunderdas Medical College, some of the teachers who are honorary physicians and surgeons attached to the King Edward Memorial Hospital are doing the teaching work without pay and they also do research work.

Research work: His Excellency the Governor of Madras has recognised the absence of any research work in the Presidency even at the commencement of his regime. It must be admitted it is a drawback in the medical profession of the Province and every attempt should be made to remove this dark aspect. It is on account of the absence of research that diseases like the Infantile cirrhosis of the liver in children which is prevailing in the province and which carries away a large number of children as its victims every year, is still left uninvestigated and proper remedies not found out. In no other civilised country in the world this state of affairs will be allowed to continue. It is the first duty of the Government to equip and maintain research laboratories till such time philanthropic gentlemen like Rockfelier and Carnegie come into existence in India. Every college should have a research laboratory attached to it and whole time professors and teachers should be given some work in it; not only the diseases investigated but food-stuffs should be analysed and indigenous medicines standardised. The maintaining of hospital should next be to that of research while the maintaining of dispensaries should never be the concern of the Government, public or local fund but to be left entirely to independent medical practitioners.

ROYAPURAM MEDICAL SCHOOL UNION AND MAJOR GENERAL SPRAWSON'S INAUGURAL ADDRESS.

The Royapuram Medical School came into existence in 1903 and after 27 years of its life, the students of the school have conceived of the idea for having an Union "to produce and maintain *espirit de corps* among the alumni of this school and to promote the cultural and social amenities of the students of this institution". The word 'moral' does not find a place in the objects of the union even formally. We trust it is not an omission as the words 'cultural' and 'social' do not necessarily imply morality and cultural attainments in a society may exist and usually does, without the commodity of good morals. The culture of a boy is put to test year by year when he has to appear for the examinations and he can keep up an average without additional help. "Social Amenities" are too much in evidence now and there is always a natural craving for them and one gets them somehow or other. But the commodity of morals which though could be had without any investment is often difficult to be possessed or demonstrated in after life unless it is reared and nurtured during the period of boyhood in educational institutions.

It was most appropriate that Major-General Sprawson, the head of the medical department and also the head of the medical profession, being the President of the Madras Medical Council, was chosen to do the inauguration ceremony. He is not only an 'educationist', an 'organiser' but a moralist of high repute worthy to be admired and worthier to be followed by not only the students but also by elderly medical men.

The Major General first referred to the welcome address read on behalf of the members of the union by its President and expressed regret that there should exist water-tight compartments in the medical profession in India and two standards of education, the University and School, and that the members of the profession passed out from the schools should be under the handicap of inferiority. He hoped that his efforts to raise the standard of education in schools in this presidency would meet with success soon and the progress in this direction though perhaps slow would be steady and in course of time, the students of the school would have the same standard as in College.

We are glad that the Surgeon-General agrees with the views expressed in "The Medical Practitioner" that in the interest of the healthy growth of the medical profession, the medical licentiates should be soon lifted up to the level of the graduates and we trust that the Surgeon-General will advise the Government to bring about the promised reforms without undue delay.

It was quite befitting the occasion that Major General Sprawson addressed the students on 'Medical Ethics' in other words,—moral responsibilities of the medical man towards his patients and towards members of his own profession. Major General Sprawson was mainly guided by the Code of Ethics as published by the Medical Councils in India on the model obtaining in Great Britain, dilating on every aspect, giving concrete examples from his own personal experience and from facts observed by him in his 30 years' experience in India. On the whole he said that the observance of rules of ethics was much better now in India than it was ten years ago, and he hoped matters would be ideal in course of time. He based his opinion on his experience regarding this subject in his native land.

Though the Major-General did not mention in so many words, his lecture on Medical Ethics will fall flat if those who belonging to the medical profession, did not cultivate the sense of responsibility in maintaining good morals without which any number of medical codes are likely to be trampled down under feet. Medical profession being the noblest of all, is and has been commanding the highest respect from the lay public in spite of the black sheep in its fold, because this is the only profession where its votary could be straight, honest in his dealings with the patients, not depending upon anybody's whims and fancies as is the case in other professions (though this is not always possible in paid service, especially when one occupies a subordinate position). So, any amount of care and attention in the matter of cultivation of good morals bestowed by the students at the Royapuram Medical School under the guidance of the Superintendent and his lieutenants, will not be too much whether it be in the school or hospital not excluding the administration offices.

Examples being always betterthan precepts, all those who are in charge of the young boys at the Royapuram Medical School will, we hope, teach the boys more by examples than by precepts and the best place for such examples is the hospital wards where there is a wide field "to produce and maintain *esprit de corps* and promote cultural and social amenities," the special items in the programme of the Union of the Royapuram Medical School. It is the hospital more than the lecture halls where the students have to learn. Unions and Societies serve merely the purpose of demonstrations and unless the ideals are latent in the brains of the youngsters, any amount of demonstrations will serve no purpose. Therefore we advise the students of the Royapuram Medical School not to neglect their more legitimate field, the hospital wards where true 'unions' should exist. All the same the 'unions' of the nature started at the Royapuram Medical School serve their own good purposes and we wish the Union a long life of usefulness.

It will not be out of place if we touch briefly, regarding a few of the views expressed by Major General Sprawson about Medical Ethics. A stranger who does not know the official position o f the lecturer would not have been able to guess that it was the official head of the medical administration of this Province that was talking to the students of a school which is directy under his control. The Major-General talked as if he were only an unit of the medical fraternity in this province. He said what the practitioner should do and should not do, all in the interest of the patient than of the practitioner. It was plain that he did not tolerate a practitioner running an open chemist shop or having any dealings with a shop and receive commission or such remuneration for the prescriptions sent by him to these shops. We wish to tell the Surgeon-General what we have told his predecessors that in this matter the worst sinners could be found more amongst those in service than in private practice. We do not claim that there are no sinners at all amongst the members of the independent medical profession who either run such shops or receive commission from firms. Regarding running of chemists' shops it is an open sin with some of the private practitioners; but with regard to the commission the chances are more amongst those in service as they are nervous to run shops especially those who cannot afford patronage from those above them and hence one usually finds the prescription books with the letter heads of the Chemists' shops inside the bags of state paid practitioners. We repeat what we said a little while ago that this may not be a virtue—the private practitioner has always a dispensary of his own and has no need for patronage and mutual benefits.

We cannot agree with the Major-General regarding his view that the rules of Medical Ethics are better followed now than it was so about ten years ago, when one usually finds, at least in this city when patients prepared and got ready the previous day for an operation, even of a minor nature, are found on beds already operated upon by a Surgeon before the attending practitioner arrives the following day or perhaps carried to the nearest nursing home. Affairs are still worse in medical practice. We will not be far wrong when we mention that the senior practitioners who are at the top are more to blame in this respect than the juniors in whom the violation of rules of Ethics may be excused to a certain extent on account of the hungry wolf at their doors.

Regarding covering which is rather a naughty question not easy of solution in India, the Major-General has suggested a wise tip. He wishes that the registered practitioner who has to visit a patient in consultation with an unregistered practitioner, Vaidyan or Hakim, should give his advice direct to the patient and not to the latter. This is by far the best way of cutting the Gordian Knot.

It was most appropriate that Major-General Sprawson did not follow the usual routine of a stero-typed address generally delivered on these occasions of inauguration ceremonies but concerned himself with the future of the medical profession and gave fatherly advice to all that assembled at the Royapuram Medical School. The best piece of advice, he dealt with, was regarding the necessity of a young practitioner to get himself registered, to enlist himself as a member of the nearest medical association and last to be a subscriber of a medical journal; all good and ideal advice not difficult to follow with benefit to oneself, if not to the benefit of the entire medical profession. But affairs of the profession are not today so congenial as to

make an youngster to realise the real implications of such advice. Though one usually takes a pride in styling himself as 'Registered medical practitioner' he rarely realises the benefits of registration. True, there are medical associations but, due to two standards of medical education it has not been possible to run these on true fraternal spirit, and naturally these associations have only mush-room growth. Journals are usually costly and very few can afford to be their subscribers. The remedies for these ills and for many more, are in the hands of Major General Sprawson him self, who is the highest officer in this province to handle the destinies of the profession. But very few Surgeons-General have realised the fact that apart from a small minority of the profession who do not number even perhaps 1,000 in the Government service, the destinies of three times this number in private practice are under their control. We trust that Surgeon-General Sprawson will devote at least ⅓rd of his time, though in inverse proportion, to the welfare of the rest of the 3,000 who are in the medical register and make them feel the benefits of his advice. If this is done, the medical associations will have real life in them. There are libraries attached to the medical schools and colleges in this province, all run at Government cost, but none in authority have conceived the idea that they have a responsibility to the members of the independent medical profession. May we suggest to Surgeon-General Sprawson to find out means and methods by which the members of the independent medical profession get access to these libraries and read not one but many journals.

Major-General Sprawson has in his short term of office given room to many fond hopes to the members of the independent medical profession and we trust that before he lays down office, he will make them realise these hopes and earn for himself eternal gratitude of the possession.

Original Articles.

Rural Medical Relief Scheme

PRESIDENTIAL ADDRESS

DELIVERED BY

DR. M. S. KRISHNAMURTHY AYYAR, M. B. C. M.

AT THE

THIRD ANNUAL CONFERENCE

OF THE

Madras Provincial Rural Medical Practitioners' Association

Held at Madras on 31st December, 1930

(Specially contributed to " The Medical Practitioner ")

I appreciate the honour you have done me in electing me to preside over this meeting. Perhaps it is the fact that I am one of the few oldest members of the medical profession living here that has weighed with you in doing so. When I was approached with the request to preside over this meeting, I readily acceded to it as I thought that with my knowledge of the medical profession for over 37 years and experience of the system of rural medical relief when I was Sanitary Commissioner in Travancore, I would be able to place before you a few important points for your consideration. During the last six years I have been contributing articles on medical relief and latterly as the Editor of " The Medical Practitioner " dealing with that and kindred subjects largely.

Family Physicians

Now-a-days in every civilised country and well-organised society family physicians have become a recognised institution. They are naturally the repositories of the confidences of their clients and weild much influence over them. In olden days in India when village communities flourished village physicians of the indigenous system existed in each and every village and these were regarded and occupied the same position as family physicians. These physicians being permanent residents of the locality, possessed an accurate knowledge of local conditions and having various opportunities of coming into contact with the inhabitants in their everyday life, knew well the constitutions of their clients and the diseases to which they were predisposed and this knowledge greatly facilitated the diagnosis of diseases and their treatment, even though the methods and means adopted were not as accurate and advanced as they are now under the western Allopathic system. With the advent of state-paid hospitals and dispensaries of the western allopathic system, these village or family physicians disappeared and their places have not yet been filled up to any appreciable or satisfactory extent. The necessity of having family physicians at present is really much more than what it was before. With the advancement in the methods and means for the prompt and correct diagnosis of diseases and the introduction of efficient and safe remedies in their treatment, there are now far greater facilities for the detection of and the predisposition to diseases particularly in children and their successful treatment and the prevention of their onset. It is well-known that prevention is better than cure. A large amount of trouble and money and a larger number of lives may be saved by prevention than by the treatment of actual diseases. In the rural reconstruction scheme now largely before the public eye, family physicians would occupy an important place. The subject of heredity and diseases which are inherited are intensively studied now and the birth of children who are feeble-minded epileptic etc., may be prevented by satisfactory marriages, or control of births in unsatisfactory unions. The family physicians would come in here also *i.e.* to advise in the

matter of matrimony. Having regard to very large number of physicians required and to the fact that these would more or less permanently reside and settle down in villages, it will be easily seen that the state-paid medical officers cannot, on account of their comparatively limited number and their liability to transfers owing to the exigencies of the service, be expected to meet the necessary requirements to any appreciable extent. It seems, therefore, that it is the private practitioners alone who can and are best suited to take the place of family physicians. The problem, therefore, for consideration and solution by Government is how to make private practice more attractive so as to induce a large number of private medical practitioners to practice their profession and settle down in rural areas.

The Rural Medical Scheme its Origin and Object

The urgent need for medical relief in rural areas, inhabited as they are by about 90 per cent of the population of the province, has already been recognised by the Government. They found that neither Government hospitals, nor Municipal and Local Fund hospitals and dispensaries could meet adequately the need and therefore organised the Rural Medical Relief Scheme.

According to the terms of the Government order inaugurating the scheme, it was intended to encourage private practitioners (allopathic) to settle down in villages for practice by the grant of money subsidies and the supply of medicines from public funds, this being the cheapest and at the same time the best method from many points of view, and thus to divert to the villages a large number of unemployed medical men, congregated in towns and to solve the problem of unemployment to a material, extent. Neither the terms of the Government order nor the steps till now taken in the administration of the scheme indicate whether the scheme is to be a preliminary to or an intermediate stage in the evolution of proper medical relief in rural areas or is to remain a permanent institution. If these medical men even to the full extent now contemplated by the Government are to be subsidised permanently in villages for practice, the scheme will neither adequately meet the requirements of medical relief in the rural area on account of the very large number of medical men actually required, nor will it satisfactorily solve the question of unemployment. The result will be more or less akin to the supernumerary honorary physicians and surgeons, etc., existing at present in the medical department and the creation of a small number of discontented quasi-state-paid medical men. The main objects of the scheme are evidently (1) to induce private practitioners to settle down permanently in villages where the scheme is in operation and (2) to make the villagers appreciate the advantages of the western Allopathic system of medicine and resort largely to treatment under the system so that when the subsidy is withdrawn the private practitioners can support themselves by their earnings in private practice. To attain these objects, taking into consideration that, until the villagers begin to appreciate the treatment, the practitioner is not expected to get any remuneration worthy of the name from private practice, the rural medical officer should at least be given Rs. 100 a month with Rs. 50 for medicines and house rent for dispensary, and a midwife on Rs. 30 per mensem, to assist him in maternity cases which require, on acccount of the high maternal mortality obtaining at present, skilled assistance. The subsidy will have to be continued for at least five years as by that period the villagers will have had sufficient time to appreciate the treatment and the medical practitioner will have become known to them thus facilitating his settling down permanently amongst them without any subsidy. In order that he might not be entirely dependent upon his private practice, the medical inspection of schools in the villages may be entrusted to him and the usual fees for inspection given him until a separate school-medical-service is organised. Even in the separate school-medical-service, the private practitioners may with advantage be included as they will have the opportunity and facility for treating, in their capacity as family physicians the diseases detected in the inspection. In this way villages or group of villages may be taken one after another for the operation of the rural medical relief scheme and all of them in course of time may be provided with private medical practitioners who will eventually work without any subsidy and constitute themselves as family physicians.

Working of the Rural Medical Relief Scheme

The working of the scheme at present is beyond doubt unsatisfactory. The Taluk Boards are at the best unnecessary intermediaries between village unions and District Boards and all such third wheels in the administrative machinery are not conductive to smooth, prompt and satisfactory working. In the case of the rural medical scheme which is working under the Taluk Boards they are a positive nuisance. They tease and wantonly interfere with the work of the medical officers under the scheme and annoy them in several ways so much so that resignations of medical officers have become frequent. The opening by Taluk Boards of dispensaries in villages where the scheme is working and appointing as medical officers for them others than those working under the scheme in those villages, are acts not only going against the very object of the scheme but of positive injustice to the medical men working under the rural medical relief scheme. Instances of such actions are not wanting and it is comforting to note that at the instance of the present Surgeon-General, the Government of Madras have declined to give permission for the opening of dispensaries in places where the scheme is in operation. In some cases these medical men were deputed by Taluk Boards for festival, small-pox and cholera duties without remuneration and sometimes even in election campaigns, and it must be said to the credit of the present Surgeon-General that an allowance was ordered to be paid for special duties—election excluded.

One man's autocratic administration may be tolerated in departments where the staff is a fully paid one but in the case of departments such as rural medical relief where the men employed are given only honoraria or subsidies, a Board consisting of the President, District Board, The District Medical Officer, The District Health Officer and at least two private practitioners will be the best controlling authority for each district.

Hospitals and Dispensaries

The opening of the dispensaries by the State out of public funds for the treatment of out-patients is objectionable and is prejudicial to the interests of the private practitioners who are now induced to settle down in villages and who are eventually to become the family physicians. As serious illness requires constant attention, rest, diet and treatment and as the large majority of the people are too poor to afford these in their own houses, the duty of opening and maintaining hospitals falls on the Government until philanthropic gentlemen come forward to assist and relieve them. The unit of State Medical relief should be hospitals as is the case in the Federated Malay States and not dispensaries for the treatment of out-patients which should be left solely to private practitioners. In the province of Madras characterised by the poverty of the people, high mortality and extensive illness, the number of beds available in all the hospitals in the province is about 9,390 which works at the rate of 1 bed for every 5,000 population. In America the richest country in the world where the number of practitioners is as numerous as 1 for every 800 population against 1 for every 10,000 in Madras and where therefore treatment in houses is possible, there is 1 bed for every 270 persons. If the salary of medical men attached to the hospitals is withdrawn and honoraries are appointed in their places a larger number of beds can be provided in the existing hospitals with the money saved thereby and without much extra expenditure. The honoraries are at present permanent supernumeraries in addition to paid men. This practice of treating the honoraries as so many permanent supernumeraries without allowing them to take up the places of paid men when vacancies occur should be put an end to at once. It is said that a Committee has been appointed to go into the question of honoraries. If any useful purpose is to be served by the committee it is necessary that a large number of private practitioners should be represented amongst the members of the committee. Till the paid officers are fully replaced by honoraries, no new permanent paid appointments should be made and the paid men already in service should be prohibited from private practice except as consultants and they should not be allowed to conduct medical inspection of schools in places where there are private medical practitioners or where the rural medical scheme is working. In the case of paid medical officers employed solely for teaching in the medical schools and colleges and in special institutions such as the King Institute, Guindy they should not be allowed to have any

practice whatever much less should paid men be allowed to attach themsrelves eithe directly or indirectly to Nursing Homes, Chemists' shops, etc.

Medical Education

Of all the provinces in India, Madras is the one which is seriously suffering from the caste system. While every attempt is being made to do away with it or at any rate, to mitigate the hardships arising from the caste system, the introduction and continuance of such a system in any profession—particularly in the medical profession—which deals with matters of life and death among the people, is most undesirable. There are in the medical profession in Madras two castes or classes, the L. M. Ps. and the University degreeholders. They are taught separately and in the matter of appointments privileges, etc., they are treated as two independent and incompatible entities. A committee was appointed sometime ago to break this caste system and improve the status and training of the L. M. Ps. and to bring them to the level of the graduates and the recommendations of this committee are under the consideration of the Government. Medical education does not end in medical schools and colleges and in passing the examinations from them. Before the successful candidates from the Medical colleges and schools enter upon their duties and undertake the treatment of the sick, they should be given practical training in hospitals, say, for at least a year and then alone be permitted to carry on their profession. To provide for practical training for a large number of persons expected to take up private practice in villages, if the rural medical scheme should be worked out in the way indicated above, all the paid assistants attached to all the hospitals should be replaced by these persons and appointed as house surgeons and physicians on a small allowance for about a year and then given permission to practice in medicine.

Research

It is indeed encouraging that His Excellency the Governor of Madras has recognised and pointed out the absence of any research in medical science while there are in the province highly intelligent and capable doctors. That research work is the most important factor in the advancement of medicine and alleviation of the sufferings of the sick, there can be no doubt. That a disease like the infantile cirrhosis of the liver which carries away every year a large number of children as its victims, should be allowed to continue without its cause and treatment being correctly investigated and determined and against which the western system of medicine is practically of little use, only proves the absence of research. In no other civilised country would this state of affairs be allowed to exist. Perhaps in course of time when His Excellency becomes acquainted with the system of medical relief in this province, he may find out the cause for the absence of research. There are at present in this province two classes of doctors (1) the purely private medical practitioners struggling for mere existence in his own legitimate field in unequal competition with the paid officers and possessing no time or energy or money to pursue research work and (2) the highly paid Government Officers who in addition to their legitimate duties take up private practice, maintain nursing homes, etc., and can afford to bring to their help all the resources available in the State institutions to which they are attached, for competing with the unaided private practitioners and who therefore find neither time nor necessity for doing research work. Between these two parties research exists nowhere. Until the time arrives, and this may be far distant, when wealthy philanthropic persons like Rockfeller and Carnegie may come into existence in India, it is the paramount duty of the Government in the matter of medical relief to provide adequately for research work more than in the matter of maintaining hospitals for the treatment of patients. Without research, medical practice is like a ship sailing without a compass. The required amount of money for this purpose can be found to a large extent by replacing the paid medical staff in the hospitals by honoraries, as private practitioners in increasing numbers are coming now to take up honorary work in hospitals. As whole time officers in colleges and schools spend only a few hours in actual teaching, they may be also entrusted with research work as is the case in the Seth Gordhandas Sunderdas Medical College, Bombay, and not allowed to spend their time in private practice. A beginning in this direction should be made early and all attempts at appointing permanent paid medical men in hospitals

including the contemplated recruitment of Assistant Surgeons and Sub-Assistant Surgeons advertised by the Madras Services Commission should be stopped and as vacancies occur in the paid appointments they should be filled up by honoraries.

Conclusion

We are close at the dawn of an auspicious time and the year which begins to-morrow will, let us hope with trust in God, mark an epoch in the history of Indian administration. There are happy indications so far that the Round Table Conference which is sitting at present in London and discussing an improved form of Government for India may bring about rest, contentment and prosperity to the people by the grant of responsible Government. It is really fortunate that at this juncture we have as the head of the administration in this province His Excellency Sir George Frederick Stanley who even at the commencement of his regime has diagnosed the disease the medical profession is suffering from and as correct diagnosis constitutes three fourths of the treatment, we may feel sure that he would find out the proper remedies. We have further a large hearted and sympathetic officer in our Surgeon-General who has already recognised the present unsatisfactory condition of the L. M. Ps. both as regards their training and appointments and we may feel sure that with his sympathetic advice, their condition will be improved and the invidious and irritating distinctions now existing between them and the graduates will disappear and that both these will become united thus enabling them to raise and maintain the dignity of the profession. Lastly, the Hon'ble Minister in charge of Public Health comes with a name for fair and open mindedness and we feel no doubt that he also will show real sympathy with the people at large, by taking prompt and necessary steps for providing them with family physicians in each and every village.

Ladies and Gentlemen, I have already taken too much of your time and taxed your patience a good deal I have given only a brief outline of the existing conditions under which the medical relief is struggling and indicated the lines on which improvements can be effected Neither is this the time, nor is it possible to treat this subject exhaustively, and before I resume my seat, I beg to thank you for the kindness and the patience with which you have heard me and offer you my sincere greetings for the new year.

Rural Medical Relief Scheme

WELCOME ADDRESS

DELIVERED BY

DR. S. RAMASUBBU, L. M. & S.,

AT THE

THIRD ANNUAL CONFERENCE

OF THE

Madras Provincial Rural Medical Practitioners' Association

Held at Madras on 31st December, 1930

(Specially Contributed to "The Medical Practitioner")

I am highly indebted to you gentlemen for your kindness in responding to my invitation at short notice and thus evinced your sympathies for my Association. I welcome you all most respectfully. Your presence will certainly serve as a good tonic, the effects of which will last after this gathering and put in new life and vigour in us, the members of the Madras Provincial Rural Medical Practitioners' Association.

The Rural Medical Relief Scheme inaugurated by the Government at the instance of the late respected Rajah of Panagal has great possibilies not only in the matter of solving the problem of affording cheap yet efficient medical relief to the masses but also in the Nation-building work where it is conceded by all that the unit of reconstruction should be a village. I am hopeful that your presence will enable us to put before the Government and the public new ideas gathered by our experience, which if accepted by those who are concerned in running the scheme will serve as a model to be copied by the sister provinces in India.

You, my Brother Delegates who have responded to my call at great expense and personal inconvenience, will, I trust, not be sorry for the zeal you have shown by going over to this city. You have an opportunity to give expression to your pent up feelings and put before this gathering your disabilities and sufferings which I trust you will do with great reserve, consistent with the dignity and prestige of the noble profession to which you and I have the honour to belong. Whatever you propose should be more in the interest of the scheme of medical relief and not in your private individual interest. Let us all hope that at this Conference we will arrive at resolutions, may I say, almost unanimously with the sage counsel and wise direction of our revered President of to day; resolutions which if accepted and adopted by Government will certainly usher in the millennium of medical relief to the rural population.

It is usual on occasions like this, to give an account of our grievances and suggest appropriate remedies. As the Secretary of the Madras Provincial Rural Medical Practitioners' Association for the past four years, I can give you a pretty long catalogue of our woes, and bore you with disgusting details if you only allow me time to do so. The other portion of the task—that of suggesting changes for the better—I confess I am quite unequal to it. I wish this duty had fallen on better and abler shoulders of whom I see many in this hall. I doubt whether I am competent to suggest anything and whether my suggestions would be acceptable to the vast majority of you. I feel embarassed, nay a bit shaky even, to suggest anything especially so in the presence of such stalwarts of the profession I mean our friends of the metropolis who have so kindly responded to our invitation at great personal inconvenience. If I am offering any suggestion now my only excuse for doing so, is that I have to, by virtue of the role I am assigned and I do so with the hope, that if my suggestions do not happen to be the exact remedies for our ills, you would at least eliminate them and by a process of *reductio ad absurdum* deduce the correct ones. I would try to be as brief as possible for I dare not take up much of your time and stand between you and our revered President who, I can assure you has very many valuable suggestions for us.

The Present Scheme Defective :

Gentlemen, it needs no saying from me that our grievances are many. But I have to concede, that the Rural Medical Relief Scheme which we have the honour to work, is with all its faults, an endeavour in the right direction. Its double objective of providing employment to the unemployed, and rendering skilled medical aid to the necessitious poor of the rural population, are quite laudable. Yet I should say, the scheme has not achieved the best results, because it is defective in details, and has not been worked in the right way by those concerned.

A subsidy of Rs. 500 or 600 a year is nothing decent to attract a medical man—less so a medical graduate to the villages to induce him to settle there permanently, while a mere S. S. L. C. gets very near that amount as a clerk in any public office. Income from private practice, there is very little scope for, at present, partly because of the nature of the people, partly because of the preponderence of quacks in rural areas, and partly because of the proximity of these rural dispensaries to other medical institutions, where unlike as at a rural dispensary, medicines are given free to all patients rich and poor alike. A rural practitioner is really in a fix, while charging fees for the patients. Even the richest villager, especially from an outlying village feigns poverty. There are really no means of knowing who is rich and who is poor. I am not exaggerating when I say that excepting a fortunate few, the average extra income of a rural practitioner is about Rs. 15 to 20 a month which is not even found to be enough to meet his charges on building rent and establishment. It is true that some Taluk Boards supplement the Government subsidy from their own funds, but such amounts are too small and in some cases are given as a prize for good conduct, which according to them is synonymous with servility. To give you just an example, a practitioner who was getting a subsidy of Rs. 50 per month no the scale of Rs. 50-3-65 had his extra subsidy withheld as he would insist on subscribing himself as 'I have the honour to be, Sir, Your most obedient servant.'

To work in villages under such depressing conditions is rather hard indeed; to continue there in the hope of settling down permanently, firmly believing in one's destiny and hoping against hope for better luck, would be impossible for a rural practitioner especially under the humiliating treatment meted out to him by his local board. Save a few commendable exceptions here and there, the attitude of the majority of the Presidents of Taluk Boards has not been either encouraging or sympathetic. Some of them seem to smart under an impression that they have not been given enough power over a rural dispensary and its practitioner, and that this is an omission in the scheme. They would therefore assume powers and treat rural practitioners worse than subordinates, on the plea that they contribute something towards the upkeep of the rural dispensaries. This attitude is more characteristically manifest in the local boards who pay an extra subsidy to practitioners. It is not my purpose or desire to portray the Taluk Boards in dark colours, but I can't help stating facts. Many of them go behind the rules purely for personal reasons. They would not equip their dispensaries as required in G. O. 761, P. H. dated 7-4-25. One President would not brook his rural practitioner signing himself as 'I have the honour to be, Sir, Your most obedient Servant' I have already told its sequel. A warning was given to another practitioner who broke a mere ounce-glass. Another President insisted upon the production by the rural practitioner, of a certificate from the nearest Taluk Board member to the effect that the practitioner had treated all the necessitious poor free during the month as a condition precedent to the disbursement of the subsidy. Payment of the subsidy is still irregular and delayed in many cases. Many practitioners are not allowed, and are reprimanded if they did so, to leave the headquarters on any account even for visiting the patients in outlying villages, without

getting the previous permission of the President. Some of these latter, would construe this as a breach of the terms of the agreement and an enough cause to dispense with the practitioner's services without notice. Indeed, it happened so in one case quite recently. Transfers of rural practitioners are still indulged in. One President issued an order that all patients attending a rural dispensary should be treated free, though fortunately this was rescinded through the kind intervention of the Government.

As to fixity of the tenure the less said the better. This has been till now a thing of personal equation. A practitioner is alright so long as he is in the good books of the President. The moment there is a rub between him and the President, experience has shown that the practitioner goes to the wall sooner or later. The same has been the case where the President has got some young medical friend or relative to provide for. The practitioner could be sent away on some flimsy pretext—a delay in sending the statistical return will even suffice; or the rural dispensary might be converted into a regular one and a new man brought in defiance of a Government order to the contrary. In one case a practitioner was ousted from his place as he was on leave for more than 15 days in the year. The causes for such absence—illness in the particular instance—the President would not discriminate between. Luckily this practitioner has been restored through the kind intervention of the Surgeon-General and the Government. In another, a practitioner of somewhat an independent nature demurred to his being transferred to another place. The President did not like to have an independent-wallah, though the practitioner had run his dispensary as per rules, and to the satisfaction of successive District Medical Officers, Presidents, Taluk Board and others. The practitioners was told that as the period for which he had agreed to serve would expire by a certain date, the Taluk Board was not prepared to renew the agreement and so his services would be dispensed with from that date. Even the Government could not do anything to this poor practitioner. Very good Presidents even get prejudiced when they hear through some of their aggrieved friends that a particular practitioner is very strict and exhorbitant in demanding fees. They do not realise that a rural practitioner is liable to err as much on the side of leniency as on that of strictness in demanding fees, so long as the practitioner has no means of ascertaining the exact income of his patients. Any day this charge could be levelled against even the most conscientious of rural practitioners. I would not accuse the President of any personal aniums in such cases for they themselves are new to the system in vogue in rural dispensaries.

Amidst such odds, the scheme could not be said to have worked successfully, neither medical men nor the rural population could be said to have been benefitted to any appreciable extent. In the words of Major General Megaw the late Surgeon general with the Government of Madras and the present Director General of Indian Medical Services, "The great majority of them the rural practitioners have sought the earliest opportunity to escape from their hand to mouth existence in the villages" and to that extent the population had suffered. To ensure continous, and efficient medical aid to the rural population better ways and means should be adopted.

Rural Scheme in other Provinces:

I now come to that portian of the task which I dread most, *viz*, the formulation of a suitable scheme to achieve the end in view. The problem is very difficult indeed. If our people knew how to appreciate the importance of timely and skilled medical aid, if the country were not quack ridden, and if all the medical institutions in urban parts were poor infirmaries under honorary medical men, then it would be time enough to expect medical men to settle down in villages as private practitioners who might also be requested to give their services as honorary medical men for poor infirmaries maintained by the state or the local bodies. Such men might also be requisitioned on a decent remuneration to be medical inspectors of and lecturers in Hygiene and Physiology, to school children in a specified area. The time is too early to think of such a system obtaining in the other advanced countries. If however the State had unlimited funds at its disposal, then the opening of regular free medical institutions in every nook and corner of the country would solve the problem. Or if the State could by a stroke of the pen convert all the medical institutions in urban areas into poor infirmaries worked by honoraries, the savings thereby effected might be utilised towards free medical institutions in rural areas. In a poor country like India, the State should provide medical relief at least to the poor. As the State has not enough funds and as it cannot afford to pay medical men their full pay and as medical men could not venture to villages depending upon private practice only, the State and the practitioner should do the work sharing the responsibilities half and half. So a policy or a scheme under which the State should help the medical man with money in return for his free services to the sick poor would seem to be a necessary evil under the present circumstances.

As to the method in which this mutual help should be effected opinions differ. There is a system in the Central Provinces where young medical men (superannuated men are discarded) are subsidised who would settle for private practice in village at a distance of not less than 8 miles from each other or other medical institutions. The Government pay the practitioner through the Civil Surgeon or the District Medical Officer a monthly remuneration of Rs. 50 and an advance of Rs. 300 free of interest and or initial equipment to be repaid at the rate of Rs. 10 per month in the 2nd year and Rs. 15 per month in the 3rd year of practice. Thereafter the Government do not worry themselves about the practitioner. No other conditions are imposed upon the practitioner nor any return obligations expected of him. This scheme has been working for the last two years and that too in a handful of places. It would be too soon therefore to pronounce any opinion on it. This scheme is defective in two ways. A period of three years is too short a one for the practitioner to be able to stand on his own legs at the end of it and that the destitute poor are left entirely to the mercy of the medical men. In Burma retired Sub-Assistant Surgeons or other qualified practitioners are subsidised to settle down and take up private practice in villages, approved by the Local Government, the rate of stipends being paid Rs. 50 upto 1925-26 and Rs. 75 from 1927-28 and at certain unhealthy and remote places Rs. 100 upto 1925-26 and Rs. 125 from 1927-28, the increase from Rs. 50 to 75 and from Rs. 100 to 125 having been made to enable the practitioners to give free treatment or treatment at nominal fees to necessitious persons. This system is a better one than the former but puts a premium on superannuated people who cannot be expected to have enough enthusiasm, especially when they are kept above want by their pension and will have too little lease of life to be expected to settle in village for a long time. There is one school of thought which holds that the State should provide the practitioner with the drugs, necessary for the treatment of all the patients, give him the necessary assistants as a compounder, midwife and servants while the practitioner would be allowed to leavy a consultation fee, for his own benefit, of one rupee from every patient that comes to the dispensary for the first time in respect of a particular disease. This scheme will benefit the well-to-do alone, and not the poor who cannot even find a copper piece for their daily salt.

An alternative Scheme.

The best scheme that suggests to me is one on the lines of Grant-in-aid schools the Government defraying about $\frac{3}{4}$ of the practitioner's entire expenses both capital and running including a decent allowance to the practitioner in return for free treatment to the necessitous poor. The practitioner should have real independance and freedom to manage his own affairs and allowed every encourgement to make the village his home. A district medical council analogous to the district educational council, composed of (1) the district medical officer (2) the district collector (3) a representative elected from each taluk and district boards and (4) five representatives elected from among the independent practitioners of the district of which three shall be from among those working under the Grant-in-aid scheme; this council, should be entrusted with the work of determining and disbursing the grant. Any dispute that may arise between those concerned in the running of the scheme and the rural medical practitioner should be referred either to the Inspector-General of Panchayats or the Surgeon-General for enquiry and report on which the Government may pass final orders and till such time the subsidised practitioner shall work as usual.

It is quite possible both financially and otherwise in instituting a medical relief

scheme for villages on the above line if only the Government wills it, and the present time with Hon'ble Diwan Bahadur B. Munuswamy Naidu as the Minister in charge of Medical portfolio and Major General Sprawson as the head of the Medical Department seems to be not only appropriate but also most auspicious. That the Hon'ble the Minister is anxious to bring about reforms in the Rural Medical Relief scheme has been made evident in his answer to the address presented to him by the Tiruppur Taluk Board on 21st instant when the Minister referred to rural medical scheme in the following words.

"The Government did not anticipate such a difficulty, as it was then thought that a small pay would be sufficient to the Doctors taking into consideration that Doctors would be able to get decent private income to boot. The question of examining and reorganising and eliminating the various evils in the present system, was being considered by the Government and the entire scheme would be re-examined at no distant date."

If I am not charged for revealing a secret you will be all glad to know and a few of my brethern have tangible proofs that Surgeon General Sprawson has a soft corner in his heart for the rural medical practitioners. Major General Sprawson has been able to induce the Government to widen the angle of vision and in a short space of time after he took charge of office in the Province, he has been able to understand in the right way the spirit and principle underlying the Rural Medical Relief Scheme as it is constituted to-day even with its inherent defects. I take this opportunity of thanking most heartily on behalf of my brethern the Hon'ble the Chief Minister and the present Surgeon-General both of whom, I trust most fervently will make us realise our hopes and keep us and the rest of the members of the independent medical profession under a deep debt of gratitute by inaugurating in the near future a medical relief scheme both for village and urban areas worthy of the profession to which we have the honour to belong.

Being one connected with the rural medical scheme ever since its inauguration and having suffered with the rest of you, my brethren, my heart is over full and I never know how and when to begin and when and how to end. This has been a real task to my humble self and you will forgive me if I have tired your patience more than necessary. I am conscious that instead of welcoming you and treating you with something sweet and pleasant consistent with the season, I have done the other way. But I am sure you will not misunderstand my purpose and motive and excuse me for my shortcomings. I feel I have a duty to you and my country as a humble unit of a scheme which if properly worked, will solve the big problem of medical relief to the masses with the minimum expense to the State and the maximum benefit to the people. I welcome you all once again and pray the Almighty to bless this gathering, guide its deliberations and bring about a rural medical scheme worthy of its noble purpose.

Abstracts.

MEDICAL AID FOR THE MASSES

What is the difference between a rural dispensary maintained at the public cost and a subsidised medical practitioner working in a village? The question is prompted by the speeches delivered by Dr. S. Ramasubbu and Dr. M. S. Krishnamurthy Iyer at the opening of the annual conference of the Madras Provincial Rural Medical Practitioners' Association. Dr. Krishnamurthy is anxious to see the rural practitioner develop into the accepted family physician of the people within his care and holds, not without justification, that "the opening of dispensaries by the State out of public funds is objectionable and prejudicial to the interests of the private practitioners who are now induced to settle down in villages." He would, therefore, make the unit of State medical relief —in which he doubtless includes all forms of publicly maintained medical relief—the hospital, and considers that the treatment of out-patients should be left solely to private practitioners. And if it really be the purpose of the Government to induce an increasing number of qualified medical men to settle in rural areas, Dr. Krishnamurthy's method would go far to secure the fulfilment of that purpose. No private practitioner, who charges for his services, can compete with the free public dispensary.

We presume, however, that in asking for the elimination of what may be deemed unfair competition Dr. Krishnamurthy is prepared, if this be granted, to abandon all agitation for an increase in the subsidy paid by Government to such rural practitioners. The latter cannot expect to enjoy a favoured position and be paid higher rates for enjoying it. Yet Dr. Ramasubbu devoted a considerable portion of his speech to an argument for the enhancement of the subsidy paid by the Government, and in his concluding paragraph hinted that such enhancement may be conceded. Without presuming to question the validity of his information on this point we would ask whether any substantial increase in the subsidy paid to rural medical practitioners would not necessarily be accompanied by further conditions regarding free treatment, etc., which would be tantamount to converting the practitioner's consulting room into a village dispensary maintained by the State. The average cost of maintaining those free dispensaries, which Dr. Krishnamurthy finds so inimical to the practice of the village family doctor is not much higher than the figure which Dr. Ramasubbu and those who think like him consider necessary to keep the rural practitioner in the village. This being so it is obvious that those who have to pay this subsidy, as well as the legislature which must approve it, will consider whether in the long run the purpose they have in view would not be better served by the opening of a dispensary in each village, thus affording opportunities of free medical relief for all.

The family doctor could not hope to succeed in establishing a practice in the face of such competition, and would, as Dr. Krishnamurty fears, disappear. The next step to the establishment of public dispensaries, and probably the only way to end the petty tyranny and interference of local dictators, would be the establishment of a Provincial rural medical service. Many practitioners, we do not doubt, would welcome such a service, but those who favour its establishment are completely out of touch with Dr. Krishnamurthy's ideal, which to many will seem the higher. Experience of the working of the National Health Insurance system in Great Britain has shown that the subsidised or State Medical service falls short in many respects of the old family doctor system, and is largely lacking that intimate relationship between patient and practitioner which the family doctor system encourages. The Rural Medical Practitioners' Association would do well to give serious thought to this question, and decide which ideal it proposes to strive for the institution of a Provincial rural medical service under the control of the Government or the development of the family doctor system under the conditions which eliminate unfair competition. Its mempers are already aware that the two systems will not mix.

"*The Madras Mail*" *Leader* (31-12-30.)

SUBARACHNOID BLOCK

Method of Dr. Gaston Labat

(Continued from last Issue)

The following procedure for inducing anesthesia for operations below the diaphragm by the method of subarachnoid block has been employed for twelve years by Dr. Gaston Labat without a death :

A hypodermic injection of morphine (gr. 1/6) and scopolamine (gr. 1/300) is given one hour before analgesia is induced, except in very weak patients. As a safeguard against circulatory disturbances, a 2 cc. Luer syringe containing a caffeine compound stimulant or 1 cc. of ephedrine solution is kept at hand.

The lumbar puncture is made preferably in the upright position, with the patient sitting across the operating table, feet resting on a stool, back arched, and leaning a little forward under the care of an assistant or nurse. The site of puncture varies with the extent of the anesthesia required. For operations on the lower extremities, anus, perineum, external genitalia, and for perineal prostatectomy, the injection is made between L 3 and L 4 ; for suprapubic prostatectomy, resection of the bladder, inguinoscrotal herniotomy, Kraske operation, vaginal hysterectomy, and operations for uterine prolapse and cystocele, between L2 and L3 ; for abdominal Hysterectomy, between L1 and L2. For operations on the kidney and ureter, and all operations on the organs of the upper abdominal cavity, such as gastrectomy, cholecystectomy, splenectomy, etc., it is necessary to inject between D 12 and L 1. The needle is introduced in the midline according to the approved technic for lumbar puncture and under strict aseptic precautions. The neck of the ampoule containing pure Neocaine is filed off immediately before the puncture is made. As soon as the dura has been pierced, the needle is stopped and its stylet gently withdrawn, care being exercised not to displace the needle even slightly.

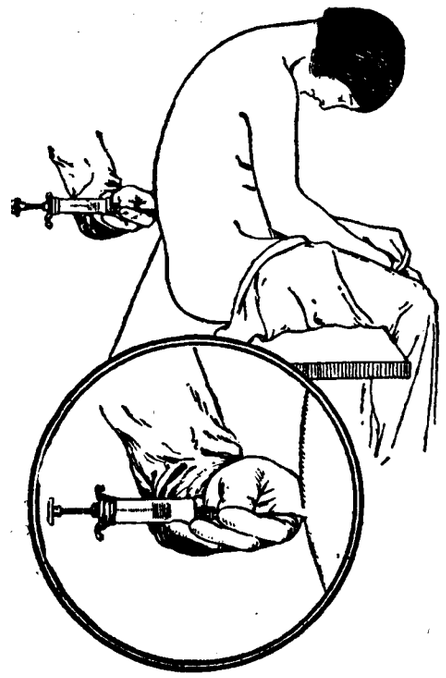
The cerebrospinal fluid is allowed to flow into the ampoule containing Neocaine crystals, until the ampoule is almost filled and the sytlet is gently replaced in the spinal needle, so as to prevent further loss of cerebrospinal fluid.

With a spare needle attached to the syringe, the fluid is stirred by repeated aspirations and discharges until the crystals are completely dissolved. It takes only a few seconds thus to prepare the solution, which is finally aspirated into the syringe. The air is expelled with the syringe held in a vertical position, needle pointing upward, and the needle disconnected while the syringe is held horizontally. The stylet is withdrawn with the greatest care and connection is made with the spinal needle. As much new cerebrospinal fluid is aspirated as the syringe contains solution. More than half of the contents of the syringe is slowly injected, new fluid aspirated in quantity equal to that now remaining in the syringe and again more than half of this injected.

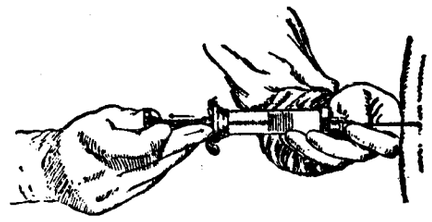
The cerebrospinal fluid is allowed to drop directly into the Neocaine ampoule, where it readily dissolves the crystals.

(From Labat's Regional Anesthesia, by permission of W. B, Saunders Co).

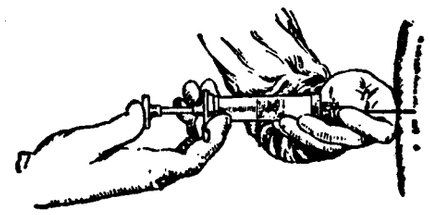
These maneuvers are repeated three or four times until the syringe is emptied. The needle is then suddenly withdrawn, with the syringe still attached to it, and the patient placed flat on his back, and the head of the table lowered just enough to raise the pelvis above the head. This must be done without loss of time. In this slight Trendelenburg position the patient must stay unlil the operation has been completed. A cushion may be placed under his head if it allows him to rest and breathe more comfortably. Anesthesia sets in very rapidly. By the time the operative field is prepared it is perfect. Its



The Neocaine dissolved in cerebrospinal fluid is gradually injected in several stages. When half empty, the syringe is refilled with cerebrospinal fluid. This maneuver is repeated three or four times. (From Labat's Regional Anesthesia, by permission W. B. Saunders Co).



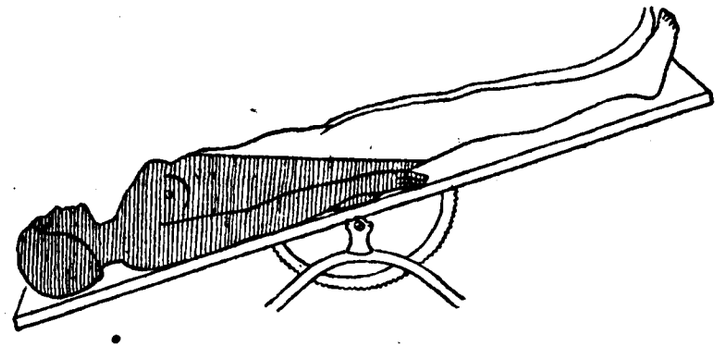
Manner of steadying needle and syringe during aspiration.



Manner of steadying needle and syringe during injection.

duration varies from forty-five minutes to one and one-half hours, but one hour is the average time available for operation.

As a general rule, the Trendelenburg position should be maintained for at least three hours after operation.



When Neocaine is injected in the lumbar region, the patient must be placed in the Trendelenburg position immediately after the injection. There is no fear of paralysing the respiratory center. The shaded area shows how the Tredelenburg position prevents acute anemia of the brain by gravitating the blood towards the dependent portion of the body.

N.B.—*The material contained in the above description is excerpted freely from Dr. Gaston Labatt's text book. Regional Anesthesia—Its Technic and Clinical Application, by permission of W. B. Saunders Company.*

A HISTORIC DOCUMENT

* Venereal Diseases—Syphilis.

METHODS RECOMMENDED FOR SUBCUTANEOUS TREATMENT.

22 (b) **Subcutaneous injection of Sulfarsenol :** Sulfarsenol is one of the most suitable drugs to use for subcutaneous treatment as it does not irritate the subcutaneous tissues.

Thesolution should be used in the proportion of 1 cc. of distilled water per 6 centigrammes of Sulfarsenol.

The injection should be made slowly into the subcutaneous tissue wherever the skin is loose fllank, scapular region, arm etc , and inject as follows:—

Take a sterilised syrings with needle attached and draw 2 cc. of distilled water into the barrel. Select a phial containing the dose of Sulfarsenol required, examine for purity, break off the neck of the phial.

Inject 2 cc. of distilled water from the syringe into the phial and make the solution of Sulfarsenol complete by drawing the contents of the phial in and out of the syring several times. Now draw the contents of the phial into the syringe and add distilled water until there is 1 cc. of distilled water for every 6 centigrammes of Sulfarsenol. Inject subcutaneously.

23. Methods recommended for intravenous injections:—

Details of technique for intravenous injection of '914' group preparations.

This group consists of:—

Neosalvarsan, Novarsenobillon, Novarsenobenzol, Neokharsivan, Neodiarsenol.

There is also a miscellaneous group which consists chiefly of:—

Galyl, Ludyl. Silver Salvarsan, Sodium Salvarsan Sulfarsenol, Hectine (French).

Of these Sllver Salvarsae has lately become popular especially in cases of Neurosyphilis, and Sulfarsenol is replacing '606' and '914' groups especially in cases of intolerance. It is easily administered, produces little or no local reaction and appears to be of equal therapeutic value.

Hectine can be used to produce a general effect, but is more used as a local injection into the sore itself.

Sodium Salvarsan really comes half way between the '606' and '914' groups.

SCHEME FOR TREATMENT

Course A. 34 for early primary cases.

No. of injection.	Day of Treatment.	Dose of Sulfarsenol.	Dose of Hg. Cream grs.	W. R.	Remarks.
1	1	0·36	1	X	
2	8	0·36	1		
3	15	0·36	1		
...	22	...	1		
4	29	0·48	1		
5	36	0·48	1		
...	43	...	...		
6	50	0·60	1		
7	57	0·60	1		
...	59	...	...	X	
...	58-100	44 days rest	...		
8	101	0·36	...		
9	115	0·36	...	X	

* Extract from the booklet issued with D.M.S. Circular No. 42 N.S. dated 1st Novr. 1928.

Course B. 35 for medium primary cases.

No. of Injection	Day of treatment	Dose of Sulfarsenol	Dose of Hg. Cream grains	W. R.	Remarks.
1	1	0·36	1	X	
2	8	0·36	1		
3	15	0 36	1		
...	22	...	1		
4	29	0·48	1		
5	36	0·48	1		
...	43	...	1		
6	50	0·60	...		
7	57	0·60	1		
...	59	...	...	X	
...	58-64	Potass. Iodi.	Grs. 4 t. d. s.		
...	65-71	7 days rest.	...		
...	72-77	Potass. Iodi.	Grs. 10 t. d. s.		
8	78	0·48	1		
9	85	0·48	1		
10	92	0·48	1		
...	93-128	36 days rest.	...		
...	129-135	Potass. Iodi.	Grs. 10 t. d. s.		
11	136	0·60	1		
12	143	0·60	...		
13	150	0·60	...		
...	152	...	...	X	

Course C. 36 for late primary cases.

1	1	0·36	1	X	
2	8	0·36	1		
3	15	0·36	1		
...	22	...	1		
4	29	0·48	1		
5	36	0·48	1		
...	43	...	...		
6	50	0·60	1		
7	57	0·60	1		
...	59	Potass. Iodi.	grs. 5 t. d. s.	X	Blood and c. s. f.
...	58—64	Potass. Iodi.	grs. 5 t. d. s.		
...	65—141	77 days rest.	...		
...	142—148	Potass. Iodi.	grs. 10 t. d. s.		
8	149	0·86	1	X	
9	156	0·36	1		
10	163	0·36	1		
...	170	...	1		
11	177	0·48	1		
12	184	0·48	1		
...	191	...	...		
13	198	0·60	1		
14	205	0·60	1		
...	206	...	...		
...	206—212	Potass. Iodi.	grs. 10 t. d. s.	X	Blood and c. s. f.
...	218—289	77 days rest.			
...	290—296	Potass. Iodi.	grs. 10 t. d. s.		
15	297	0·36	1	X	
16	304	0·86	1		
17	311	0·86	1		
...	318	...	1		
18	325	0·48	1		
19	332	0·48	1		
...	339	...	...		
20	346	0·60	1		
21	353	0·60	1		
...	355	...	...	X	Blood and c. s. f.

Course D. 37. For secondary or late cases with Clinical signs.

No. of injection.	Day of Treatment.	Dose of Sulfarsenol.	Dose of Hg. Cream grs.	W. R.	Remarks.
1	1	0·36	1	X	
2	8	0·36	1		
3	15	0·36	1		
...	22	...	...		
4	29	0·48	1		
5	36	0·48	1		
...	43	...	...		
6	50	0·60	1		
7	57	0·60	1		
...	59	...	...	X	Blood and c. s. f.
...	58—64	7 days rest			
...	65—77	Potass. Iodi.	grs. 10 t. d. s.		
8	78	0 60	1		
9	85	0·60	1		
10	92	0·60	1		
...	94	...	...	X	Blood and c.
...	93—133	41 days rest			
...	134—147	Potass. Iodi.	grs. 11 t. d. s.		
11	148	0·36	1		
12	155	0·36	1		
13	162	0 36	1		
14	176	0·60	1		
15	183	0·60	1		
16	197	0·60	1		
17	204	0 60	1		
...	206	...	...	X	Blood and c. s. f.
...	205—212	7 days rest			
...	213—225	Potass. Iodi.	grs. 10 t. d. s.		
18	226	0·60	1		
19	233	0·60	1		
20	240	0 60	1		
...	242	...	...	X	Blood and c. s. f.
...	241—316	66 days rest			
...	317—329	Potass. Iodi.	grs. 10 t. d. s.		
21	330	0·48	1		
22	337	0·48	1		
23	344	0 48	1		
24	358	0·60	1		
25	365	0 60	1		
...	367	...	...	X	Blood and c. s. f.
...	366—433	68 days rest			
...	434—455	Potass. Iodi.	grs. 10 t. d. s.		
26	456	0·48	1		
27	463	0·48	1		
28	470	0·48	1		
29	484	0·60	1		
30	493	0·60	1		
...	495	...	...	X	Blood and c. s. f.

N. B.—The doses of Sulfarsenol noted in the different courses of treatments are hand written in red ink in this booklet, but we are informed that they are entries from the D. M. S. office.

Notes on Treatment of Diseases

N.B.—These notes are intended to supplement the treatment given in ordinary text books and neither to be expected nor possible to be exhaustive.

Chorea : Fouler's solution m.15 a dose ; the treatment should be continued for a week and not more. To this solution may be added with advantage Ext. Ergot Liq. m.20 to 1 dram and Pituitrine. If arsenic fails Trymol 10 to 15 gr. three times a day will surely succeed. If the disease is associated with rheumatism-salicylic acid is better than arsenic. Hedonol is good.(Sajous and Leonard Williams.)

2. Thymus gland gr. 5 three times a day or Mag. sulph in sterile solution of 10 per cent. 1.c.c. subscutaneously or Luminol (Practical Medicine.)

3. The disease is often associated with left handedness and stammering; Tryparacamide gr. 1.5 to 3 injected weekly. On the whole 6 injections will be required (J.A.M.A.).

4. **Chorea-mian**: In the morning of the 1st day O.1 milligram of adrenalin in I.c.c of salt solution given intravenously. This is repeated in the afternoon. In the course of the day 5 to 6 teaspoonful of Soda Bicarb are mixed with food and the same medication is continued for 4 days with the exception that the afternoon adrenalin injection to be given subcutaneously. From the 5th day adrenaline is given subcutaneously twice a day and soda bicarb continued.

5. Mag sulphate l.c.c of the 25 per cent. solution either intraspinally or subcutaneously (Practical Medicine.)

6. Luminol gr. 1½ with Liq. Arsenecalis m. 4 is useful.

7. Arsenic, chloral, bromides, antipyrin, chlorotone, and Neo-arsephenamine (Modern Medicine.)

8. Tonsillotomy is attended with good results. Typhoid vaccine with 20 to 30 mms in killed bacilli is useful; autoserum is good (Year Book.)

9. Intravenous injection of Sodium salicylas consisting of Soda salicylas gr.15 pure dextrose gr. 10 double distilled sterilised water 100 grams. 10. c.c. of this mixture to be given intravenously every other day (Doctor).

10 Borosodine Lumiore has been used with encouraging results.

Cold —In its earliest stage purgative and hot pad with Liq. Opi. sedative ms. 20 at bed time and afterwards Quinine effervescence (Leonard Williams.)

2. Dionine is very good.

3. In early stage when there is inflammation, a sedative expectorant containing Vin. Antimony mms. 15; Spt. Aeth. Nit. mms 30; Liq. ammon acetas dr. 2; Syrup Lemonis 1 dram and add mixture Amygdale 1 ounce to be taken every 4 hours but not to be given if there is heart disease. In the chronic stage a stimulating expectorant containing Ammon Carb gr. 5, Tinct camphor co. mms. 20, Syrup tulu mms 30, Syrup scilla 1 dram and inf. Senega. 1 ounce to be given every 4 hours. If squill excites stomatatis it may be left out. If there is muco purulent exudation and mainly from the trachea then 20 gr. of Cubeb in cache three times a day is good. (Leonard Williams.)

4. For feverish cold with fever and pain all over the body, and generally mistaken for influenza, after giving a hot pack and purgative asperin 10 to 15 gr. doses three times a day cuts down the disease. In healthy persons even 20 gr. may be given.

5. Calcium lactate 3 to 4 gr. Dionine 0.04 gram, Aqua distilled 100 c.c. to be taken during the day.

6. For cold with middle ear disturbance renoformed snuff is useful.

7. At the beginning before exudation has taken place sol. of Adrenaline chloride 1:1000 2 drams, Quinine hydrochlor 5 grams, acid carbolic 1 gr. and water one ounce ; warm this and instil 20 drops in each nostril every 3 hours ; if there is no relief within three hours the following spray before the anaesthetic effects of cocaine passes away may be given; antipyrin gr. 4 in an ounce of water to be sprayed into the nose. Afterwards swab the nostril with cotton wool dipped in menthol 5 gr. Olium menthol m.15 petrolium one ounce. In the 2nd stage when there is no exudation, snuff or irrigation with warm salt solution is good (Practical Medicine.)

8. By means of a spray put into each nostril a few minimums of a 4 per cent. solution of adrenaline 1:10,000 solution of antipyrin 2 to 4 gr. in an ounce of water to be sprayed to continue the effects of cocaine and to be used only after anesthetization with cocaine and not before. Afterwards the mucus membrane to be washed with menthol 8 gr ; camphor 5 gr ;

petrolium liq. 1 ounce; internally camphor 5 gr; Ext. Belladona 5 gr; Quinine 10 gr; Soda Bicarb gr. 20 every two hours for three doses. All the above treatment should be resorted to before the secretion is established and after it Quinine sulph gr, 2 to 4 and Ammon. chloride grs. 5 to 10 to be given.

9. Novacaine 6 gr., Adrenaline sol. 1 : 1000 m.30, aqua 6 drams paint the nostrils with this followed by painting of silver nitrate 1 per cent. sol.

10. Bacte Rhino Phage (D'Herelle) is a race of Bacteriophage which has been specially trained to rapidly destroy cultures of such staphylococci, streptococci, pneumococci, enterococci etc. which are found in Coryza sinusitis, rhinitis and bronchitis, and when used as a spray by mouth or through the the nose, can rapidly subdue such inflammations without the use of drugs and without any possible harm to the patient. Where asthma is due to the patient being hyper sensitive to bacterial proteins Bacte-Rhino Phage is an effective remedy.

Prescribe one or more ampoules, according to severity, per day, to be vaporized in a nasal spray or throat spray.

Notes on Thereapeutics, Diagnosis and other Medical Subjects

The rate at which nervous impulse travels through the nerves both afferent ans efferent is 120 metres per second in man; the carticle motor centres are so related to the segments of the body that the centred for the toes and feet are highest and those for the face are lower-most in position. It is in the profratal the largest of the association areas intellect and the mind have their seats. Of the three main layer of the neo pallium the lowest, the infragranular layer which is the first to be laid down and the first to attain maturity that instinctive reflexes men and lower animals reside. In the adult male the neo pallium is 2352 square millimetre or 1½ square feet, 2.5 to 3.5 millimetre thick and 1360 grams or 3½ lbs. in weight, Consciousness does not reside in the nervous system until they had attained to a certain degree of intrological differentiation.

BACTE-COLI-PHAGE

(BACTE-PHAGE NO. 2)

Each cubic centimeter of sterile bouillon contains :

1. One billion bacteriophagi capable of producing complete destruction of a large number of different strains of pathogenic bacilli coli and paracoli.

2. The soluble substance of 200 millions of the bacilli coli and paracoli utilized by the bacteriophagi for their re-production.

Presentation

Boxes of 10 ampoules each, of 2 c.c. for ingestion and subcutaneous injection

Indications

All affection produced by the Bacillus coli.

Mode of Use

For emptying an ampoule, file a line at one end with the ampoule-cutter and break off the corresponding tip File a similar line at the other end, place the ampoule vertically over a receptacle containing water for dilution, its opened end below, and then break off the upper tip already filed for that purpose. The contents of the ampoule immediately flows into the receptacle.

The water receiving the contents of the ampoule should be of a temperature no higher than that of the body (37° to 40°C., or 98.6° to 104°F.), the bacteriophage being destroyed by heat.

Affection of the Urinary tract

Since the bacteriophage acts but slightly or not all in an acid medium, it is well, before beginning the administration of Bacte-Coli-Phage, to place the patient upon alkaline medication sufficient to render the urine of distinctly alkaline reaction to litmus. For this purpose, prescribe a vegetable diet, or at least reduce the consumption of meats to a minimum, and give 20 to 30 grams sodium bicarbonate daily, distributed in four doses, taken at intervals as far from the meals as possible. Such alkaline medication should be continued throughout the entire period of treatment with the bacteriophage, the dosage of sodium bicarbonate being so regulated as to maintain the frankly alkaline reaction of the urine, whose pH should be equal or superior to 7.4, the degree of alkalinity corresponding to that changing red litmus to blue.

As soon as the urinary reaction becomes alkaline, and not before treatment with the bacteriophage may be begun, as follows :

1. Give a single subcutaneous injection of 2 c.c. Bacte-Coli-Phage, consisting of the contents of a small ampoule.

2. The patient should swallow the contents of an ampoule of 2 c. c. Bacte-Coli-Phage, diluted in half a glass of Vichy water in the morning, on waking, and with the stomach empty, and ingest a similar dose in the evening, at least 3 hours after the last meal of the day. This daily dosage should be continued as desired.

3. During the therapeutic period, give an intra-vesical instillation daily of the contents of a large ampoule, of 10 c c. Bacte-Coli-Phage, diluted in about 50 c.c. lukewarm boiled water. The water should be suitably cooled before receiving the contents of the ampoule. These instillations must be made by a physician, with strict observance of the rules governing asepsis. The bladder should be emptied before making the instillation and the patient should remain recumbent during two hours following it, in order to avoid desire to urinate and thus to retain the bacteriophagi in the bladder as long as possible. Should daily instillations prove too fatiguing, the instillations may be given every second day, without interrupting daily administration of Bacte-Coli-Phage by mouth.

The duration and efficacy of the treatment depend upon the duration and chronicity of the case. With acute cases, treated as soon as the first symptoms appear, cure occurs as a rule, and rapidly, after treatment continuing from two to five days.

In chronic cases, cure is much less certain, largely owing to the fact that, in such cases, the humers of the patient possess "antibacteriophagic" properties. These properties should be diminished or annulled before undertaking treatment with the bacteriophage. The desired result may be obtained by resorting to auto-hemotheraphy, ten cubic centimeters of blood being taken from a vein of the patient with a sterile syringe and reinjected into the muscular tissue of the gluteal region. This procedure should be practised five times, at intervals of forty-eight hours.

Various affection attributed to the Bacillus coli

Bacte-Coli-Phage may be administered in all affections which appear due to infection with the bacillus coli (as in various affections of the digestive tract and its annexes, the urinary tract, the genital system and similar systems). In all cases, the single subcutaneous injections of 2 c. c. Bacte-Coli-Phage should be given initially and then the contents of an ampoule, diluted in half a glass of Vichy water, should be taken morning and night every day, as indicated above. In case of metritis or salpingitis, the daily treatment should also include vaginal irrigation with boiled water, to which is added the contents of a large ampoule of Bacte-Coli-Phage. With intestinal affections, a daily enema should be given, consisting of the contents of an ampoule of 10 c. c. diluted in 100 c. c. boiled water, the enema being retained as long as possible.

We wish to call attention to the fact that the pathogenic role of the bacillus coli, wnich is postively proved with respect to affections of the urinary tract has not been as surely established concerning affections of the digestive and genital tracts, in which sites the most careful bacteriological tests often fail to determine just what pathogenic bacteria are present. For these reasons we are of the opinion that. in place of the Bacte-Coli-Phage, it is preferable to administer :

1. Bacte-Intesti-Phage for all affections of the digestive tract and its annexes (gastro-enteritis, colitis, enteritis, cholecystitis and similar affections), for the following reason : While Bacte-Coli-Phage is a mixture of strains of bacteriophagi which act only upon the bacilli coli and paracoli the Bacte-Intesti-Phage is a mixture of strains of bacteriophagi which act both upon the bacilli coli and paracoli and many other species of pathogenic intestinal bacteria. In all cases in which the physician begins treatment with Bacte-Coli-Phage, treatment employing Bacte-Intesti-Phage should be considered should the initial treatment fail of success.

2. For similar reasons, we advise Bacte-Pyo-Phage, rather than Bacte-Coli-Phage, in the treatment of affections of the genital apparatus.

Important Note

The bacteriophage acts exclusively and selectively upon bacteria susceptible to it,

and with which it is placed in contact. Such bacteria are thus destroyed in a few hours, while the bacteriophagi themselves multiply and reproduce. The bacteriophage thus selectively destroys the cause of the affection present and has no action whatever upon the organism of the patient. From this fact, it follows that no contra indication, whatever, exists for the use of the bacteriophage. If the pathogenic bacteria present are sensitive to its action, they are destroyed by it and the patient recovers. If, for any reason, such as erroneous bacteriological diagnosis, for example, the bacteria present are not sensitive to the bacteriophage no result is obtained but no injury whatever can occur for the patient.

On account of the special behavior of the bacteriophage with respect to the bacterial species known generically as the bacillus coli, we have been obliged to isolate a large number of different strains of bacteriophagi and select those which are most active and " polyvalent," in order to produce the mixture constituted by Bacte-Coli-Phage, which is capable of destroying bacteriophagically most strains of the coli and paracoli bacilli which may be isolated during the course of urinary affections. The Bacte-Coli-Phage acts upon about 99 of these strains out of 100. Our research laboratory is continuing study of the question. With Bacte-Coli-Phage are incorporated all strains of the isolated bacteriophagi which present special character of activity or polyvalence.

VARICOSE VEINS

Injection Treatment.

BY

SIR W. I. DE C. WHEELER, F.R.C.S.I.

The tardy recognition of this method of treatment was due to the fear of detachment of emboli. This fear from a practical point of view is groundless, although a few cases ending fatally from this cause have appeared in the literature. The thrombus formed by the sclerosing agent becomes so adherent that its detachment is almost impossible. Unpleasant reactions, however, have occurred from time to time from the use of Sodium Salicylate. Cold sweats, slowing of the pulse, nausea, and vomiting have been noticed. Injections of quinine also have occasionally been followed by toxic reactions, itching of the skin, and multiple eruptions. L. A. Greensfelder and R. I. Hiller have used chemically pure Sodium Chloride in 20 per cent. concentration.

Ulceration or eczema of the leg is not a contra-indication to the use of this or other sclerosing agents. The Sodium Chloride solution does not appear suitable in the thin-walled veins of women with an abundant fat deposit in the subcutaneous tissues of the legs. Sloughing sometimes follows. This type of case is difficult to inject, and some of the Sodium Chloride probably reaches the extravascular tissues. As in the case of the operative treatment, the main saphenous column must be obliterated. If the main trunk is not injected, recurrence of the varicose veins is to be expected.

E. E. O'Neil, like other writers, believes that, if Sodium Salicylate is used, it is necessary to begin with a weak solution on account of a possible susceptibility on the part of the patient. He draws attention to the fact that the use of this agent is followed by severe muscle cramps which subside in a few moments. Glucose, he thinks is uncertain in its effects, and he found Sodium Chloride in the stronger solution was too irritating. It also produces muscular cramps. Quinine-urethane is the combination which most nearly approaches the ideal. It causes no cramps and, even when injected (to a small extent) outside the veins, sloughing does not follow. The idiosyncrasy of patients to quinine must be remembered. In O'Neil's experience, a 20 per cent. solution of Sodium Chloride gives good results in the large varices, and quinine-urethane gives the best results in the smaller veins. In testing the function of the deeper veins, the leg is raised and emptied of blood and a constricting tube is placed around the upper thigh. The patient then stands up. If the veins below the point of constriction fill rapidly, that is, within thirty seconds or less, it is thought to indicate involvement of the deep veins and incompetence of the valves of the perforating veins resulting in regurgitation from the deep to the superficial system. This condition contra-indicates operation. A number of authorities do not believe in the practical importance of this test. The history of the case is more important. A deep infective thrombosis following pregnancy or typhoid fever can generally be ascertained with ease and operation avoided.

Technique: The reviewer finds the procedure easy with an ordinary hypodermic needle and syringe. The patient sits on the table with the legs hanging. The veins are injected from below upwards with not more than 2 c. c. of quinine-urethane solution at each injection, or from 3 to 10 c. c. of 20 per cent. sodium chloride solution. The needle is first passed for a short distance under the skin to steady it and then the point is directed more deeply towards the vein and plunged into it by a sharp stab. It is an advantage to use a new sharp needle for every injection. The plunger of the syringe is withdrawn a little to make certain that the needle is in the vein. Not more than three injections are made at one sitting. The needle is withdrawn slowly and then a small pad is firmly bandaged over the injected segment for a few hours. No veins are injected above the lower third of the thigh. When there are marked varicosities in or about the saphenous opening it is better to operate upon these under local anaesthesia.

H. C. McPheeters points out that pulmonary embolus following the operative care of varicose veins is very infrequent—0.53 per cent—but that after the injection treatment this complication is quite negligible.

N. J. Kilbourne deals with safety considerations in technique. He states that 5 cases of emboli in 53,000 cases have been reported. He thinks that 2 c. c. of quinine-urethane should be the maximum injection and that less is advisable. If used it must be injected slowly. He states that performing the operation by high legation of the veins, as in the Trendelenburg operation, and subsequent treatment of the lower veins by injection has a higher incidence of embolism than has simple injection. Furthermore, he shows that the patient is more prone to embolism when kept in bed. When the patient is lying down, the flow of blood is towards the heart and lungs, in the erect position is towards the feet. Therefore, if one is timid on the subject of thrombi being dislodged after an injection, the worst possible position for the patient is recumbency. He mentions one reported case of gangrene of the leg following injection, and emphazizes the necessity of inquiring for the history of tyhoid, intermittent claudication, phlegmasia alba dolens, and such like conditions. Recently a patient with obvious intermittent claudication and coincident varicose veins was sent to the reviewer for the injection treatment. The contra-indication to the operation was explained to the patient. Diabetes, rheumatism, and nephritis are not necessarily contra-indications.

F. C. Pybus reminds us that elastic support in the form of a stocking or bandages, if efficient, will do much to prevent further extension of the varicosities; and will allow patients to carry out their ordinary work. He believes also that the best sclerosing agent is quinine combined with urethane, that is, 2 c. c. in distilled water, and put up in ampoules. Three or six weeks elapse before the vein becomes reduced to a thin fibrous cord. In using quinine it is usual to start with a small injection to test for idiosyncrasy, after which the full amounts may be used at intervals of four to seven days. Two days usually elapse before the sclerosing action becomes noticeable.

G. H. Colt writes an interesting paper on the modern treatment of varicose veins. He says it is quite common to obtain an almost complete obliteration of a valveless internal saphenous system after one injection. The patient stands on a chair near a table and a lightly applied tourniquet is placed around the upper part of the thigh. The patient then lies down on the table and the vein is entered above the knee or in the main trunk just below the knee. The tourniquet is loosened; the vein is emptied of blood near the needle and a finger is placed on it above the middle of the thigh. The injection is then made towards the groin. The limb is elevated to 30 degrees for three seconds and then the patient rises slowly and stands on the chair. The finger is removed and the charge of solution sweeps downards into the saphenous system. Colt thinks that this is better than beginning at the distal radicles and working against gravity with multiple injections.

References :

Surg Gynecol. and Obst 1929, May 639; New Eng. Jour. Med. 1929, May 9, 973; Surg. Gynecol. and Obst. 1929, June 819. 4 Jour. Amer. Med. Assoc. 1929, April 20, 1320; Newcasele Med. Jour. 1929. Jan-111; 6 Brit. Med. Jour 1928, ii 525.

USEFUL PREPARATIONS AND THEIR THERAPEUTIC USES.

Hemoplase Lumiere.

Composition: Hemoplase is a protoplasmic extract from the blood globules of healthy animals absolutely free fromtuber culosis.

The method of preparation was made known by A. & L. LUMIERE in an article given by Professor CHAUVEAU to the Paris Academie des Sciences in July, 1905.

The animal blood, obtained by bloodletting, is mixed with 20 parts of an isotonic solution, and then centrifuged. The globules are thus isolated and afterwards washed several times with an isotonic saline. Mixed with a quantity of distilled water to make the whole equal to the volume of the original blood, the mixture then undergoes a succession of freezings with the purpose of bursting the cells.

The protoplasmic contents are thus liberated. A fresh centrifugilization then removes the globular stromas. The final solution thus obtained is **Hemoplase Lumiere** and is supplied in 10 c. c. ampoules for intramuscular injections as hereafter indicated. Dried at a low temperature it forms a powder which is perfectly stable and is made up into Dragees

Therapeutic Action: It is simple, considering the constitution of **Hemoplase**, to foresee its therapeutic value. The phenomena consequent upon its administration are complex, but may be grouped into three very distinct classes of symptoms. The first of these symptoms are related to an action of stimulation and of general dynamogenic solicitation. The second are related to a general antitoxic action, which according to the nature of the cases, leads to a lowering of temperature, the cessation of coughing and the suppression of night sweats (influenza, uberculosis). Finally, the third are proof of a reconstitution of the blood and of the organs. They are made manifest by a noteworthy increase in the richness of the corpuscles, he progressive disappearance of the external signs of cachexia, the retur of the natural complexion, and rapid increase in ody weight.

Indications: Hemoplase treatment is applicable in all organic weakness whatever the origin (convalescence, tuberculosis, cancer, influenza, various infectious conditions) and very particularly in cases which are relatted to alteratio in the blood (chlorosis, anæmia, malaria, posthæmorrhagic depression, etc.). In tubercular affections, **Hemoplase** causes a rapid increase in weight and the cessation of night sweats.

Forms and Dosage: Hemoplase is supplied for oral use in Dragees. The Dragees are given in doses of 6 to 10 daily.

Subcutaneous administration: The solution for intramuscular injection is supplied in ampoules of 10 c. c. For Adults the dose is generally I ampoule of 10 c. c. twice weekly. For children from 5 to 8 years of age, 2 c.c. twice weekly. For children from 8 to 13 years of age, ½ to 1 amp. twice weekly.

Method of Administration of Hemoplase: (1) Generally two injections weekly are sufficient treatment, but as **Hemoplase** is non toxic, the dosage may be increased to 3 ampoules weekly, allowing 2 to 3 days between each injection. The length of treatment varies with the nature and gravity of the case.

(2) Each ampoule contains 10 c.c. and this quantity should be given at each injection.

(3) Use an all glass 10 c. c. syringe which is easily sterilised.

(4) Sterilise the syringe and needle by prolonged boiling.

(5) Cut the ampoule at the neck with the file supplied.

(6) Make the site of injection aseptic by the usual means (ether, tincture of iodine etc.)

(7) Draw into the syringe the quantity of **Hemoplase** to be injected, free from any froth produced.

(8) Make the injection directly into the muscles. The most usual region is the buttocks, approximately in the superior external quarter of the buttock, alternating the left and right sides at each injection. Stretch the overlying skin with the left hand and insert the needle with one stroke. The needle should be 3 to 4 centimetres long according to the adiposity of the patient.

(9) Make the injection slowly. On withdrawing the needle, seal the wound with collodion. Occasionally, in certain subjects who are particularly susceptible, there is a slight localised swelling of the skin at the site of injection, sometimes pruriginous. It is the usual serum rash, but with **Hemoplase** it is unusual and very mild. It appears after the first few injections only, and the treatment should not be suspended on this account.

CRYPTARGOL LUMIERE

Argentothioglycerine Sulphonate of Sodium

Constitution: M. Aug. Lumiere has given the name **Cryptargol** to a silver derivative of thioglycerine-sulphonate of sodium discovered by him and of which particulars of its composition and princi pal properties were given in two communications to the Societe deTherapeutique of Paris (13th Oct. 1920 and 12th Oct. 1921).

Cryptargol Lumiere contains 35 metallic silver.

It is a yellow non-deliquescent powder, very soluble in water, its solution being neutral and not precipitated either by sodium or by dilute solutions of the alkali chlorides.

The characteristic reactions of silver salts are therefore absent except that of ammonium sulphydrate which produces the sulphite

Internal Use: Gastro Intestinal Antisepsis:

Cryptargol Lumiere has given, as an intestinal antiseptic, remarkable results much superior toany other medicament yet used for disinfection of the intestinaltract.

In a communication, 19th February 1923, to the Paris Academie des Sciences, M. A. Lumiere reported the extremely conclusive experimental results on dogs. After giving 1 gramme mixed with food, on 4 consecutive days, examination of the faeces showed that practically complete sterility had resulted, only one microbic colony being observable on the gelatine plate. The same trials made with benzonaphtol in doses of 1 gramme on 10 consecutive days showed 100 colonies in a diameter of 10 millimeters.

Numerous clinical trials confirmed its complete innocuity and its remarkable efficacy as an intestinal disinfectant.

Cryptargol Pills, for Adults, contain 10 centigrams of the salt and are administered in doses of 2 to 6 pills daily with meals.

These pills are without doubt the best treatment for infectious conditions of the digestive tract.

Various diarrhoeas, diarrhoea of tuberculosis, typhoid fever, paratyphoid fever, diarrhoeas due to Shiga or coli bacilli. amoebic dysentry, cholera, enteritis, entrocolitis, gastro-intestinal dyspepsia with coprostasis, intestinal fermentations, etc.

The use, however prolonged, of **Cryptargol Pills** does not cause any of the troubles associated with the uso of silver nitrate pills, usually described by the name Argyrism (dyspnea palpitations, oedema of the lower limbs, slate coloured pigmentation of the mucosa and skin).

TREATMENT OF ALL HYPERPLASIAS (TUMOURS, NEW GROWTHS, FIBROIDS, Etc.)

BY MEANS OF

BACKERINE

THE FIGURED FERMENTS INTRODUCED BY DR. D. BAKER, OF PARIS, ACTIVATED BY SALTS OF MAGNESIA

Results Obtained by the Method of Active Ferments or Backerine: For more than thirty years past my method has been put to the test and its success has been such that we imagine no other can have shown itself more fertile in good results in the diseases that we have enumerated.

Hitherto it had been found impossible to maintain our ferments in an active state for more than a fortnight. As matters stand we are able to preserve them indefinitely in a glycerine medium so that now we are in a position to place them on the market. Then too fresh researches have shown us the very great advantage there is in associating them with salts of magnesia which singularly activates their therapeutical properties in such wise that we are now able to organize a treatment the effects of which are greatly superior to those previously obtained.

The results: return of the appetite, restoration of the general health, and diminution of the local symptoms are sometimes manifested very rapidly and thenceforth progress daily. In other cases they may

be delayed in which case the treatment must be reinforced which for that matter is invariably well borne.

It should be remarked that our method is not only applicable to the sick but also to those who for any reason: loss of strengh, arthritism, etc., appear likely to become so. Its principal effect is to transform the organism and to render it refractory to the development of disease. Ferments taken by the mouth suffice to effect this change in the soil.

Patients who have been operated should take a prolonged course of treatment in order to avoid recurrence, resuming it on the slightest warning.

Notes of Cases: The notes we propose to give here will be very brief:

All the patients whom we have cured have been seen at the same time by other practitioners consequently my diagnosis and treatment have in every instance been verified.

1. Pyloric obstruction :—Celine G., 99, boulevard Haussmann. Seen by Dr. Legroux and by me; dying of inanition owing to obstruction of the pylorus by an enormous mass. The first injection was given on December, 3, 1893. Rapid recovery. The tumour was reduced to the size of a filbert. In nine years she had several threatening recurrences which were immediately arrested by the treatment. Since then the cure has been maintained.

2. New Growth of stomach :—M. M.. treated in the wards of Professor Albert Robin, at the Pitie Hospital. The immediate result was most surprising Dr. Robin was pleased to recognize the fact.

3. Same as above :—M. R., of Paimbœuf, was seen by Dr. Bousseau, of Paimbœuf, and me in presence of his children gathered together to be present at his last moments. The patient was in a state of frightful emaciation. Two months after, Dr. Bousseau, wrote me. I have just seen M. R. on his way to his vineyard. He is as well as possible.

4. Epithelioma of the rectum :—M. V. D., of Chalons-sur-Marne, seen by Dr. Brettenacker and me, derived benefit from the treatment for several years.

5. Fibrosarcoma of the uterus :—Mrs. B. under treatment by Professors Berger and Landouzy. Operation declared to be urgent in view of approching fatal termination. Patient refused operation. I instituted our intensive treatment. Three months later the tumour had disappeared. No recurrence. Her present health is perfect.

DIRECTIONS FOR THE TREATMENT

Activated Backerine is administered by subcutaneous injection, in cachets or in drages.

The ampoules now in use are of one kind only, of yellow glass. They contain a mixture of selected figured ferments and salts of magnesium. Formerly these two products were delivered separately in two sorts of ampoules but their preparation has been perfected so that now one ampoule suffices thus facilitating their use.

The content of one ampoule is to be injected every fourth day. In apparently grave or urgent cases and when the inflammatory reaction is not very pronounced, the injection may be given every three days.

The injections should always be given in the immediate neighbourhood of the mischief when possible otherwise as near as possible thereto.

Before making use of Backerine ampoules take care to rub them briskly between the palms of the hands in order to liberate the deposit that forms on the walls.

The cachets and dragees of activated Backerine are composed of figured selected ferments and salts of magnesia. Either can be prescribed as preferred by the patient. Give four cachet or eight tablets a day on an average, more in case of urgency. The patient should take them during meals.

The injections are completely inoffensive. They may set up an inflammatory reaction at the site of injection puncture (the effect of the remedy is the greater the more pronounced the reaction) and a constitutional reaction which lasts about twenty four hours. The reaction having passed off, appetite and strength return along with an improvement of the general state and local lesion. The use of the cachets or tablets increases and maintains their efficacy and it reinforces the effect of the injections in the cure of neoplasms. This is no cause for surprise for we have to radically change the blood and humoral milieu in which the tumour is running its course. But the tumours often date very far back, long anterior to the date of their becoming manifest.

Dr. DE BACKER (of Paris).

SPECIAL CONTRIBUTION TO THE MEDICAL PROFESSION

On the Therapy of Bronchial Asthma.

(*Reprinted from a Medical Journal*)

The cause of Bronchial Asthma is in nearly all cases the Emphysema of the lungs. However different may be the theories of the Emphysema of the lungs, whether the inspiratory, as already dealt with by Laennec, or the expiratory, there exists in all cases an impediment to the free exit of the air, causing the great efforts at exhaling, or whether nutritive changes of the lung tissues (Rotikansky's Rarefaction of the tissues) are the cause, primary or supplementary, the symytoms and complaints of the patients are in all cases the same, varying in degree only. And not only those suffering from the Emphysema, but all who ever witnessed an attack of Asthma know how terrible the suffering is. The patient strains every effort of the respiratory organs in order to force expiration. In the case of dry catarrh of the bronchii, whose swollen mucous membrane constricts the lumen, the patient suffers days and nights of combat with the mucous which tends to close up the opening. Great efforts to cough and clear the finest bronchioles of the small mucous globules, combined with deathly fear of suffocation, loss of appetite, and sleepless nights, extending over weeks, often reduces the patient physically.

The remedies used and the claims made for them are of a great variety and vary from a modest to a complete relief. There is however no single treatment which in every case and stage of the disease will definitely, completely and forever remove the respiratory disturbances. It is quite evident that this is impossible, since the original condition of the lungs, *i. e.*, the flatulency of the air vesicles of the lungs, is irreparable. It is impossible to restore to a worn-out rubber band its original elasticity.

During the many years of suffering, the asthma patient has, as a rule, tried the long list of remedies, one after the other. Some give relief for a short time and then fail, or they help in light attacks, or when an excessive amount of mucous has accumulated. Others again, give results in the case of dry catarrh. A new remedy is tried and the patient is pleased. He feels great relief, but only to be disappointed in the end as the expected result does not realize.

Every Asthma sufferer as a rule, has his pet remedy on which he falls back from time to time, with greater or less satisfaction. Saltpetre-paper and stramonium cigarettes are seldom missing from the bedroom of the sufferer. All these, of course help some, but not completely.

Best known of the remedies are the internally used narcotics, codein and bitter almond; those of dissolving characteristics as sal-ammoniac, iodide of potassium, ipecacuanha; those that invigorate or vivify, such as benzoic acid; balsamic oils, such as turpentine and creosote. Aniseed and the old and well-known pectoral tea are much in vogue, though the latter cannot be obtained any more in its old time excellence. Morphin injections should above all be avoided, especially if they are administered by the patient himself. They should be resorted to only in the most serious cases. Chloral hydrate, once much used, is only seldom prescribed now.

Pneumatotherapy and thorax massage can now only be afforded by few.

The inhalation of non-narcotic remedies is lately much in vogue. The apparatuses used for this purpose are brought to a high degree of perfection. Finely atomised, the drugs are brought in direct contact with the inflamed mucous membrane. Principally used in this connection are the cell-reducing, secondary kidney preparations and atropin, the latter reducing excretion. Others again administer secondary kidney extracts hypodermically, for example Kade, with hypothesis combined in astmolysim. The success is often undeniable and the introduction of these remedies into the therapy of Asthma marks a progress and constitutes a great benefit to all Asthma sufferers.

In many cases of Bronchial Asthma and Emphysema, some very severe and of many years' standing, and may I add, in my own case, I have lately used a new remedy with good success. I recommend it to all fellow suffers as well worthy of a trial.

The preparation is marketed under the name "Felsol," by the British Felsol Company. I am not familiar with the eymology of the name. The preparation is sold in original packages containing 12 powders per box, the dosage for an attack being 1 to 3 powders according to severity and duration. The

powders are easily swallowed with a little water.

It is a correct assumption that although the heart is in some cases not directly affected in expressed cases of Asthma of the lungs, yet the heart, and especially the right ventricle, is greatly overburdened through the impediment of the pulmonary circulation.

No bad by-effects have ever been noticed even on administering a double dose of the powders. "Felsol" promises success, whether it be a case of pure Bronchial Asthma, or whether it is a condition of cardiac disorders, or insufficiency, or a case where the functional defects of the pulmonary organs cause the cardiac disturbances, or vice versa.

In a number of severe and most severe cases of the first kind, *i.e.*, pure Bronchial Asthma, I have obtained successes with "Felsol" as with no other of the beforementioned drugs. My observations, involving also some more obscure cases are being continued.

Regarding the action of "Felsol" it will be noticed that soon after administering the first powder the uproar in the chest, as one patient described it, subsides, the wheezing and panting diminishes, the respiration becomes more regular and easier even before the ejection of much sputum. The respiration continues to grow deeper, fuller and less frequent. At the same time the pulse becomes more normal and regular, the cyanosis disappears, the feeling of distress gives way to a feeling of ease, finally terminating into recuperating sleep. The results are readily discernible after half an hour and they are greatly increased by absolute physical rest, abstaining from any and all exercise of the muscles, and by refraining from all mental work. As a rule they extend over a period of 24 hours, and it may, in some cases, be advisable to give a second powder after 3 to 4 hours. A third powder is seldom necessary in this attack. The stomach has not been found to react in any way. The results or effects do not decrease even after frequent or repeated use of "Felsol."

I am unable at present to say whether "Felsol" if used before an approaching attack will entirely prevent the latter, as on this point my observations have not been concluded. There is, however, a probability that such is the case within certain limits.

Wherever I used "Felsol" the patients were delighted with it, and I am myself since it has relieved me of many hours of misery and suffering, caused by gas poisoning received during the war. In my case the condition is due to cauterisation of the small and smallest bronchioles by phosgene gas (chloro-carbonic acid) $COCl_2 + H_2O = CO_2 + 2HCl$, the hydrochloric acid being formed on the mucous membrane of the bronchii. The progressive reduction of the lumen leads to the Emphysema. The cauterised places of the bronchii which for years manifested itself at certain intervals of time as the cause of severe spitting of blood, are now cicatrized, but the Emphysema still remains. The use of "Felsol" relieves my condition considerably and I again recommend its investigation to my colleagues and to all fellow sufferers.

I am pleased to give you the formula for the preparation as communicated to me by the compounders:—(Phenazon 0.25, + Anilipyrin 0.4, + Iodopyrin 0.25) Caffein 0.1. Susc. alb. 0. 01, and Extr. Brachycladii 0.01.

Dr. G. S.

Extracts from Standard Literature

"MODERN DIAGNOSIS AND TREATMENT OF SPHILIS, CHANCROID AND GONORRHOEA

BY

L. W. HARRISON, D.S.O., M.B., CH. B., M.R.C.P., EDIN., BREVET COLONEL R.A.M.C. & K.H.P. (RET.),

Director of Venereal Dept., St. Thomas's Hospital, London.

Page 115.—"Sulfarsenol, given subcutaneously, is usually chosen for patients who are apt to react severely with vasomotor symptoms after intravenous injections. It is eminently suitable for use throughout the course, and has the advantage that the patient need not fast before the injection."

Page 119.—"The technical difficulties connected with intravenous injection of infants have caused many to employ the intramuscular method; the best plan, then, is to dissolve the dose in the smallest possible bulk of water, say, 5 minims, and inject into the gluteal region, as in adults. Sulfarsenol is probably the best remedy for the purpose, as it causes much less pain in adults than any other preparation on the market."

Page 90.—"The deep subcutaneous injection is carried out as follows: The remedy is dissolved in the ampoule in 1 to 2 c.c. of sterile distilled water."

"A piece of the skin and fat overlying the upper portion of the gluteal region is pulled away from the muscles, and the needle is run into the base of the pyramid thus formed, so as to under-run the fat and land the needle point on the fascia covering the muscles.

"When Sulfarsenol is used, the patient usually feels later only a little soreness following the larger doses, and this is rarely so severe as to preclude continuation of the treatment by this route."

Page 92.—"The therapeutic effect is also influenced by the method of administration, and it is quite clear that, in the case of those preparations which can be given either intravenously or subcutaneously, the subcutaneous route affords by far the better results.

'Preparations which can be given subcutaneously are retained longer and thus given an opportunity of being converted to the active derivatives; hence the greater therapeutic effect of subcutaneous injection, as tested by the serum reactions."

II

"THE TREATMENT OF THE COMPLICATIONS OF GONORRHOEA WITH SULFARSENOL" DR. F. HADI

Thesis, Alger, 1924.

"In gonorrhoeal complications Sulfarsenol seems to have a more certain and regular action than other medicaments usually employed (vaccines, milk injections, etc.)"

"Of the complications cystitis and prostatitis are most influenced. In orchi-epididymitis and rheumatism the results are also good but in these cases it is occasionally advisable to supplement with other treatment.

"Sulfarsenol may act as a microbicide in contact with the gonococcus or on the toxins, but we are of the opinion that the action is rather hemopoietic as the general condition of the patients is invariably improved.

III

"PRECIS DE SYPHILIGRAPHIE ET DES MALADIES' VENERIENNES"

JEAN-SELME AND SEZARY,

Bailliere, Paris, 1925.

"TREATMENT OF SYPHILIS"

Page 295.—.....The Sulfarsenol of Lehnhoff-Wyld is essentially composed of the base present in 606, combined with a molecule of acid sodium sulphite. It is a yellow powder, soluble in water, with an activity comparable with that of 914. Its principal advantage is the one constituted by the fact that it may be injected into the subcutaneous cellular tissue or muscles in doses which may reach 60 centigrams, and in a quantity of water not exceeding 10 c.c. While this method may not necessarily serve absolutely to prevent the occurrence of nitritoid crisis. it renders them more unusual....."

"THE ADVANTAGES OF SULFARSENOL IN THE TREATMENT OF SYPHILIS,"

B. SHERWOOD-DUNN, M.D., NICE.

"American Journal of Clinical Medicine." Sept. 1923.

"The tremendous percentage of increase in syphilis, that has been left us as one of the consequences of the war, makes it extremely necessary that we should have a remedy that can be readily applied by every practitioner without the need of special training and without the fear of any disquieting consequences. Sulfarsenol would seem to supply this requirement. The only precautions necessary are, that the hypodermic injections must be made antiseptically, which, is necessary in the employment of any hypodermic injection, and that the solution should be injected into the deep muscular tissue of the gluteus maximus. It cannot be denied that, even for an experienced practitioner, intravenous injections present, at times, annoying difficulties, especially with women of rather full habit and very fine, imperceptible veins; also in unmangeable children; it is, therefore, of tremendous advantage to have a satisfactory remedy that can be injected directly into the muscular tissue.'

It is requested that non receipt of the journal and change of address should be intimated to the Managing Editor before the end of the month.

PRACTICAL MEDICINE.

Moods, Mind and Functional Disturbances

(Continued from last issue)

Sleeplessness.

There are two days of inducing sleep in cases of insomnia. The one is to *put* the patient to sleep. The other is to let sleep come to the patient. There are, of course, a variety of details. For instance you could *put* a person to sleep by giving such a dose of some poisonous narcotic that sleep *must* be obtained.

Such sledgehammer tactics however would ill become a sympathetic physician.

Modern bedside manners demand a more considerate attitude.

Inability to sleep is often more a matter of mental or psychic disturbance than one of the peripheral nervous system. Some remedy is therefore required which can quieten a mental or psychic excitement as well as the peripheral nerve and for that purpose Elixir Bromo Valerianate (Gabail) is the best. Give only just enuogh to keep the mind and nerves quiet all the time. Sleep will come when it is required, and go when its purpose is served, in a natural way, as nature intended.

Repose as a Factor in Nerve Nutrition

During ordinary repose, if there are no irritating factors in operation, the nutrition of the nerve can proceed steadily. This building up process will occur more slowly waking than in profound sleep, but if the irritability of the nervous system is reduced and the mind quietened, so that neural anabolism is permitted during twenty four hours every day, progress can be very satisfactory. Glycerophosphates, though useful are really a minor consideration compared with repose. Without repose, Glycerophosphates may be decomposed and eliminated much more quickly than it is possible for them to be absorbed from the digestive tract. With repose they can be elaborated in the system as rapidly as they are required. If the patient can take even a moderate quantity of milk daily, the phosphorous supply can be considered sufficient and complete. The only factor remaining to ensure nutrition of the nerve tissue is Repose.

Wherever the physician considers that the nervous system of a patient requires nutrition to be assisted, the only medicine required is a mild sedative capable of inducing repose of mind and nerve. For that purpose nothing could be better than Elixir Bromo Valerianate (Gabail). Begin with doses of two teaspoonfuls three times a day in ordinary cases. In extreme nervous irritability with mental equilibrium disturbed as well, doses of a tablespoonful may be necessary.

Nerve Substances

Myelin is composed mainly phospholipoids of the cerebrin class. But nerve substance has been shown to be a good conductor of electricity, and pure cerebrin is a very bad conductor. Therefore we may conclude that something else is present in the nerve substance to act as conductor. So far as the nourishment of the nerves is concerned, the main consideration is the supply of phospho-lipiods. Now the greater the ratio of lipoids as compared with "conductors", so the greater will be the impulse required to excite a nerve to action. This is in agreement with clinical findings, and explains the progressive character of so many nerve cases.

Where a deficit once occurs in the nutrition of a nerve it becomes more excitable, more restless, less inclined to remain in that condition of repose in which the anabolism of nerve substances can proceed in a normal way. If we could restore that restful state (and we can) then time and patience would do the rest. The fact is also well supported by clinical findings, for where such cases are allowed a few doses of Elixir Bromo Valerianate (Gabail) daily, gradual improvement of the nervous state is soon in evidence.

Elixir Bromo Valerianate (Gabail) therefore assists nature to check the progressive character of nervous troubles, and to build up a sound nervous system, as well as to quieten the peripheral and central nervous system and the psychic condition.

News and Comments

Cholera in Madras : Epidemics have lost their horror in this city. The Corporation machinery has been running more smoothly than ever. The departmental autonomy now enjoyed by the heads of the department, though desirable, do not seem to have yielded good fruits so far. Cholera is a disease brought about by filth and usually carried by water. In Madras, it has not been possible to prove so far that the infection is spread by drinking water, though for all practical purposes, the water leaving the filter beds at Kilpauk and running through the underground pipes cannot be said to be free from subsoil sewer infection as is evidenced by the foul smell, emnating from taps with the flow of water, at least in some parts of the city. Filth we have enough and more. For the accumulation of filth inside the houses, ignorance due to want of education is responsible; we agree with this theory enunciated by the Health Officer in his administration report. But, what about street filth which one sees heaped in hillocks in open streets waiting to be removed by motor lorries, the drivers of which are found busy training apprentices, for motor driving and at times these heaps accumulate unnoticed for a number of days. What about the filth sold in markets ? Rotten fish and decomposing eggs have a larger sale these days. The festivities of the Park Fair are just over and before the health staff could wipe off their perspiration due to their activities at the Park Fair, the Pongal Health Fair has to be gone through and they have to store their energy for this purpose. The health department seems to have greater faith in educating the people by Exhibitions in the park than by actual demonstrations in streets and markets and if possible inside the houses.

Cholera inoculations are being done perhaps by a special staff. In every nook and corner of the divisions in this city we have independent medical practitioners and the Corporation would have tested and proved the efficacy of these inoculations as a preventive by having recourse to mass inoculation as soon as a case of cholera is detected in a particular locality, by entrusting this work to the members of the independent medical profession, paying them a small honorarium for each case injected. This would have served as a good means for detecting cholera cases, as notification involves a responsibility on a medical practitioner even in case he might not treat the case. In all civilised countries, private practitioners help and cooperate if requisitioned by the Health Department and a small fee is paid to the practitioners for even notifying diseases. Health department in India cannot conceive of such an idea We wish the health staff spends some of their time in markets and street visiting. If this is done more diligently than now, we will have less deaths from cholera and other intestinal diseases which are prevalent on a large scale now.

The Medical Association, Vizianagaram : We have had exceptional opportunities of knowing medical associations in India in big cities as well as in small towns but we have not seen such a comprehensive programme as that of Vizianagaram Association, which is worthy to be copied and followed by even the biggest association in our country. Apart from the stero-typed professional and social activities which are common in all societies, the Vizianagaram association has formulated rules entailing on its members civic responsibilities which, if properly recognised by the authorities, will certainly make that historic town an ideal place to live in. The municipality has been requested in these rules to supply the members monthly statistics about births and deaths and prevalence of epidemics and the association in its turn has volunteered to take upon themselves the responsibility of advancement of high principles of good health including social hygiene. We know that all the initiation for the enactment of these rules is original and is the more creditable. The existence of a rule "Distinctions in degree position are not allowed and all members are treated as equals" and the scrupulous care taken in honouring this rule by all concerned, has made this Association a reality and its existence has been ensured on sounder foundation, unlike many, medical associations which due to observance of castes never live and in case they live they die soon as mushroom.

The yearly special meeting of this Association took place on 21-12-30. After the usual social items of tea and group photo Dr. G. Subba Rao, L.M.P. was elected as President for the current year in the place of Dr. G. Rama Ayyangar, L.M.S.

whose term of office ceased and Dr. V.S. Rao, L.M.P. was voted as the Secretary for the third time. The spirit of real fraternity existing in this Association is evidenced by the fact—if evidence is needed at all—that the outgoing President Dr. G. Rama Ayyangar gave a dinner to all the medical men in the town.

We wish the Vizianagaram Medical Association a long life of usefulness.

Rural Medical Practitioners' Conference : The subsidised rural medical practitioners met in Conference on 31st ultimo at Madras. Dr. M. S. Krishnamurthy Ayyar Editor, "The Medical Practitioner" presided. The Secretary Dr. S. Ramasubbu welcomed the delegates and the visitors, and as is usual with such welcome addresses, pointed out the defects in the present scheme and laid before the audience typical instances of some of the hardships of the rural practitioners under the rule of the Taluk Boards and after discussing various rural schemes in vogue, in other provinces suggested a grant-in-aid scheme (*Vide* page 120 of this issue.) The President had his say regarding the rural medical relief scheme as now working and pointed out most appropriately that it was desirable to inaugurate a scheme which will revive the old system of family physicians.

We are glad the proceedings of the Conference did attract the attention of almost all the dailies in the city though it is to be regretted that the medical profession in Madras did not evince any interest. Their attendance would have encouraged this useful class who have been doing work under most difficult circumstances. We intend commenting upon the various aspects of good the Rural Medical Relief Scheme in our next issue elsewhere. In the meanwhile we refer our readers to the "Abstracts" columns of this issue wherein appears the leader from "The Madras Mail".

The comments of "The Madras Mail" have our highest appreciation. We are not for multiplying Government departments and have always been writing that the medical relief of the general public should rest solely on the independent medical profession. As stated in the Editorial of "The Madras Mail" even in Great Britain, with its Parliamentary Government, the State Medical Service falls short in many respects of the old family system and is largely lacking that intimate relationship between patients and practitioners which the family system ensures. In India the State medical service cannot be expected to do better with all its defects.

On the whole the Provincial Rural Medical Practitioners' Association must be congratulated on the idea in holding the Conference at Madras. We hope they would realise where they are, regarding help and patronage from outside including the members of the medical profession. If they did not help themselvs as they did in running this Conference under the able guidance of their energetic Secretary, God would not have helped them to the extent, He did on this occasion quite true to the adage, "God helps those that help themselves". We could see that the Secretary was rather nervous even to acknowledge the little help from outside though it came unasked. None can find fault with him as Madras is too big a place to enervate even one with the strongest nerves.

* * *

We offer our congratulations to Dr. T. Krishna Menon, Hony. Physician, General, Hospital, Madras on the New Year honour conferred on him being the recepient of Kaiser-I-Hind Medal II class. It is but appropriate that honorary services should be rewarded by the bestowal of civic honours even more than those conferred on paid services. Dr. Menon richly deserves the honour. At the same time we regret that Dr. M. Subramanya Ayyar, who is an older practitioner than Dr. Menon and whose honorary sevices at the Government Hospital for Women and Children, Madras have also been appreciated by the Superintendent, and extend to the same period as Dr. Menon's should not have been rewarded. We hope that the omission will be remedied in the near future.

Services of a Rural Medical Practitioner Dispensed with: We learn that the President, Taluk Board Devakottai has dispensed with the services of a subsidised rural practitioner at Neikuppai. The charges seem to be (1) delay in submitting annual statistics for 1929, (2) delay in the submission of quarterly returns (3) failure to send copies of extracts from the visitors' book about District Medical Officer's inspection of the rural dispensary and (4) leaving Headquarters without permission.

Whatever be the nature of charges it is preposterous that the rural medical practitioner was not asked to submit his explanation before his services were dispensed with. We are informed that the aggrieved practitioner has appealed to the Government against the illegal action of the President, Taluk Board, and we trust that without going into the merits of the case Government will restore this practitioner to his place and call upon the President, Taluk Board to deal with him as per terms of agreement between the rural medical practitioner and the Taluk Board.

One more Civil Surgency: It is rumoured that a full time professor will be appointed to teach Medical Jurisprudence at the Madras Medical College. We have pointed out more than once that there is no need for one more appointment to teach this subject and that the Police Surgeon is the best person who should be entrusted with the work as is the case in Bombay and Calcutta. This is a practical proposition and a sound one on financial point of view. The Professor of Medical Jurisprudence should be one who has had vast experience in Medico-legal cases. Knowledge of Pathology and post-mortem experience will not in themselves do to qualify him to teach medical jurisprudence. If for any reason the Police Surgeon cannot be thought of for this post a senior District Medical Officer who has had exceptional opportunities to deal with this subject in his official capacity would certainly do better service to the students as well as the subject. It cannot be said that such an officer is not available. Under any circumstances the choice of an young Assistant Surgeon who had not any district experience and who had very little to do with medical jurisprudence except in post-mortem room or transforming him as a Professor of Pathology displacing a senior and appointing the latter as the Professor of Medical jurisprudence will certainly be deplorable from all points of view. We trust that Surgeon-General Sprawson will not give room to discontentment in service and dissatisfaction in the minds of the public.

Errata : Page 110 current issue under the heading *Expenditure* 660 should be read as 6,600 and 1,200 as 12,000.

List of postings of Sub-Assistant Surgeons for the month of December, 1930.

Name of Sub-Asst. Surgeon	From	To
1. Dr. K.V. Narasimha Rao.	L. F. Dy. Guntakal	L. F. Dy. Kalyandrug
2. ,, R. Krishna Ayyar	L. F. Dy Kalyandrug	c/o, P.D.B. Anantapur.
3. ,, M. Viraswami Naidu	Hd. Qrs, Hl, Madura	c/o, C.M.C. Bodinayakanur.
4. ,, D. Krishnamurthy	Muni. Dy. Bodinayakanur	Hd. Qrs. Hl. Madura.
5. ,, B. Narayana Murthi	Govt. Dy. Gaizlbady	Hd. Qrs. Hl. Nellore.
6. ,, M. Lakshminarayana	L. F. Dy. Gudur	Pol. Hl. Kurnool.
7. ,, S. Kuthalam	Pol. Hl Kurnool	c/o. P. D. B. Kurnool.
8. ,, M. Jacob	Hd. Qrs. Hl. Calicut	Govt. Dy, Androth.
9. ,, R. Sundararajan	leave	Hd. Qrs. Hl. Trichinopoly.
10. ,, S. Seaha Reddi	leave	Hd. Qrs. Hl. Chittoor.
11. ,, Dennis Anthony	Hd. Qrs. Hl. Cuddapah	c/o, P. D. B. Kurnool.
12. ,, A.V. Krishna Ayyar	Hd. Qrs. Hl. Madura	c/o, P. D. B. Tanjore.
14. ,, T.R. Venkataraman	.....	Forst Coll. Coimbatore
14. ,, S. Sundaram	.....	do do
15. ,, K.S. Sankaranarayana Unni	Borstal School, Tanjore	c/o, P.D.B. Tanjore.
16. ,, P. Narasimha Rao Naidu	Munro's Hl. Gooty	c/o, I. G. of Prisons Ootacamund.
17. ,, K. Srimantha Rao	Hd. Qrs. Hl, Guntur	do do
18. ,, D. Jagannatha Rao	Central Jail, Vellore	Hd. Qrs. Hl. Guntur.
19. ,, B. Rukmanga Rao	Central Jail Rajahmundry	Hd. Qrs. Hl, Cocanada.
20. ,, K. Krishnamurthy	Hd. Qrs. Hl. Cocanada	c/o, P. D. B. East Godavari
21. ,, M. Adinarayanaswami	L. F. Dy. Bicoavole	Govt. Hl. Tuni.
22. ,, T. Kothandaramayya	Hd. Qrs. Hl. Vellore	Itinerating Dy. Maharattipalayam (N. A. Dt.)
23. ,, M. A. Subramanyam Pillai	Hd. Qrs. Hl. Ramnad	c/o, P. D. B. Ramnad.
24. ,, L.A. Subramaniam	L. F. Dy. Watrap	Hd. Qrs. Hl. Ramnad.

Continued on page 148

Correspondence, Reports, etc.

PROCEEDINGS OF MEETINGS

RESOLUTIONS PASSED AT THE SECOND TANJORE DISTRICT RURAL MEDICAL PRACTITIONERS' CONFERENCE

HELD AT ADUTHURAI ON 22—11—1930

UNDER THE PRESIDENTSHIP OF

DR. S. MUTHUKUMARASWAMI PILLAY, M. B. B. S.,

1. Resolved that our Executive Committe be asked to consider measures to standardise all the Rural Dispensaries in the District.

2. Resolved that the Government be requested to allow at least one month's leave per year, since 15 days is found insufficient.

3. Resolved that the Government be requested not to open any new Rural Dispensary within seven miles of an old one.

4. Resolved to thank heartily the Editor of the "Medical Practitioner" for his services to us.

5. Resolved to inform the Government that the subsidy is still too poor and praying for a further increase.

6. This Conference strongly supports the suggestions of our Secretary dated 3—6—30 regarding Building, Furniture, and Instrument, Grants and resolved that the Government be requested to expedite orders thereon.

7. This Conference views with horror the ill-treatment meted out to the Rural Medical Practitioner of Perambur by the Mayavaram Taluk Board President, and resolved to request Government to see that justice is done to him.

Kilayur (*Via*) *Negapatam* 1-12-30. } R. SUBBARAYA BHUTT, *Secretary.*

Licentiate Medical Practitioners' Meeting at Calicut

Drs. A Balakrishna Nayar and V. Krishna Menon organised a meeting of the Registered Medical Practitioners (other than the Medical Graduates) on the 7th December, 1930 at 5 P.M. in the Paran Hall, Calicut, at which several independent medical practitioners and those in service attended.

Dr. C. Sumukhan one of the oldest practitioners of the place occupied the chair.

The following resolutions were unanimously passed.

1. While the meeting of the Licensed Medical Practitioners of Calicut warmly appreciates and welcomes the idea of the inauguration of an All India Medical Council, it views with apprehension and dismay the narrow and ill-considered attempt to whittle down its usefulness by excluding the large body of Licensed Medical Practitioners all over India from its operation.

2. This meeting appeals to the Government that in the interests of the medical profession in India, the institution of an Indian Medical Council is long overdue and to bring within its scope all Allopathic Medical Practitioners registered under the various provincial Medical Councils on the same democratic principles as of the British General Medical Council and that the standardisation and control of Medical Education in India be entrusted to that body.

3. It is the considered opinion of this meeting that any attempt to perpetuate caste-distinction or create water-tight compartments in this noble and democratic profession will be fraught with disastrous consequenees to the Allopathic System of treatment in India.

4. This meeting authorises its president to send copies of the above resolutions to the President and the two representatives of Group iii of the Madras Medical Council, the Minister in charge of the Medical portfolio, Madras, the Surgeon-General with the Government of Madras, the Director-General of Indian Medical Services, India, the Secretary of the Government of India, in charge of Education and Medical Department and to the Press.

Resolutions passed at the Third Provincial Conference of the Rural Medical Practitioners of the Madras Presidency

(Held on 31st December, 1930.)

1. This conference reiterates such of the resolutions passed at the 1st and 2nd conferences, not given effect to by the Government and requests them to appoint a committee to reorganise the Rural Medical Relief Scheme on a sound and workable basis, taking into consideration all the evils of the present system, inherent or otherwise, and suggests that the proposed committee might consists of (1) the Surgeon General with the Government of Madras (2) A senior civilian having experience of district administration (3) Two members of the Madras Legislative Council, preferably those who were or are Presidents of Taluk Boards (4) Two senior independent medical practitioners and (5) two experienced rural medical practitioners to be nominated by the Provincial Rural Medical Practitioners' Association.

2. (a) This Conference expresses its deep sense of gratitude to the Hon'ble the Chief Minister for his concern in rural medical relief as expressed by him in his reply to the address of welcome presented to him by the Taluk Board of Tiruppur on 21—12—30 and referred to in the Welcome address of the Secretary of this Association and also feels thankful to Major General Sprawson, Surgeon General with the Government of Madras who within a brief period of his regime was able to point out to the Government a few instances of grave injustice done to some rural practitioners and got the same rectified by the Government; and

(b) resolves that a deputation consisting of the provincial secretary and two members of the Association to be led by a nominee of the President of the Conference do wait upon the Hon'ble the Chief Minister in company with the the Surgeon General to bring to the notice of the Government our grievances and suggestions and for this purpose places once again before the Government for considera tion, and kind acceptance the resolutions passed at the previous two conferences, as well as the following resolutions.

III. This Conference approves the principle advocated by the President of this Conference in his address, that the unit of the medical relief by the Government should be a hospital and not a dispensary, and that for the purpose of effectively popularising scientific methods of treatment, the rural medical practitioner should be more liberally subsidised than at present and for this purpose reiterates the principle contained in No. 1 resolution of the first conference and suggests the following modified resolution for kind acceptance of the Government.

(2) This Association of the Provincial Rural Medical Practitioners suggest to Government that as no uniformity prevails in the maintenance and administration of the rural dispensaries, even in the same district, the District instead of the Taluk be taken as the unit of administration and independent medical men be encouraged to settle in villages, by subsidising them with money grants through a District Medical Council composed of the following. (1) The District Collector, (2) The President of the District Board and (3) Two Independent medical men of the district nominated by the District Rural Medical Practitioners' Association.

IV. This Conference is of the considered opinion that a subsidised practitioner would have greater incentive and chance to settle in a village if he hails from the same village, or taluk or district in the order mentioned as that where a dispensary is proposed to be located and therefore roquests the Government to direct that natives of the place shall be given preference for the purpose of subsidising, other things being equal.

V. This Conference condemns the proposal of some of the Taluk Boards to open rural dispensaries at or near villages where medical men have already settled as private practitioners; and if however it is desired to provide for the free medical aid to the necessitious poor of the locality, this conference requests the Government to direct that in all such cases the first option to undertake such work on the usual terms and conditions, shall be given to the existing private practitioner, and that new person should be brought into the place, only when the former refuses to do the work.

VI. This Conference desires to point out to the Government that the withdrawal of the power of appointing midwives from the rural practitioner is not conducive to the good working of the scheme, as in this case the rural practitioner is not able to control the work of the midwife and therefore requests the Government to restore to him the power of appointiug and controlling the duties of the midwife, and pay him the subsidy direct for disbursement to the midwife in turn.

VII. (a) This Conference requests the Government that each rural practitioner should be paid a minimum of Rs. 360 per year in cash, and in advance towards the cost of drugs, permitting him to purchase drugs for the use of the poor; also that

such drugs shall always remain the property of the practitioner and proportionately so to the period he had treated the poor free if he should leave the place before the end of the year for which the advance had been given ; and

(b) This Conference also requests that in cases where the daily average attendance exceeds 30, every practitioner shall be paid a sum higher than Rs. 360 proportionate to the extra attendance.

VIII. This Conference brings to the notice of the Government that no uniformity prevails in giving travelling allowance and batta to rural practitioners that attend courts as witnesses, and therefore requests the Government to allow to a rural practitioner a batta of Re. 1 per day and an allowance of annas 4 per mile of journey by road and second class fare by train.

IX. This Conference thanks the Government for having (a) recommended the payment of a daily allowance of Rs. 5 to rural practitioners deputed for epidemic work and requests that a conveyence allowance of four annas per mile be given to them as they have to go in some cases, even to places fifteen miles off their headquarters.

(b) This Conference desires to bring to the notice of the Government that certain Taluk Boards deduct from the allowance, a sum equal to the daily subsidy of the practitioner and so requests the Government to direct that no such deduction shall be made.

X. This Conference requests that at least one independent registered medical practitioner within the limlts of the Taluk Board area be nominated as a member of that Board to safeguard the interests of the public in matters of village sanitation rural medical relief, child-welfare, medical inspection of school children and other allied subjects and that necessary provision be made for such nomination in the rules.

XI. This Conference thanks the Editors of "The Medical Practitioner" and other journals, and others, who sympathise with the aspirations of the rural medical practitioners and help them in their progress.

Letter Addressed to the Secretary, Drugs Enquiry Committee

BY

THE JOINT HONY. SECRETARY,
Indian Medical Association
5-A, CORPORATION STREET, CALCUTTA.

Calcutta, 17th December, 1930.

Sir,

We have the honour to acknowledge receipt of your circular letter dated the 2nd September, 1930, with a copy of the questionnaire issued by your Committee for the members of the medical profession

Our Association feels that whilst under other circumstances and in more favourable times the desirability of such an enquiry might be admitted considerable misgiving prevails amongst the members of the independent section of the Indian medical profession as to its necessity at the present time. It is apprehended that some of the findings of this Committee will be used with the ulterior purpose of prejudicing the position of the infant drug industry in this country. This belief is strengthened by the fact that uptill now very little effort has been made by Government to help this industry by State aid towards manufacture or by supporting the consumption of the products by using them in Government hospitals. This indifferent attitude of the Government has been responsible for making India a good dumping ground for foreign drugs and preparations. It is widely believed that the nascent indigenous manufacturing concerns will not get justice through the enquiry that has been sent on foot and that many of them may be unjustly condemned. Colour is lent to thisapprehension by the fact that although it was as far back as 1927 that the resolution for the appointment of such a committee has been passed by the Council of State it was not given effect to until a few months ago, when manifestations of a strong national desire for using indigenous preparations and drugs became noticeable. It is strange that for 150 years of British rule no such solicitude has been evidenced for the control of drugs in India. In 1929 out of Rs. 2,01,84,000 worth of drugs and medicines imported into India medicines worth Rs. 88,99,000 came from the United Kingdom. It should be noted that though the Food and Drugs Act in U. K. makes it compulsory to examine all drugs and food substances consumed in U. K. the products for export in India are beyond the provisions of this Act. This apprehension is also to a certain extent supported by the fact that in the composition of the Drugs Enquiry Committee although a place could be found for a representative of a British firm no room could be found for a representative from an Indian manufacturing firm. Our Association apprehends that no useful purpose will be served by a committee constituted as it is, without properly qualified expert personnel to represent the various aspects of the chemical, pharmaceutical and biological drug trade.

In paragraph 3 of your letter under reference the following statement appears : " It is well-known that many unscrupulous people realising that to analyse and standardise medicinal preparations requires experienced men and expensive and elaborate laboratory equipment, take advantage of this knowledge to carry out extensive adulteration, use inferior drugs, and in the case where raw material is expensive, purposely reduce the quantity that should be used in order to sell it at a low price.

This is not only carried out in India but some European firms export medicines specially manufactured for the eastern bazars." Our Association finds it difficult to accept this statement in the absence of accurate and proper evidence. If this had been the real state of affairs any effective control over them would mean the creation of well-equipped laboratories and test houses under the conduct of honest, impartial and competent men who enjoy the confidence of the public in different parts of India as a first and essential requisite. It is doubtful whether the Government would in the present state of financial distress be in a position to find money to give effect to the recommendations, which may be made in this behalf, in the near future. The detection and collection of samples, etc. would require elaborate staff in addition to officers who would have to be employed in analysing and carrying on the standardisation of drugs and medicines in the different laboratories all over India. Whereas, on the one hand, we do not find the picture as gloomy as depicted in your statement quoted above, we do not on the other, see our way to support a scheme of control organised under Government, particularly as their attitude towards Indian manufacturers is not likely to be sympathetic and unbiassed. Further, there are ample reasons to apprehend that a quasi-officia-controlling body created by official legislation should only introduce an engine of oppression in a field in which signs of healthy development are already noticeable. And when the proper time came it may be desirable to appoint a sympathetic and enlightened, competent and interested controlling agency for the purpose of giving guidance and prompting the progress of the young concerns through coordination and co-operation.

As regards the question of enquiry preliminary to control we are of opinion that the whole of the drugs and preparations trade should not be placed on one uniform level—there must be differential treatment for indigenous products including manufacture, from foreign products. The former should be carefully handled, nursed, helped, supported and encouraged in every way. No restricting or cramping or pruning devitalising legislation should be made applicable to them at this stage. Guidance is required and must be provided with sympathy.

As regards foreign products imported into India, an enquiry might be desirable. But, as we have shown, the machinery required for giving effect to the findings and conclusious of the Enquiry would be extremely expensive and if formed under the prevailing circumstances, can hardly be expected to do justice to different parties concerned.

But the Association feels that the pre, sent political situation is not the proper time for introduction of legislation of such great importance. Before any legislative action is introduced, standards for the drugs should be set up and this can be done by the compilation of an Indian Pharmacopoeia by intensive research work. In the compilation of such a pharmacopoeia three categories of drugs will have to be incorporated. (1) Preparations taken from pharmacopoeias of other countries, (2) those indigenous medicines which have been already scientifically studied and standardised and can therefore be forthwith incorporated and (3) those indigenous medicines which have been found efficacious on clinical trial but which requir further investigation. This means that a good deal of research work will have to be

carried out to obtain the necessary knowledge about these preparations and to determine their standards of purity and efficacy. *Pari passu* with research work extensive testing of drugs prepared in or imported into India will have to be done in various testing laboratories in different parts of the country. To establish standards we shall have to study the methods developed by the various League of Nation Committees, American and German pharmacopoeias as also of those in Great Britain. This means that we shall have to devote at least the first ten years of this scheme to study and to research with a view to gaining exact knowledge. When this is obtained we will have to think of legislative control. It will be seen therefore that no legislative control can be conceived for the present. It has been stated by some that India has been made a dumping ground for adulterated and inferior quality foreign medicines, but we have no exact knowledge of the state of affairs prevailing. We do not know what preparations are adulterated and to what extent and what preparations are understrength. Unless and until we have exact scientific information about it legislative control could not be justified. We would like to point out in this connection that in the composition of the Pharmacopoeia Committee there should be included all the available talents and special workers in the country and that it should not be an *ex parte* committee haphazardly made like the present one.

Our Association feels that owing to poverty a very great bulk of the population in the villages and small towns resort to indigenous systems of treatment. Though statistics as to the quantity of the different kinds of drugs manufactured locally and consumed are not available, the figures of the imported drugs and medicines available show that the western system of treatment can be only resorted to by a small proportion of the population only. It follows, therefore, that if any legislation is undertaken for ensuring the purity of drugs, it should not be confined to drugs used by one small section of the population, *viz.*, those resorting to the Allopathic system of treatment only. As to how the drugs, etc., prescribed or manufactured according to the indigenous systems of medicine could be tested, our Association has no suggestions to offer as they have practically no knowledge of these systems of medicines or of their pharmacopoeia.

Our Association is of opinion that the profession of pharmacy should be restricted to qualified persons. In this connection our Association is that there should be provision for the training of pharmaceutical chemists and pharmacologists because without such well-trained personnel, it would not be possible to utilise the enormous raw material that exists in India for the manufacture of drugs which are at present exported abroad and brought back to India in the form of finished products at high cost. Our Association believes that the best method of assuring the purity of drugs, etc., at a cheap cost is by manufacturing them in this country with the help of trained staffs and under adequate supervision. Every possible means should be adopted to develop the pharmaceutical industry in this country, if necessary by bounties or protective tariffs. The various Universities in India may also be requisitioned for helping in the matter of training of pharmacists and pharmacologists. Pending the creation of the training facilities of these pharmacists and pharmacologists every effort should be made to improve the training of the compounder class.

In conclusion our Association would like to point out certain difficulties with regard to the drug trade in India. (1) There is no system of sampling of raw materials of good quality; the result is that the manufacturer does not know how much of finished product of the required potency he would expect from a certain supply of raw materials. It is the duty of the State to develop this line of vast indigenous drug trade; (2) Unnecessary restrictions and tortuous procedures are imposed by the Excise Department in certain provinces regarding the import of alcoholic medicinal preparations from other provinces. For example, the Governments of Bombay and Madras realise duty on all alcoholic medicinal preparations imported into their provinces and have developed intricate procedures in the issue of Import Permits and collection of duty on arrival at destination. It may be pointed out that in the case of alcoholic preparations imported into India from foreign countries, there is no restriction regarding the export from one province to another after the duty has been once paid at the port of landing. In this case alcoholic medicinal preparations manufactured in India have to work at a disadvantage when compared with similar foreign preparations introduced into India. Further, Indian made rectified spirits or absolute alcohol have been prohibited into the Punjab and restricted in C.P., U.P. and Bihar and Orissa. This is a great handicap for the manufacturers.

In this connection our Association would like to point out that a liberal supply of duty free alcohol should be allowed in all *bonafide* research laboratories engaged in medical research, if we conceive that it should be the aim of the Government to help the indigenous drug industry.

Yours faithfully,
(Sd.) K. S. RAY,

An adequate treatment of Syphilis

(BY A SPECIALIST)

An effective treatment, such as demanded by Dr. E. H. Cary and Dr. C.S. O'Brien must be carefully computed, considering the weight of the patient and the time which has elapsed since the infection. In primary cases, a fewer number of courses of treatment are required as compared with cases in which secondary symptoms or a negative Wasserman reaction have time to develope.

Regarding the weight of the patient, this decides the amount of Medicament to be given in one course.

As an arsenical treatment we give the requirements for Sulfarsenol as this is proven the best for the curative as contrasted with palliative treatments. For the Bismuth part of the course we give details as applied to Benzo Bismuth as with soluble preparations only can we exactly compute the amount repuired.

For every pound weight of the patient at least three centigrames of Sulfarsenol should be given in each course. A patient who weighs 100 lbs. requires than 300 centigrammes of Sulfarsenol for a single course. This must be divided up into suitable doses. Thus the 300 centigrammes may be given as one dose of No. 2 (12 ctg) and 16 doses of No. 3 (18 ctg.) giving two injections per week; the course lasts 8½ weeks, but if the first eight injections are given twice a week the remaining injections may be given at weekly intervals if desired, especially where Benzo Bismuth is given along with the Sulfarsenol.

A patient who weighs ten stone would require 420 centigrammes of Sulfarsenol in each course. This may be divided up into two initial doses of No. 3 (18 ctgr. each) and sixteen doses of No. 4 (54 ctg. each). As suggested above, the first eight doses should be given at intervals of 3 to 4 days, and the remainder may be given either at the same intervals or as weekly injections, as best suits the individual patient.

Since now-a-days mostly all strains of Treponema Pallida are more of les-Arsenic-resistant, it is imperative that an effectual bismuth treatment should supplement the arsenical.

If insoluble Bismuth preparations are used, we cannot compute the dose required, because we do not know how much will be absorbed.

If Benzo Bismuth be adopted, the computation of the dose per course is easy. In that case the dose per course is about one centigramme of metal for every three pound in weight of the patient.

Each ampoule of Benzo Bismuth represents 4 centigrammes of Bismuth metal, so that for a patient of about 100 lbs. weight, eight ampoules should be given as a supplement to each course of Sulfarsenol. These injections may be made once a week over eight weeks of the course or over a shorter period once every four or five days.

For a patient of 10 stone (140 lbs.) 12 ampoules may be given during the one course of Sulfarsenol treatment. This may be given as a six weeks treatment of two ampoules per week, or as best suits the needs of the individual patient. If a case comes up for treatment early in the primary stage, two such courses are usually sufficient. If not seen till later on, when a Wassermann reaction may have developed three courses would likely be required, or if secondary symptoms have developed, four such courses. The period between one course and the next should be eight to twelve weeks.

Iodides may be given for a period of from one to three weeks immediately before the second and subsequent courses.

Review

SIMPLE LESSONS IN PRACTICAL HYGIENE IN TAMIL FOR FORMS I, II AND III, BY MR. S. SUBRAMANYAM, ASSISTANT MASTER, HINDU SECONDARY SCHOOL, VIRAVANALLUR.

Mr. M. S. Subramanian has written three books on Practical Hygiene for the used of students reading in I. II and III Forms respectively and they are accepted by the Text Book Committee. They are well written and it is highly creditable for a lay man to write a book on Hygiene in such a way as the author has done and we congratulate him on his success in the production of these useful books. Writing a book is one thing and teaching the subject is another thing. We believe that only medical men can make the subject of Hygiene interesting to the pupils with simple illustrative examples taken from everyday life, easily understandable by and familiar to them and can answer questions which the teaching may provoke the pupils to put, to their entire satisfaction and conviction and then enable them to practise what is taught. Now that medical inspection of schools has been recognised and conducted in some schools, though in a perfunctory manner, the question of appointing medical men as part time teachers to teach Hygiene and Physiology and also to conduct medical inspection must be looked into by the authorities concerned, as it would be in our opinion, an economical, efficient and satisfactory arrangement in the long run.

Continued from page 141

List of posting of Sub-Assistant Surgeons for the month of December, 1930—(Contd.)

Name of Sub-Asst. Surgeon	From	To
25. ,, P. M. Sridharan	Hd. Qrs. Hl. Calicut	c/o, D. M. O. Ganjam.
26. ,, G. Suryanarayana	Hd. Qrs. Hl. Vellore	Hd. Qrs. Hl. Bellary.
27. ,, P. S Somaskandan	Hd. Qrs. Hl. Bellary	c/o, I. G. of Prisons, Ootacamund.
28. ,, S. Ramanathan	District Jail, Cuddalore	Hd. Qrs. Hl. Cuddalore.
29. ,, M. Venkataratnam	King George Hl. Vizagapatam	L. F. Dy. Chodavaram.
30. ,, R M. Patro	L. F. Hl. Chodavaram	Govt. Hl. Bimilipatam.
31 ,, B. Sankara Rao	Hd. Qrs. Hl. Masulipatam	c/o, P. D. B. Kurnool.
32 ,, P. Kunhambu	Hd. Qrs. Trichinopoly	P W. Dy. Thekkadi.
33 ,, M.A. Subramanya Pillai	Hd. Qrs. Hl. Ramnad	L. F. Hl. Sattur.
34 ,, B. Panchapakesam Pillai	leave	c/o, I. G. of Prisons, Ootacamund.
35 ,, Abdur Razzack Sahib	L. F. Dy. Kuppam	Govt. Hl. Tiruppathur.
36 ,, V. Gnanayya	L, F. Dy. Sadam	Govt. Dy. Ponneri.
37 ,, R. Seshagiri Rao	Govt. Dy. Ponneri	c/o, I. G. of Prisons; Ootacamund.
38 ,, D. Rajah	Govt. Ophthalmic Hl. Madras	c/o, P. D. B. Salem.
39 ,, T.S. Ramachandran	Central Jail, Coimbatore	Hd. Qrs. Hl. Madura.
40 ,, B. Appalanarayana	Hd. Qrs. Hl. Chittoor	c/o. P. D. B. Nellore.
41 ,, M. Venkobachar	.....	c/o, Superintending Engineer, Canal circle, Cauvery Metur Project, Tanjore.
42 ,, C.S. Venkataraman	Hd. Qrs. Hl. Ramnad	Govt. Hl. Attur.

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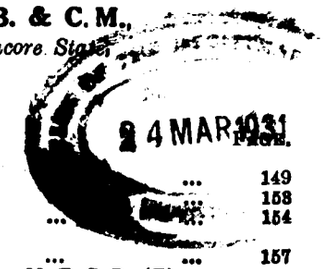
The Medical Practitioner

A Monthly Medical Journal

EDITED BY
Dr. M. S. Krishnamurthi Ayyar, M. B. & C. M.,
Retired Sanitary Commissioner, Travancore State
AND
Dr. V. Rama Kamath,
Member, Madras Medical Council.



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Business Notice.

Scientific articles and notes of interest to the profession are solicited. Contributors of original articles will receive a copy of the journal in which they are published.

Communications on all matters connected with the journal, literary and business should be addressed to the Managing Editor, 147, Purasawalkam High Road, Vepery, Madras, as he alone is responsible for the conduct of the journal. Annual subscription to the journal is Rs. 1-8-0 including postage, payable in advance. Papers and articles forwarded for publication should be either typed or written legibly on only one side of the paper. They are understood to be offered to "The Medical Practitioner" alone and any breach of this rule will be followed by non-publication. When any such of the article appears in "The Medical Practitioner" the copyright automatically becomes the joint property of the author or authors and of the publishers. Papers and articles sent will be sent back to the contributors, if so desired, and postage sent for the purpose. The Editors of "The Medical Practitioner" cannot advise correspondents with regard to prescriptions, diagnosis, etc., nor can they recommend individual practitioner by name as such action would constitute a breach of professional etiquette.

that the disease is at its maximum during the South West monsoon in some parts of India and during the same period at its minimum in Lower Bengal. But humidity has been almost a sure and determining factor for the prevalence of the disease in in all endemic areas. It is agreed by all experts as is evidenced by the prevalence of cholera in endemic areas that a humidity of over 0'400 always ushers the outbreak of this disease. In the endemic areas mentioned above the humidity has been over 0'400 almost throughout the year.

Etiology of cholera seems to be to-day as vague as it is indefinite inspite of the fact that Koch discovered the Comma Bacillus in the faeces of patients suffering from cholera first in Egypt in 1883 and later in 1884 in Calcutta. His observations have since been amply proved by other eminent bacteriologists. Yet one reads in literature even this day that several instances have been recorded by bacteriologists of no mean order that "while ingestion of the bacillus is necessary to the production of cholera, it appears to be certain that this is not the only condition; possibly the state of health of the individual, or the degree of acidity of the gastric juice renders some persons susceptible and others immune to the infection." The profession knows that "cultures of cholera vibrios have been swolled-many times by way of experiment and although in some instances diarrhoea has resulted, in only one case has true cholera been produced; further, a few cases have been described which from a clinical point of view, appear to be cholera, but in which the Coma Bacillus has not been discovered after a most careful bacteriological examination. Probably for the production of cholera several conditions are necessary of which the Comma Bacillus is only one."

We wish our readers to note also that the cholera vibrios thrive on alkaline medium whether it be outside or inside animal bodies. Experiments both bateriological and other have proved the above observations. It has been found that the infection in Ganges water dies rapidly at times when the re-action of the water is either acid or highly alkaline. Though it has been found very difficult to produce cholera in lower animals by the administration of cholera cultures, recently cholera-like symptoms have been seen in ground squirrels by administering cultures in alkaline medium. This phenomenon explains the rationale of giving acid drinks to cholera patients and is worth remembering.

Cholera Vibrios are found in two distinct types, the agglutinating, and the non-agglutinating. The former are usually seen in the evacuations of patients suffering from cholera and the latter are seen in the faeces of persons who are, to all intents and purposes quite hale and healthy and also in individuals who had an attack of cholera. The non-agglutinating vibrios are usually seen in filthy water of wells, tanks, and rivers in an endemic area, and the bacteriologists also say that agglutinating vibrios from the faeces of cholera patients assume the non-agglutinating phase after they come in contact with the water. It is quite possible that a sudden outbreak of cholera during religious fairs, and festivals in places where such places were quite free from cholera epidemic, is due to the fact that a large number of pilgrims might be cholera-carriers who had in their intestines non-agglutinating cholera vibrios which change into the active agglutinating bodies due to insanitary surroundings, and unwholesome food and other conditions prevailing at the places of pilgrimage.

What little we said about the Aetiology, Epidemiology, Endemiology and other various factors regarding cholera would help us in dealing with the treatment of cholera both preventive as well as curative. The average case mortality in cholera amounts to 50 per cent. as is reported in literature. At least a few cases in 50 per cent. will be due to fear and panic, and a large number due to want of care and attention in the early stages of the disease, during the stage of evacuation. It is at this stage, all that a practitioner can do, has to be done to save his patients. The patients are usually very indiscrete, the fear that death is more certain than recovery obsess them. The idea that each fit of vomitting makes them weaker forces them to drink large quantities of liquids such as milk congies, water, etc., only to be vomited again or purged out. The first indication at this stage is to avoid all food in any form and lessen the chances of vomitting and purging, and to keep the patient warm underneath blankets. The practitioner has to be stern in his directions and should create an atmosphere of optimism. Complete starvation till at least vomitting disappears or checked considerably is to be enjoined. It is not to be forgotten that each fit of convulsive vomitting brings the patient nearer collapse. If there is a history of the ingestion of bad or indigestible food, there should be no doubt whatever that this foreign material should be got rid off and we know no drug which is most suited for this purpose than calomel in fractional doses of not more than $\frac{1}{4}$ gr. even less—repeated every quarter or half an hour till about 3 or 4 grs. are sent in. We all know that fractional doses of this good old drug controls vomitting of whatever origin. When the attack is sudden in its onset, as is usual, the question arises, "Shall we resort to opium by the mouth?' Our answer—after having carefully considered the statements of a large number of authors, is "No". But we cannot think of any other drug except morphia of which 1/4 gr. with 1/120 gr. of atropine has wonderful effects in relieving cramps and lessen the shock in very early stages. Camphor, has been considered universally from time immemorial as a most useful drug in the treatment of cholera by all systems of medicine, Allopathic, Homeopathic, Ayurvedic and Unani. It checks diarrhoea, and relieves pains and cramps from the beginning to the end of the attack. Whether camphor exercises any germicidal effect we do not know, but we are quite certain that all volatile oils possess distinct antiseptic powers. Apart from this, camphor is useful as a general systemic stimulant and has been proved by wide clinical observations that it has extraordinary power in the control of all forms of serious diarrhoea. Camphor stimulates also torpid kidney and thus prevents anuria. We would strongly recommend the use of camphor wine as advocated by Hare in his book on Practical Therapeutics, which preparation is so simple as it is rational. Wines are distinctly contributory to the growth of cholera vibrios probably because of the presence of tannic or other acids. 75 grains of finely powdered camphor is dissolved in a couple of ounces of alcohol. 2 or 3 drachm of gum arabic is rubbed with a little wine. The solution of camphor in alcohol is mixed with it and more wine is added to make up a quart. The dose of this mixture is a teaspoonful in peppermint tea, every hour to a child of six years, for an older child a dessert spoonful and for an adult, a wine glassful. Hare says: "Those who first used this mixture were wiser than they thought....." The other remedy which is based on "very rational grounds" and yet usually not thought of by the profession is salol. Hare writes in his book that Lowenthol conducted investigations by adding 10 Gm. of salol to 50 Gm. alkaline solution of pancreatic juice and to this mixture 3 Cc. of a virulent bouillon culture of the bacillus (cholera). Examinations in forty-eight hours to a week showed this to be absolutely sterile. There is also clinical evidence that salol prevents anuria.

It is not always that a practitioner is called in to treat cholera in the early stages. Very often the doctor has to step in to see the patient in extreme exhaustion if not in collapse. It is at this stage when everybody including the doctor are in an enervating atmosphere, that the doctor is on his trial. Instead of getting furried, the practitioner should maintain a calm, considerate and judicious temperament. The state of the patient in the 2nd stage depends entirely on the treatment adopted at the initial stage. If the patient is well looked after on rational lines, the 2nd stage is one of rapid convalescence. If on the other hand the patient does not recieve the amount of care and attention proportionate to the advent of symptoms at the early stage, he gets into the—algid condition—which may terminate in death convalescence or febrile re-action.

In addition to the treatment already given in the 1st stage, we have measures which must be resorted to for the relief of dominant symptoms which manifest themselves as the disease progresses. Even here camphor is the sheet anchor. Camphor in ether hypodermically combined with small (5 mins. of 1 in 1000 Sol.) doses of Adrenalin at 2 hours or longer intervals depending upon severity of symptoms has marvellous effects on the heart and vasomotor system. If one resorts to these two drugs earlier in the way indicated, it is very likely that the patient will not reach the algid state. There is ample clinical evidence that pitutrin is useful to combat collapse and if administered early during an attack, prevents anuria also. Other methods to prevent death from cold and of internal congestion of thickened blood, the circulation of which the heart and vasomotor system are unable to control, are the employment of heat by means of hot water baths, hot water beds, hot water bottles,

the most practical and easily obtainable material for this purpose are heated bricks which can be kept as if in a kiln in rows of two or three to a height of one to one and a half feet round the edge of the bed, preferably on the floor—the bricks and the patient being covered with thick blankets or mats. Next to heat there is the necessity of supplying the body the lost fluid on account of which the heart is not able to propel the thickened blood. This is done mechanically by transfusing into the system through the subcutaneous tissues 2 to 4 pints of normal saline, which has much better and more sustaining effect in combination with the measures already suggested, and is certainly safer than the intravenous injections of normal or hypertonic solutions of Roger which if not given with the precautions advocated by the author, leads to disastrous after effects such as hyperpyrexia, oedema of lungs and at times even general dropsy. Both these methods have their own advocates and have to be resorted towith all due care mentioned in text books. Italian Doctors rely on enteroclysis, *i.e.*, bowel-washing with a solution of common salt a drachm to a pint of warm water or much better still a solution of tannic acid 1 to 8 drachms to a pint. They claim that this process helps not only the washing away of the toxines, but supplies also liquid to the system.

Suppression of urine and other symptoms in the progress of the disease have to be treated on general principles. So also, the symptoms attendant with the febrile re-action which at times brings a patient to a typhoid state.

In the matter of nursing there is nothing special or more than what one usually does for patients suffering from typhoid fever. The evacuations should be disinfected with strong lotions, such as hycolor cresol in 2½ per cent solutions. Soiled linen, utensils and everything else used for the patient should receive careful attention regarding their disinfection,in the interest of the public. It is a very fortunate circumstance that the cholera vibrios die a natural death within a few hours if dried. The best, most efficient, and practical disinfecting agent is the sun, whose rays should be allowed inside the infected rooms from the ceiling by taking away the tiles.

Quarantine and inoculation are the preventive methods largely used by Public Health Departments. We shall quote the opinion expressed in Mansons's book about quarantine: "Theoretically, quarantine should be an efficient protection against the introduction of cholera into a community; practically, it has proved a failure. Unless they are stringent and thoroughly carried out, quarantine regulations can be of little use. Even if the utmost care, intelligence, and honesty succeed in excluding individuals actually suffering from cholera, or likely within a reasonable time to suffer from cholera, there is yet no guarantee that the germ of the disease may not be introduced." The best quarantine is the patient's house itself-if it is not over-crowded-under the care and observation of a practitioner. The immunity produced by inoculation does not seem to last more than 4 to 6 months and in a country like India which is the birth place of cholera and where one has to combat an outbreak almost every year, the application of this method as a prevention is as costly as it is impracticable, and the results noted cannot be satisfactory. These inoculations are done sometime after the outbreak of cholera and it is a known fact, that the virulency of cholera infection fades away as quickly as the outbreak spreads. Under the circumstances the success of the result of inoculation is likely to be faulty. The samething may be said about bili-vaccine. Sanitation and personal hygiene have to be depended upon with greater certainty than all other prophylactic measures yet to be found out.

Bacteriophage seems to have a brighter future for the prevention of cholera. D'Herelle the famous French Bacteriologist who has been able to produce bacteriophages for the successful treatment of dysenteries and other intestinal infections such as by the coli bacills, etc., and which are now in the market for sale, avers that patients in whose stools there is no bacteriophage die of cholera and those in whom the bactriophage is strong from the outset rapidly recover. This substance has also been found in well-water. But he has not been as yet able to produce this stuff safe enough to be introduced for use as a prevention for cholera. Nearer in India, at the instance of the Government of Bihar and Orissa experiments are being conducted regarding cholera bacteriophage and the result is awaited with much interest.

Though so much has been said about the causation, propagation, treatment, and prophylaxis of cholera, there seems to be nothing definite about this horrible disease. The more so, there is a grave responsibility on the shoulders of the members of the profession especially those belonging to the independent section of it, who to-day exist in much larger numbers than the small section under Government service. It is true that the Government has not recognised their existence, nor will they do so for the mere asking. All the same, we cannot afford to remain quiet when our brothers and sisters are being carried away in large numbers every year by such preventible diseases like cholera, but should organise ourselves not only to treat and cure diseases, but also to prevent them, and in case we do it, the mortality of cholera can certainly be brought down from 50 per cent. to a much lower figure, if we cannot eradicate the disease altogether.

THE PROVINCIAL HEALTH CONFERENCE

It is not known whether the Provincial Health Offiers' Conference used to be held annually at the office of the Director of Public Health is abandoned and in its place the Provincial Health Conference is held under the auspices of the Health Propaganda Board. The Health Officers are either Government or Local Fund servants and it is necessary for them to meet once in a year to exchange their views and discuss about scientific and administrative aspects of their duty. It is desirable that such discussions should be restricted to the members of the department only like the conference of the Collectors and not open to the public. If the combined conference is to be held in addition to the official conference, the officers of the same health department will have to come to Madras twice in a year, once for the official conference and again for the combined conference, and whether such double journey and absence from their duties are necessary and would not interfere with their duties will have to be considered. This year is noted for the amalgamation of the health organisations and their joint activities. The Provincial Health Officers' Conference was held under the Health Propaganda Board and the Annual Health Baby Week Exhibition organised under the joint auspices of the Madras Corporation and the National Health Association of South India was held in conjunction with the Educational Department exhibitions. The former was opened by the Minister of Public Health and the latter by His Excellency the Governor of Madras. Lectures on various subjects connected with the public health were delivered. Exhibitions, Demonstrations and Baby Show were held and these continued for a few days and brought to a conclusion by a tea-party given by the Sheriff of Madras. The combinations were effected evidently as the anniversaries of the associations separately had not been found to be as successful as one would expect and it remains to be seen how far the combinations will be successful in their activities. We would suggest a combination of all the four associations or societies, as we think that the Public Health and Education are closely connected with each other. Whatever may be the result of such combinations the expenditure on the combined anniversaries,—these functions are nothing but anniversaries—will be much less than that spent by each, if the results of the activities of the associations are to be gaged by improvement of the health of the public and not by the number of lectures delivered, number of exihibitions shown and number of persons assembled, etc., it is as stated by Dr. Lakshmanaswami Mudaliar to be very little. The general maternal and infantile mortalities do not show any appreciable reduction not unaccountable by the usual annual variations. On the other hand the small decrease in the number of deaths of infants is counterbalanced by a large number of deaths of children above one year. It is not satisfactory as this involves the waste of money and energy spent in bringing the children to die before they attain their effective age. The lower death rate of infants, children and young mothers will eventually bring past the reproductive age many weaklings who would otherwise have to be left with no offsprings. It does not mean that weaklings and immature infants should be neglected and left to their own fates but along with the care bestowed on them, steps will have to be taken to prevent bringing forth of such infants as stated by Sir George Newman by "advising the people of the poorest classes to have very

small families." No such suggestion which was considered very essential for the welfare of the people both by Col. Russell, the late Dierector of Public Health, Madras and Major-General Megaw, Director of Indian Medical Service in his book on " Tropical Diseases," was brought forward either by any ef the speakers or by the Surgeon-General or Director of Public Health who participated in these activities.

Surgeon General Sprawson and Mr. Raghavachari suggested the teaching of Hygiene in all schools and the latter pointed out the inadequacy of medical inspection as now conducted in schools.

In the Annual Conference of the Far Eastern Tropical Medicine held at Singapore the President Hon'ble Dr. A. L. Hoops said as follows; " Further having once raised the really and properly educational body of medical men in a country the next essential step is the diffusion of knowledge concerning the origin, mode of prevention and spread of diseases to the population at large. The adult as a rule is too case hardened to benefit; but the school boy is still impressionable. Hygiene should be a subject in every school and should be so taught that the subject becomes interesting and is liked." As the lectures and demonstrations given in the Annual Conferences are only attended by adults, who for reasons given by Hon'ble Dr. Hoops are very little benefitted and as the development in them of *sanitary conscience* is extremely doubtful, the best thing would be to make the subject of Hygiene and Physiology compulsory in all schools and medical men appointed as teachers as their teaching only will make the subject interesting to and liked by the pupils. If for teaching mathematics and science, etc., the teachers qualified in those subjects arelrequired and appointed why not for teaching Hygiene and Physiology teachers qualified in these subjects (medical men) should not be appointed. Besides teaching these subjects the medical men can take up the duty of medical inspection of schools to which they are attached and thus the inspection can then be done leisurely and sytematically. These medical teachers need not be full time officers but they can be allowed private practice. As the Government have recognised the overcrowding of doctors in towns and their unemployment, their appointment as teachers in schools will make them to go and settle in villages and solve the unemployment question to a large extent and they will also in a way supplement the Rural Medical Relief Scheme. Instead of, or in addition to compelling the cinema companies to arrange for free shows on health subjects as a condition for license as suggested by the Chief Minister, the recognition of schools may be made to depend upon managers of schools appointing only medical men as teachers for teaching Hygiene and Physiology and for conducting medical inspection.

THE PROVINCIAL RURAL MEDICAL ASSOCIATION

The third Conference of the above Association was held in Madras on the last day of last year and we are glad to see that it has attracted the attention of the lay journals in the city such as "The Hindu", "The Madras Mail" and "The Federated India," etc. We think that "The Madras Mail" with the knowledge and experience of the system of medical relief obtaining in Great Britain where Medicine and Medical relief are advanced much, has correctly understood the views of the President of the Conference set forth in his Address and in approving of it has expressed "That the ideal of the President will be seem to many to be high". As it is evidently too high for "The Federated India" to comprehend it, it has in its issue of the 7th January took exception to the scheme of the President. The objections advanced by it may be conveniently brought under the three following heads: (1) The dispensaries for the treatment of out-patients should be increased and the ideal of encouraging independent medical men to become family physicians is only a dream under the existing economic conditions in India, (2) The displacement of paid medical officers by honoraries is objectionable as otherwise doctors like Col. Hingstone, Col. Bradfield, Col. Malcomson, Col. Skinner and Guruswami would not be produced and if doctors like them were appointed as honoraries their services could not be fully utilised in the hospitals as they would be called out to treat patients outside and (3) Medical Officers employed in Special Institutions like the King Institute should be allowed to practise as otherwise their *skilled knowledge* would not be available for the public. We would not have wasted our time and paper in discussing these objections which show beyond doubt the limited knowledge of the correct system of medical relief and the narrowness of vision regarding it betrayed by the journal, had it not been for the fact that we thought it would be better to take this opportunity of giving details of the scheme more than what it is possible to give in an address. Before dealing with the objections which seem to have been raised more in the interests of servicemen than those of medical relief and independent practitioners, it must be stated as a general axiom that the care of souls "Religion" and the care of diseases "Medicine" must be purely private concerns and not those of the State. The duty of the State should be confined in seeing that proper facilities are afforded without bringing into conflict with one another the practitioners of the several systems and assist them during the transitional stage as far as possible. Further as there are numerous religious faiths and systems of medicine in India, it is not justifiable to spend money out of public funds on any one system; nor is it practicable to meet adequately the medical needs of the population of the province as the cost of providing, and maintaining free dispensaries and hospitals etc., by the State would come to several crores of rupees annually. Family physicians are not unfamiliar to India and it was only after the opening of dispensaries and hospitals etc., by the State, family physicians disappeared. Further it was never intended that the scheme set forth by the President should be given effect to all at once. It would take at least 25 years if the scheme is worked on the lines suggested by him to provide each village with a qualified doctor. With the advent of the Federated India as a result of the Round Table Conference, the economic condition of the people of India will certainly be changed for the better. Thus the scheme will be only a dream to the unthinking with a narrow vision of the future as it is neither foreign to India nor absent in other countries. It is nowhere stated in the address that all the dispensaries should be closed at once; but it was suggested that in those places where the rural medical relief scheme was or is in operation, the State dispensaries should be closed. To open more dispensaries out of public funds and at the same time extend the rural medical relief scheme is an impossibility and it goes against the object of the organisation of the Rural Medical Relief Scheme. As regards objection No. 2 the doctors mentioned in the journal are no doubt capable officers in service in Madras but the makers of the Modern Medicine of whom India, much less Madras, has contributed few or none are mostly honoraries attached to hospitals in Europe and America, etc. It is feared that if honorary doctors are appointed in charge of State hospitals, they would spend little of their time in hospitals and would resort to private practice. At present even the highly paid medical officers not only resort to private practice but open or attach themselves to Chemist's shop and Nursing Homes, etc., and between the honorary men resorting to private practice and paid men doing so, the former should be preferred to the latter. In respect of the 3rd objection that the *skilled knowledge* obtained b the medical officers employed in special institutions such as the King Institute would not be available for the public, the skilled knowledge acquired there, is with reference to experiments on animals. In no country of the world doctors paid and solely employed in such special institutions are permitted to practice medicine. If the pay given to them is inadequate let them by all means by given higher pay in compensation for private practice but never should they be allowed to practise their *skilled knowledge* on human beings. It is only in hospitals where patients are under constant supervision and observance that vaccines, etc., manufactured in these iustitutions should be tried with all precautions, before private patients who are seen only occasionally by doctors can be treated with them. To allow doctors employed in these institutions to treat private patients straightaway will be a source of danger to the public and must be prohibited completely. "The Madras Mail" in its editorial "says that if it really be the purpose of the Government to induce an increasing number of qualified medical men to settle in rural areas Dr. Krishnamurthy's method would go far to secure the fulfilment of that purpose." According to the G. O. inaugurating the Rural Medical Relief Scheme the object is to induce a large number of medical men to settle in villages, but the action so far taken has gone against the object of the scheme. We could recommend to the Minister of

the mouth in 1/20th to 1/10th grain doses. It is found useful in children who are deliquent and do not show distinct indications of other glandular insufficiency and in children upto 12 or 15 years of age with low mentality and evidence of retarded bodily development.

CRIME AND INSANITY IN INDIA*

By Captain G.R. Parasuram, B.A., M.R.C. P. (E)., Dipl. Psych., Member, Royal Medico-Psychological Association, Deputy Superintendent, Govt. Mental Hospital, Madras.

Medical men are often called upon to give evidence to help the presiding judge in finding out the mental condition of an individual who has been charged with the commission of a crime, at the time of committing the crime. They are also expected to give an opinion as to whether by reason of insanity the accused was not capable of knowing the nature and consequences of his act or whether he did not know that what he was doing was either wrong or contrary to law. The question frequently is one of life and death so far as the accused is concerned and therefore it is very necessary that Medical men should understand the inner working of a criminal's mind before they could venture an opinion regarding his mental condition. At best we depend for our guidance on books written by learned authors who based their conclusions on conditions prevailing in their own countries and who are not expected to know the conditions of life here. I feel the time has come when we should start getting first-hand information regarding the criminals from our own observations and by a study of the conditions of life prevailing here. I am afraid very little work has been done in this field in India and it is time that we compare our results with those obtained in the West. It is only with this object that I venture to submit this paper so that it may stimulate others also to work on these lines.

This paper is a study of 175 criminal patients in the Madras Mental Hospital including 6 juveniles. Of these, 156 are males and 19 are females.

Under conditions prevailing here in India, it is very difficult to get a decent history in all cases of mental disorder. The patients often do not help, nor could their statement be taken for what it is. The relatives, either through ignorance or disinclination or false pride are unwilling to help and it is no wonder that in the medical history Sheet supplied by the Police all the columns are marked " unknown " including even the names of patients in some cases. In criminal cases, the committing magistrates often do not even send a copy of the judgment.

In spite of these difficulties, I have tried to give as much information as possible.

Incidence of insanity amongst Criminals

Of the 175 cases, 36 were acquitted on account of insanity at the time of crime and were sent here ; 89 were undertrials ; and the remaining 50 were undergoing imprisonment in jail when they were transferred here for their mental condition. The daily average of the criminal population in the various jails of the Madras Presidency in 1929 was about 15,000. This gives a proportion of 89 plus 50 that is 139 to 15,000 or 0·81 per cent. (all criminal insanes in the Madras Presidency are admitted only to this Hospital).

Age Incidence

The age incidence is rather interesting. The youngest murderer at the time of his committing the crime was a boy of 7 to 8 years and the oldest man of about 60 years. It will beseen that amongst males there is a gradual increase in crime which reaches the maximum between 26 and 30 years of age and then gradually subsides, the largest number of crimes being between the age of 21 to 40, just the age when the brunt of life is at its height. Amongst women the maximum is reached between the age 16 to 20, for the reason that in India amongst the lower class that is the beginning of the child-bearing age when there is a great deal of strain on the woman. This is more or less in accordance with the Madras Jail

* Paper read on 5—1—31 at the Indian Science Congress, Nagpur and contributed to " The Medical Practitioner "

figures which show that the age incidence reaches its maximum about these ages in sane criminals.

Districts of Criminal Insanes.

It will be noted that Malabar, Coimbatore, Tinnevelly, South Kanara and Vizag agency contribute the gratest number of criminal insanes. Why should these districts alone contribute the greatest number of criminals ? Is it that there is something in their environment which predisposes them to criminality ? The Malabar Moplah, the Coimbatore Gownden, the Agency hillman are all types by themselves. They are all strong, sturdy and daring people and the use of the knife is like play to them. And the Moplah as far as his religion is concerned is a fanatic.

Occupation

Practically all the patients excepting a few are tillers of soil and hewers of wood, They are illiterate, with no chance to be civilized and no social status, leading a hand to mouth existence. It is no wonder then that in their struggle for existence their instincts get the upper hand. Cultivators andcoolies predominate ; unemployed form a good few ; petty traders some ; 5 from the police ; toddy tappers 6; and all the professions involving manual labour are represented.

Heredity

Heredity plays an important factor in the history of these criminal insanes. In 36 males and 6 females a definite family history of insanity could be got. In the remaining cases it is not that the family history is clean, but that in the majority of them the family history is stated to be not known. I am sure that with a complete history, which is unfortunately lacking at least in 50 per cent. of these people, hereditary taint could be got, as could be gleaned from a complete study of the case records.

Previous History

Out of the 125 cases who were found to be insane at the time of crime, in 73 males and 6 females there was a definite history of the person being insane sometime before the crime ; in some cases, it was months and years before ; in some a few days before and in others the insanity continued right up to the time of crime and even after. It is unfortunate that a good history is lacking in many of these cases, but from a careful perusal of the judgment and other records it is possible to presume that in at least 80 per cent. of these cases the crime was directly the result of insanity.

The General Health at the time of crime was fair in 100 cases and indifferent or poor in 75.

Present Mental Condition

There are 36 cases who have recovered pending disposal, 36 are permanent dements, and the rest are still suffering from their ailments. One inference which could be drawn from the preponderance of the continuity of insanity in most of these cases from the time of trial, is that possibly they were either actually insane at the time of crime or that they were bordering on it.

Ganja

In 4 cases of murder, 1 of arson and 1 of theft, the patients were definitely known to be addicted to ganja-smoking. In these cases ganja habit appears to be more a symptom than a cause of insanity used as a means to drown the patient's miseries ; a solution to his insoluble complexes. At the same time a vicious circle was formed, the disease leading on to ganja habit—the ganja occasionally giving rise to an acute confusion when the patient did not know what he was doing and so resulting in crime. Ganja here is only a contributing factor.

Alcohol

Alcohol plays a very minor role in the causation of insanity and consequent crime in this country. These people are poor and cannot afford the luxury of intoxicating beverages. Amongst these 175 cases, there have not been more than 6 in whom a history of alcohol could be got. The common drink being toddy in this Province, one has to consume a good quantity before one can get intoxicated, and even in such cases toddy drinking is a very secondary factor as they all show other causes for their mental condition.

Syphilis

8 cases showed a syphilitic taint. 2 were G. P. I. and 1 Cerebral Syphilis and in the rest Syphilis was only an additional factor in the causation of insanity.

Nature of Crimes

As many as 101 cases out of 175 are murder cases. In a good few of these cases there has been either a murder

of more than one person or an attempt to murder one or more persons, or an attempt to commit suicide or causing grievous hurt. In almost all these cases there was little or no pre-meditation, the motive was slight, there were no accomplices, there was no attempt to hide and there was more violence used than was necessary to kill the victim. There have been a few double and triple murders. It is very characteristic to note that in as many as 57 cases out of 90 among males and 10 out of 11 amongst females the murdered person was a close relative of the patient.

Murder of wife, children or parents seems to be the commonest among males, and amongst females murder of their own children. Besides murder, there have been 6 cases of attempted murder and 11 cases of hurt among men. It is only accidental that in these cases the victims were not actually killed.

Theft is the next commonest crime. This had often been done clumsily, in broad day-light, without premeditation or attempt at concealment; they were petty thefts too.

There are 9 cases of *Arson* and the rest are minor crimes.

Mental Diseases among Criminals

DEMENTIA PRAECOX is the predominant disease (75 males and 5 females). In about 15 cases Dementia Praecox is super-imposed on a previous mental defect (high grade). In the majority of these cases of D. P. there is a certain amount of irresponsibility. They know their crime but there is a don't care attitude about it. Some of them though dements now, have a good memory for their crime and there is a complete lack of emotional reaction in them. They give varying reasons for their crimes but when confronted with a straight question they either evade or just give some answer for the moment which has no meaning. They are neither pleased nor sorry for what they did.

A few of them have no knowledge of the crimes committed and their cases records as well as their conditions before and after the criminal act show a definite super-imposed confusional state.

Some of these cases show definite delusions, but there are no true cases of Paranoia. The delusions are neither fixed nor systematised but they seem to have played an important factor in determining their crimes. All these are cases of Dementia Paranoides.

Maniac Depressive Insanity

It is rather surprising at first sight to find that these cases lead on to crimes especially murder. But in some cases the confusional state on the top of this seems to be the determining factor. In a few an underlying mental defect led to the irresponsible act. In a few other cases insanity developed after the crime.

These cases are emotionally unstable, easily upset on the slightest provocation and explain away their crime by the excuse that there was provocation (not sufficient for an ordinary individual). In some definite delusions led to the crime. In a few cases, pure mischief was the motive for the minor crimes.

Epilepsy

There are 13 cases of Epilepsy. Of these, 8 were responsible for murder and the others for minor offences. 6 are still suffering from fits and are more or less dements. In a few there is a history of Epilepsy but they have had no fits since admission into hospital. There are two cases of Epileptic Equivalents. In all these cases the history and the character of the patient, their amnesia for the crime, the circumstances of the crime and their present condition, all point to their being epileptics. One of these was a case of Epileptic Equivalent in a man of 42, who murdered his own wife whom he loved, and attempted to murder his aged father and some others. There was a history of his having suffered from attacks of giddiness and having been queer for a few days after the attacks, when he was sleepless and used to wander about. He has complete loss of memory for all the events of his crime. There was neither motive nor attempt at hiding and he had no accomplices. He had practically butchered his wife and would have killed his father and others too if he had not been prevented. Throughout there was no attempt at malingering. He had no fits since admission and is practically normal now. Though he was convicted in the lower court, he has been acquitted on appeal.

Mental Deficiency

There are 12 of these exclusive of those who had a trace of this defect in association with some other disease. In almost all these cases the patients were known to be of unsound mind before the crime and there is a family history behind. Irresponsibility seems to be the characteristic feature and the crime according to them is only a trivial incident. All of them remember their crimes.

Senile and Presenile Psychoses

There are 9 cases of this type, all in men, of which 6 are of murder. All of them are above 45, some of them though not old, look prematurely old. The majority of them have a poor memory and cannot give a proper account of themselves, and are more or less dements.

Confusional States

There are 8 cases of Confusion, all ending in murder, 4 of these are women who committed the crime during the puerperium or soon after. In all these cases delusions and hallucinations played an important factor.

These are exclusive of the cases where Confusion was superimposed on a pre-existing disease.

Neuroses

There are 2 cases both of Anxiety Hysteria. In one of them Hysteria has been the direct outcome of murder and jail life. In his ordinary moments he shows the hysterical character.

Organic Diseases

Organic diseases amongst these patients bear either a direct or an indirect influence on their mental condition leading to crime. Encephalitis, Beri-Beri, Relapsing Fever, Pituitary Diseases, Tubercle, Dysentery, Heart Disease, Fistula in Ano, Middle Ear Diseases, Cataract both eyes and various other conditions are found in these patients.

In women, Pregnancy or Child-birth is the starting point of the disease which led to the crime.

There are 15 cases where crime was definitely not due to insanity but insanity developed as a direct sequence of the crime and its aftermath. In all these cases the previous history and the family history are clean. Only in 4 cases could an unstable mental equilibrium be traced and the crime, punishment and jail life hastened the onset of insanity.

There are one or two definite instances where the shock of crime has led to the recovery of the patient's mental condition.

No Appreciable Disease

There are 6 cases—5 males and 1 female—where the case records show a crime committed by a normal person. There is neither previous history nor hereditary taint. The conduct of the individual before and after the crime is that of a normal person. No definite symptoms of insanity could be made out either in their jail or hospital life. Some of these are habitual criminals and very intractable to discipline. Their symptoms are more objective. It looks as though the jail seemed to be tired of them. But I would not call them malingerers nor would I call them mental defectives. They are all of unstable mental equilibrium and I would classify them as border line cases.

The Role of Delusions and Hallucinations

There are 28 cases of murder which show definite hallucinations and delusions which influenced their murder. Probably with a clearer history we may be able to trace more crimes to delusions. In some there was a divine command to kill which could not be resisted; 2 performed human sacrifice; a few killed to obtain salvation for themselves or their victims; some killed those who were doing sorcery on them; a few saw murders being committed and came to the rescue of the victim; some of them killed giants, wild-animals, etc., while the others killed their enemies because they could not suffer persecution at their hands any more.

In conclusion, I have to express my deep sense of indebtedness to Dr. Hensman, the Superintendent of this Hospital, for the very valuable help and advice he gave me throughout the preparation of this paper. I have also to thank my colleagues in the Mental Hospital for their valuable assistance.

ON THE NECESSITY FOR A PUBLIC HEALTH ACT FOR THE MADRAS PRESIDENCY*

BY

DR. A. TIRUMALIHA, M.B.,

L.R.C.P., L.R.C.S., D.P.H. (CAMB.)

Professor of Hygiene, Medical College, Madras.

The success of any effort for the protection of the Public Health of any community depends on a number of factors, the most important of which being the existence of adequate sanitary legislation. It has been said that sanitary instruction is even more important than sanitary legislation, but it is equally certain, nevertheless, that Public Health must have, as an essential foundation, practical laws which can be invoked when necessity arises. Unfortunately, education and moral persuasion will not always bring about the desired results, unless it is realized that behind them is the long arm of the law. The famous doctrine "speak softly, but carry a big stick" is particularly applicable to Public Health work.

If we trace the evolution of Public Health legislation in the more progressive countries, we find that it runs parallel with the evolution of Public Health itself. About a hundred years back, when all disease was supposed to be caused by filth, Health legislation was merely confined to the control of nuisances and the Health official was not much more than a Police man. The next stage of advance was made when Pasteur established the Science of Bacteriology and its close connection with the Science of Preventive Medicine. Now, Sanitarians began to control the environment and regulate the movements of individuals when they affected the Public Health. Health legislation then assumed a wider scope. The present era envisages Public Health more as a promotion of positive Health than mere suppression of disease. Thus, in addition to control of the individuals and environment, Health education as regards personal Hygiene and the rules of right living have rightly occupied the foremost place in Public Health administration. When the sanitary millenium does arrive, then perhaps there may be no need for Health legislation, but until then adequate legislation is indispensable for adequately safeguarding the Public Health. The right to the enjoyment of sound health is a sub-division of the right of personal security one of the absolute rights of persons and it is a recognized principle that among all the objects sought to be secured by Governmental Laws, none is more important than the legislation intended for the preservation of Public Health.

Now, coming to the conditions in our own Presidency, we will just examine the existing legislation affecting Public Health. At the outset, it must be stated that it is not the want of law that we are suffering from, but more the want of co-ordination between the various public health enactments that lie scattered about in a number of widely different sources. The remedy that is suggested is not for introducing anything new or drastic by way of legislation, but is merely for codifying all the public health provisions that are found in the various Acts and rules now in force, with some alterations that are found necessary as a result of the difficulties that have been so far encountered in the actual working of these provisions.

To mention the different sources in which rules affecting the Public Health are scattered about:—

1. The Madras City Municipal Act.
2. ,, District ,,
3. ,, Local Boards Act.
4. The Village Panchayat Act.
5. Town Nuisances Act.
6. Town-Planning Act.
7. Prevention of Adulteration of Foods Act.
8. Port and Marine Regulations.
9. Indian Factory Act.
10. Indian Leper Act.
11. Indian Mines Act.
12. Public Resorts Act.
13. Indian Railway Act.
14. Epidemic Diseases Act.
15. Plague Regulations in Madras City.
16. Plague Regulations in the Presidency outside the City of Madras.
17. Act III of 1899 for Registration of Vital Statistics in rural areas.
18. Criminal Procedure Code.
19. Indian Penal Code.
20. Canal and Public Ferries Act.
21. Hindu Religious Endowments Act.
22. The Police Act, etc.

* Paper read on 15-1-31 at the First Provincial Health Conference, Madras and contributed to "The Medical Practitioner"

Besides these there are also rules and regulations framed under many of these Acts which have statutory force, *e. g.*, the cholera rules, vaccination rules, etc. The number is still further increased by numerous departmental orders and codes, which have an important bearing on the actual administration of Public Health, although they do not possess statutory force, *e. g.*, the Educational Code, the Village Officers' Manual, Boards Standing Orders, the Public Health Code, etc.

The very multiplicity of these enactments, scattered as they are in such widely different sources, introduces a confusion and uncertainty in the administration and makes it unnecessarily complicated and difficult to carry out. It needs no saying that in Health legislation the rules should be easily accessible and well defined, the procedure should be simple and the difficulties due to want of law and dubious interpretation of law should be minimised, so that in case of need the actual worker in the field could invoke its aid without any confusion.

In addition to the confusion caused by this multiplicity of Acts relating to Public Health there are many defects to be rectified in the existing provisions themselves. For example, there is no question that such branches of Preventive Medicine as Industrial Hygiene, Maternity and Child-welfare, Medical Inspection of Schools, control of venereal diseases are all Public Health problems, but the administration of these is not at present a statutory duty of the Public Health authorities, as it legitimately ought to be.

The confusion in administration exists not only in the central authority but also in regard to the administration by the local bodies.

To give a few examples of this overlapping at the central authority:

In Medical Inspection of Schools there is overlapping between the Ministries of Education and of Local Self-Government.

With regard to Factories and Industrial Hygiene there is dual responsibility between the Ministries for Local Self-Government and for Development. The administration of Marine Hygiene is in the hands of the Government of India and is dealt with through the Finance Department. The Public Health provisions in the Town Nuisances Act, the Indian Penal Code and the Criminal Procedure Code are dealt with by the Law Department. The Epidemic Diseases Act is administered by the Governor-in-Council and the Plague regulations framed under this Act, are administered by the Collectors. Jail Hygiene is administered by the Home Department. An arrangement like this, at the centre, could not lead to co-ordinated action and uniformity of procedure and dual—or rather multifarious—responsibility at the central administration, and overlapping in the administration of the different branchesof *one* subject *viz.*, Public Health is certainly not conducive to efficiency.

Taking the administration of Public Health by thelocal bodies, the confusion is worse here, and a thorough re-arrangement of duties and responsibilities is necessary and for this statutory legislation is required.

To give only a few examples :—

The District Board has charge of some branches of administration although these are mainly the concern of Taluk and Union Boards. The control of epidemic diseases is in charge of the local boards and the necessary expenditure has to be met by the Taluk and Union Boards ; but the staff—the Health Inspectors and District Health Officer are paid by the Local Government and are working under the District Board.

In the case of Plague, the Collectors are held responsible, and the District Health Officer and Revenue Divisional Officer are both the Plague Officers and there is dual responsibility. Even here, part of the Plague expenses are to be borne by the Government, and part by the local board. Such an arrangement can never be efficient.

With regard to Vaccination, the Taluk Board has to pay and equip the staff, and the Health Inspectors supervise their work. These vaccinators have to work in Union areas also, but the Union Board is free from all financial obligation. As regards Registration of Vital statistics in rural areas, the village officers are authorized by statute to be in charge of the work although Union Boards, who are in no way less competent to do the work, are debarred from doing the same. There are different Acts which deal with it, *viz.*, Indian Penal Code, Prevention of Adulteration of Foods Act and the Municipal and Local Boards Act, and the provisions are by no means concordant, or capable of easy working in practice.

Another anomaly is the omission, from every statute dealing with Public Health to recognise any officer of the Public

Health Department as the one who is to carry out the provisions of the Law, although he is the person who has the requisite technical knowledge and who is the man on the spot doing the actual work. The Public Health officer has not been given at present any statutory duties or responsibilities. It is highly desirable that the Public Health Officer should be given statutory powers to take immediate action whenever circumstances demand, as, for example, in the case of control of epidemics, unwholesome articles of food etc. Unless this is done, the full advantages that might have been other wise available to the public from the Health Officers, are all lost and progress is not possible.

Again, as regards housing and overcrowding, the existing provisions are very vague. Another serious defect in the existing statutes is with regard to such an important matter as the problem of contacts of cases of infectious diseases and the equally important problem of carries of infectious diseases. At present, practically very little could be done to deal with this problem which is a serious menace to the Public Health as they form a fruitful source of spread of many an epidemic.

The remedy : To ensure that all the existing provisions regarding Public Health legislation are not lost sight of in actual practice, and are properly co-ordinated they should be collected together into a single act—the Public Health Act Re-drafting of many of the provisions might be necessary to secure co-ordination. The existing defects will have to be removed by making suitable provisions to solve the difficulties on the lines indicated above. The central administration of the Act will be by the Ministry of Health, which will have to be statutorily constituted, and the other central departments of Government who now exercise powers with regard to Public Health will make over the same to the Ministry of Health.

As for the administration in the districts and municipalities, when once the powers and responsibilities and duties of the Presidents, Chairman and officers of the Health Department are statutorily defined the administration of Public Health is bound to be much more efficient than what is possible under the present conditions.

A Public Health Act on the lines suggested above is an urgent necessity. The rapid advance made in countries like England and U. S. A. with regard to Public Health, is due. in no small measure, to the framing and working of a properly drafted Public Health Act. Madras can legitimately take credit for the " best organised Public Health Department in India " as stated by Col. Russell who had occasion to see all the provinces in India as Medical Assessor to the Labour Commission. A Public Health Act is the next progressive measure that will consolidate the results so far achieved and help in bringing about a very tangible improvement in the Public Health of our Presidency.

Abstracts

THE ANAEMIA SYNDROME AND ITS RATIONAL TREATMENT.

Translation from " L'avenir Medicale " May 1930.

Anaemia is no longer classed as a disease but ranged more as a symptom. It is no longer confused with yellowish, slightly icteric pallor, the fugitive pallor of emotional angiospasm. It may be masked by a degree of lividity, a degree of cyanosis a degree of more or less marked icterus.

Anaemia is characterised by (1) Pallid complexion—Decoloration of the mucous. (2) Associated symptoms—heart murmur ; dyspepsia ; dyspnea following effort ; palpitation ; splenomegalia ; hemorrhage of the retina. It should not be forgotten that certain hemorrhages are due to the anaemia syndrome and do not cause it. Neverthless, clinical observation alone is insufficient to determine the existence of anaemia and a blood test is necessary for the diagnosis. Macroscopically, considerable decoloration should be determined with the aid of the Tallqvist Hemoglobinimeter, the most simple in clinical use to-day. Microscopically, the decrease in the number of red corpuscles, from 5,000,000 to 500,000; the irregularity in the size of the hematites ; poikilocytosis ; polychromatophilis ; basophilic granulations ; presence of nucleated hematites ; normal quantity of white corpuscles. All this indicates positively the plastic nature of anaemia evidenced by the medullary reaction against the destruction of the hematites. Aplastic forms of anaemia ; Biermer's disease (before the advent of calfliver treatment) are very rare in France.

Once anaemia has been diagnosed, the cause of it must be ascertained. A Jousset assembles the anaemic factors according to the following classification, which is practical, etiologic and pathogenic:—

I. Symptomatic Anaemias—Following on hemorrhage of a traumatic surgical origin, either spontaneous or due to affections such as purpura, hemophilia, scorbutus, epitaxia, metrorrhagia, hemoptysia, hematemesis, ankylostomiasis, hemorrhoids etc.

II. Anaemias caused by Toxic Alteration of the Hematids.—(a) Infectious and post-infectious anaemia of which the following should be remembered:—(1) The three important chronic affections: Paludism, Tuberculosis, Syphilis. (2) The three important acute infections: Typhoid fever, acute articular rheumatism, various suppurative affections.

(b) True toxic forms of anaemia of which the most important are, the three important classic intoxications: Oxycarbonic (not to be confused with the brain anaemias of town dwellers), lead poisoning, mercurial poisoning.

(c) Autotoxic anaemia caused by Bright's Disease, hepatism, endocrine dysfunction.

III. Anaemia Resulting from Insufficient Regeneration of the Hematids.—This is caused by Splenomegalia, polyadenopathia, leucemia, medullary lesions, pluriglandular deficiency.

IV. Cryptogenic Anaemia.—This is of unknown or obscure origin and which has up to the present been named 'essential anaemia'.

To Summarize.—According to SAVY's words: "Before diagnosing essential anaemia one must eliminate all the causes of symptomatic anaemia, and to that purpose question the patient on possible previous affections, hemorrhages, paludism, infectious diseases of different origins, repeated pregnancy, occupations exposing the patient to lead and oxycarbonic poisoning.

Look for signs of pulmonary tuberculosis, active syphilis, infectious endocarditis, gastric or intestinal cancer, chronic nephritis and try the following tests: Examine the stools for ankylostomic cells, botriocephalus and concealed hemorrhagia; examine the blood to trace a deficiency of leucocytes; verify the degree of the anaemia by counting the red corpuscles; examine the eyes for hemorrhage of the retina, the existence of which indicates non-neoplastic pernicious anaemia."

Treatment.—The Anaemia Syndrome having been diagnosed and the origin discovered, it goes without saying that the treatment should be etiologic. It is also indispensable that treatment should be at the same time symptomatic, stimulating the regeneration of the blood, because in order to combat anaemia

the organism must be assisted to self-defence against the causal agent. The practitioner will therefore utilise all the physical, dietetic, medical, cytogenic and hematogenic agents which therapeutics have placed at his disposal.

ALIMENTATION—Small quantities only of fat and carbohydrates.

NITROGENOUS DIET: Red meat ; yoke of egg ; puree of dried vegetables ; cereal meals, fresh cheese, Bordeaux wine.

APPETITE STIMULANTS: Bitters (the action of which is often factitious) ; Persodine Lumiere (3 tablets one hour before meals in a little water) which suractivates the hemoglobin ; it is an oxydising medicament and the increase of appetite which results from its administration is merely evidence of an increase in the general metabolism.

PHYSIOTHERAPY Aeration ; alcoholic frictions ; administration of oxygen subcutaneously ; radiotherapy of the spleen or the long bones.

HEMATOPOIETIC MEDICAMENTS : the arsenicals ; iron (contraindicated in congestive tuberculosis where their action is doubtful) Manganese hypophosphite.

LEUCOCYTIC EXTRACTS AND SUBSTITUTIVE MEDICAMENTS.—But above all SERUM THERAPY, principally indicated in hypoglobular anaemia. HEMOGLOBIN as a substitutive medicament in anaemia in which there is a want of blood globules.

This association is above all realised by HEMOPLASE LUMIERE. In fact, appreciable results are obtained by administering simply animal serum to the anaemic patient, thus stimulating the increase of globules. It is also useful to administer the fundamental substance of the red corpuscles : Hemoglobin replaces the deficient substance and to activate the oxygen exchange on the surface of the tissues. But the results are much more satisfactory if the extract of the white corpuscles is added to the serum and hemoglobin, as those extracts contain ferments which have well known defensive properties and their presence suractivates the ferments of the white corpuscles. Realisation of these 3 principles which govern the treatment of anaemia has been uncertain. Never before the work of A. LUMIERE had a total extract of the red and white corpuscles been administered, although their actual importance had never been questioned.

HEMOPLASE LUMIERE, known since the communication made on the 10th July, 1905 by Prof. Chaveau to the Academy of Medicine, is a preparation embracing all the indications which we have defined. It actually contains:—

(1) Serum which has retained all its vitality.

(2) Hemoglobin of absolute purity and which has not been de-oxygenised in vacuo, in fact, a true integral hemoglobin.

(3) Extracts of red and white corpuscles which constitute its originality and which are the most active agents combating the poisons of the organism.

Serum, hemoglobin and globular extracts are prepared by a special process which does not devitalise them. They have neither been submitted to a vacuum, nor to heat, nor to the action of a chemical agent. They therefore retain a maximum activity and it can be said that HEMOPLASE is a total extract of blood with the exception of fibrine and the globular stromas. These have been eliminated, not only because they are useless, but also because they make intramuscular and intravenous injections impossible on account of the coagulation they provoke.

HEMOPLASE not only contains Hemoglobin of the red corpuscles, but their lipoids as well, and the work by WOLF has shown that the lipoids, especially in conjunction with a complex albumen (on this occasion that of the serum contained in the Hemoplase), also activate the hemopoiesis by a different process from that of the serum as the suractivation is not specific. They have a synergic action together with the extracts of leucocytes by increasing the fermentative processes and reducing the albumen expenditure of the organism. They also have a bacteriologic action *vis-a-vis* the Koch bacilli by formation of an anti-body dissolving the bacillary wax. Of course, this last affirmation is open to question, but the works of Mattaush cannot but leave one impressed as they carry clinical conviction. This author is of the opinion that Hemoplase treatment should not merely be considered as a symptomatic therapeutic directed against anæmia, but as a specfic medication in tubercular affections, even when of a serious nature. We emphasize the fact that Hemoplase Lumiere permits of the application of the general principle of Opotherapy because the globular ferments contained therein are themselves active, particularly as they suractivate the production of analogous ferments by means of the globules. This is a peculiar action associated with their stimulation of which the increase of phagocytic power is yet another aspect. Further, the white corpuscle is an unicellular gland and Hemoplase is an opotherapic medicament as regards this gland. We see therefore that Hemoplase is the medicament which will achieve a rational and integral treatment of anaemia. It stimulates all the defenses of the organism against infections and intoxications ; it is a palliative and helps the etiologic treatment of the symptom in question. Hemoplase is not only indicated in anaemia, this word being used in a hematologic sense, but it is also the medicament of choice in all organic wasting of every origin. It achieves the treatment of the anaemic condition, and the hyposphyxia of tuberculosis by means of the three cardinal principles it embraces : A nourishing and hemapoietic serum, a vital oxydising agent ; hemoglobin ; lipoids and fermentz, bath opotherapic and antitoxic.

PRINCIPLES OF MEDICAL ETHICS

OF THE

American Medical Association

CHAPTER 1

THE DUTIES OF PHYSICIANS TO THEIR PATIENTS

The Physician's Responsibility

Section 1.—A profession has for its prime object the service it can render to humanity ; reward of financial gain should be a subordinate consideration. The practice of medicine is a profession. In choosing this profession an individual assumes an obligation to conduct himself in accord with its ideals.

Patience, Delicacy and Secrecy

Section 2.—Patience and delicacy should characterize all the acts of a physician. The confidences concerning individual or domestic life entrusted by a patient to a physician aud the defects of disposition or flaws of character observed in patients during medical attendance should be held as a trust and should never be revealed except when imperatively required by the laws of the state. There are occasions, however, when a physician must determine whether or not his duty to society requires him to take defenite action to protect a healthy individual from becoming infected, because the physician has knowledge, obtained through the confidences entrusted to him as a physician, of a communicable disease to which the healthy individual is about to be exposed. In such a case the physician should act as he would desire another to act towards one of his own family under like circumstances. Before he determines his course, the physician should know the civil law of his commonwealth concerning privileged communications.

Prognosis

Section 3.—A physician should give timely notice of dangerous manifestations of the disease to the friends of patient. He should neither exaggerate nor minimize the gravity of the Patient's condition. He should assure himself that the patients or his friends have such knowledge of the patients condition as will serve the best interests of the patient and the family.

Patients must not be neglected

Section 4.—A physician is free to choose whom he will serve. He should, however always respond to any request for his assistance in an emergency or whenever temperate public opinion expects the service. Once having undertaken a case, a physician should not abandon or neglect the patient because the disease is deemed incurable ; nor should he withdraw from the case for any reason until a sufficient notice of a desire to be released has been given the patient or his friends to make it possible for them to secure another medical attendant.

(To be continned.)

USEFUL PREPARATIONS AND THEIR THERAPEUTIC USES

Aurothysin (Lumiere)

A new organic gold salt, the administration of which appears to be free from the inconvenience associated with the intravenous injections of the gold Thiosulphate salts. It contains about 35 per cent of its weight of gold, is soluble, stable and injected intramuscularly or subcutaneously, and is readily absorbed. Its toxicity is feeble and the injections, in general, do not appear to be accompanied by any local or general reaction. The average dose is one to two injections a week. In certain cases as many as 30 consecutive injections may be given equivalent to 7·5 gm. of Aurothysin. Supplied in ampoules in doses of 5 and 10 ctgr. each ampoule being accompanied by an ampoule of saline for dilution.

Acetylcholine

Acetylcholine (H. C. T. 7/11). This is the acetyl derivative of choline (hydroxyethyl-trimethyl - ammonium hydroxide), and has been shown to be a normal constituent of the tissues. Both acetylcholine and aqueous solutions of its salts are unstable, and glucose is usually employed to prevent decomposition. It is for this reason that manufacturers supply the compound in a dry stabilised form. It has a powerful dilating effect on the arteries and arterioles, and in this respect differs from histamine, which is a capillary dilator. Its most important use is in the treatment of Raynaud's disease—a vasomotor disturbance in which an initial dose of 0·05 gm. is injected, followed by successive daily doses of 0·1 gm., increased to 0.2 gm. if really needed. This is continued until the trophic troubles disappear, when a series of injections during one or two weeks a month may be given until definite improvement is established. In arteritis and arterial hypertension similar doses have been found to produce good results. For tuberculous sweats, 0.01 to 0.02 Gm, injected daily, or on alternate days, is considered to be sufficient whereas in abdominal surgery a minimum of 0.2 gm. to a maximum dose of 0.6 is suggested, according to the severity of the case. Injections may be given either intramuscularly or subcutaneously. Intravenous injections are dangerous and all solutions must be freely prepared immediately before use.

Extract from "The Pharmaceutical Journal".

Arseno-Solvent

A solvent for Sulfarsenol, ensuring painless administration in concentrated solution by the subcutaneous and intramuscular routes.

The most notable advantage possessed by Sulfarsenol in comparison with other arseno-benzenes is the fact that it can be administered subcutaneously or intramuscularly, even in the largest doses. Endothelial traumatism and the nerve shock of intravenous injections are thus eliminated and the remedy being absorbed more slowly, it has time to undergo physiological adaptation before mixing with the blood stream. To take full advantage of these easier modes of administration, the injections must be painless. Sulfarsenol injected in a solution of 6 c. gms. per cc. of re-distilled water (6 per cent) is practically painless. In large doses, however, the large volume of a 6 per cent dilution constitutes a difficulty. Some practitioners use a much more concentrated solution for the large doses: these concentrations although frequently well supported, give rise in some cases, to painful symptoms. To obviate this difficulty, the A.F.D. laboratories have after experimentation, perfected a solvent, namely, Arseno-Solvent, which permits of the painless injection of Sulfarsenol in concentrated solution called Arseno-Solvent which is a glucose-saline solution containing Guaiacol and Chloretone, available in sterile ampoules of 2cc. One ampoule is used for doses of Sulfarsenol from 6 to 30 cgms. and three ampoules for the higher doses upto 96 cgms.

Arseno-Solvent is a clear, colourless liquid. Ampoules which are coloured (yellowish for example) or show a sediment should be discarded.

Directions for use.—Intramuscular injections are made into the buttocks or the dorsi-lumbar muscles at about 3 centimetres from the median line.

Subcutaneous injections are made in the flanks, in the back, between the scapulae, below the fat covering the buttocks, etc. There should be no pain if the injection is made well under the skin into the subcutaneous tissue.

The necessary quantity of solvent should be aspirated into the syringe, and then discharged into the ampoule containing the Sulfarsenol. Solution is quickly accomplished by slight shaking of the mixture. The solution together with an air bubble is aspirated into the syringe. The needle, removed from the nozzle of the syringe, is inserted at the site of injection previously cleansed and sterilised—it is advisable in intramuscular injections to wait for a few seconds until it is ascertained that no blood appears at the hub of the needle—the syringe is then fitted to the imbedded needle and the contents including the lateral air bubble, injected. On withdrawing the needle, pressure should be exerted on the site of the puncture to prevent any escape of the injected solution.

Notes on Treatment of Diseases.

N.B.—These notes are intended to supplement the treatment given in ordinary text books and neither to be expected nor possible to be exhaustive.

Colic : Flatulance in old persons ; capsicum is the best remedy.

2. In infants ; Spt. Aeth. Nitrosi. 2 drams, glycerine 3 drams, aqua 3 ounces, a teaspoonful in hot water every 2 or 3 hours (Rudolf)

3. Biliary ; Benzyl Benzonate 30 mms. of the 20 per cent. solution taken with water (Rudolf).

4. Hepatic: due to gallstones, morphia and atropine to relieve pain and promote expulsion of stones; during the attack large quantity of olive oil in ½ pint doses to be given. If there is nausea one dram of ether to be added to each dose; immediately there will be a relief of pain by the passage of stone. If the liver is turpid calomel in small doses several times a day and Benzonate or salicylate of sodiumin 10 to 20 gr. doses will increase the flow and make it alkaline. To prevent the formation of stone turpentine is good and can be taken as follows: Ol. turpentine mms. 5. Syrup acacia ½ an ounce, sodium phenol sulph gr. 20, Spt, aeth co, mms 10. aqua menthol add 1 ounce to be taken twice a day (Hare).

5. As a prevention Boldine pills 6 to 10 a day may be taken.

6. In vagotonia the irritable condition of the autonomic nervous system caused by hyper acidity, there is a tendency to the excessive contraction of the pylorus colon and anal fissure. This may be found associated with gastric and deodenal ulcers. Drinking of water is highly beneficial, as soon as the first symptoms of the pain appears. If the pain appears 2 or 3 hours after meals a copious draught of hot water 2 or 3 glasses dilutes the acid and relax the spasms. If the pain comes during the night, it may be relieved by taking a small quantity of bland food followed by hot water (Kellog).

Colitis : Mucous or Membranous : Thyroid gland is good (Endocrine Survey).

2. The best diet is banana flour ; milk and eggs to be avoided as also nuts, seeds, fruits and potatoes (Graham).

3. Buttermilk enema is good as lactic acid bacilli are introduced into the colon, or a dram of lactic acid in 2 or 3 pints of water is good in obstinate constipation. Three ounces of sugar or milk in equal quantity of dextrine is good (Kellog).

4. Castor oil several times a day in combination with salol ; betanaphthol ; paraffin oil 1 to 2 tablespoonful at night ; Injection into the colon of 10 to 12 ounces of olive or cotton seed oil by high enema at bed time (Modern Medicine).

5. Intravenous injection of Hexamethylinamine 15 grains every 3 days at least making 12 injections on the whole (Intravenous therapy.)

6. Best lucca oil as inferior oils will irritate, to be given 4 or 5 days until it is retained for 10 hours and then astringent enema of argyrol 1 per cent or Pot. permanganate 1 : 2,000 (Leonard Williams.)

7. If colitis is due to bacterial infection of the colon, Bacte-Inteste-Phage (D'Herelle) both in adults and children may be given with advantage.

8. Mycol (containing Bile extract, Lactic Ferments, Beer yeast) is indicated as a bowel disinfectant and educator in colities of whatever origin.

8. Proliferase (yeast with living and viable cells capable of proliferating at the temperature of human body) is yet another preparation indicated in colitis of toxic origin.

10. Orargol an electrically-prepared colloidal silver and gold, works as a non-toxie antiseptic in certain cases of colitis.

11. Thoroxyl a preparation consisting of formiates and carbonates of Thorium, Dydimium and Cerium is also useful.

12. Cryptargol a non-irritating colloidal preparation of Silver has been tried with success in colitis due to intestinal fermentations.

Notes on Therapeutics, Diagnosis and other Medical Subjects

Some Stray Points about Nervous System

Sensibility-tactile-normally at the tips of the fingers a distance of 2 millimetres is recognised, but in the thigh 15 millimetres; in human beings there are 9,218 million neurons in the cortex. In the case of medullated nerves the acquiring of the fatty sheath is the sign that the neurone is ready to function. The number of neurons is fixed. The cells have no centrosome *i.e.*, they will not reproduce and there can be no tumours of neurons. The organ of Corti responds to vibrations from 30 to 30,000 per second and the retina to ethereal vibrations from 4 to 8,00,000 billions per second. Pons regulates skilled movements. Optic Thalamus is the oldest portion of the brain to which consciousness may be attributed. The choroid influences behaviours through the Optic Thalamus. The kinetic system consists of adrenals, brain, liver, thyroid and muscles and looks as it were an automobile. The self-starter of the machine is the brain with storage battery and ignition combined, in the adrenals caburetter and the thyroid is the accelerator.

Blood-Pressure

For the present day treatment of diseases the requirement of a sphygmomanometer is as essential as a stethescope or a thermometer. The best instrument for taking the blood-pressure is evidently a mercury one, as aneroid etc., are not reliable and sometimes may be positively harmful particularly under the climatic conditions obtaining in India. The blood pressure should be taken at least 2 hours after a meal or between two meals. It is better to take it when the patient is in a reclining position or lying down. The blood pressure consists of 3 items (1) the systolic pressure (2) the diastolic pressure and (3) the pulse pressure. In a normal person the diastolic pressure is 2/3rd of the systolic pressure and the difference between the systolic and diastolic pressure is the pulse pressure. The systolic pressure and the diastolic pressure in a normal man aged 20 at the level of the heart is as follows :—

	In minimums of mercury	
	Systolic pressure	Diastolic pressure
Left ventricle	0.200	...
Aorta	150—200	100—120
Brachial artery	105—140	80—100
Radial artery	95—125	...
Arterioles	80— 95	...
Medium capillaries	50— 60	50— 60
Smallest capillaries	20— 35	20— 35
Smallest veins	20— 30	20— 30
Large vein of the arm	1— 15	1— 15
Right ventricle	20— 60	...
Pulmonary artery	25— 60	15— 25

In lying down position the pressure in the length of the aorta is very nearly constant whereas if one is standing the pressure will materially vary at different levels. The systolic pressure is a measure only of the maximum cardiac energy at a certain time. It is subject to variations whereas the diastolic is a measure of the load which the arterial cells have continually to support. It is the measure of the resistence in the aorta which has to be overcome by the blood stream in separating the Aortic valves during the initial stages of the left ventricular contraction. During a normal day of activity in a perfectly normal individual the blood will undergo considerable alteration. While an individual is absolutely relaxed in sleep the blood-pressure both systolic and diastolic is lower and the blood-pressure is the lowest about 2 hours after the individual goes to sleep. From that time onwards, it gradually raises until sometime in the afternoon when it reaches its highest daily variation. This fall during the sleep is believed to be the result of decreased nervous stimulation and relax musculature. The diminished blood-pressure during absolute rest is comparable to the pressure of the individual in sleep. In females the blood-pressure is lower than that of the males. Prior to menstruation it is found to be slightly increased and also during menopause. For sometime a rule for judging the blood-pressure in its relation to age has been in general use. The age plus 100 is fairly close to the average. Hallsdally's rule for calculating the systolic pressure is a little different and perhaps a little better. It is for ages from 20 up to 60 ; standard systolic pressure equals 120 plus 1/5th of the age and at the age of 60, standard systolic pressure is 135 and for each year above this upto and including age 80, 1 millimetre mercury. It is considered that unless the blood- pressure is always higher in persons who live on mixed diets than of those who live on pure vegetable diet. The systolic pressure has been found to be at the brachial artery among Europeans to vary from 111 to 130, among Bengalis 90 to 115 and Chinese 111. This point has to be taken into consideration when treating Indians.

Natural and Artificial Adrenalins.

The cheaper synthetic suprareni is composed of a mixture of Dextro and Laevaratory compounds while the natural drug is the Laevo-compound only. The latter is fifteen times more active than Dextro compound.

News and Comments

Medical Ethics: As mentioned by us elsewhere in the last issue, we cannot agree with Surgeon-General Sprawson regarding his views on Medical Ethics at least in this City. We feel we should in the interests of the profession bring to his notice through these columns some typical cases. It is our considered opinion that better purpose will be served by this course than by taking the opinion of the Medical Council in such cases in the present state of affairs in our country when the general ethics regarding matters medical as observed by the lay public is not in keeping with the ideals one finds in Medical Ethics and any attempt to set right a wrong is likely to frustrate the very purpose especially when the offending party is a person in high position. If he is a medical man in Government service matters are likely to be worse still: There was a patient under the care and observation of a practitioner who in consultation with a Senior, suspended drugging the patient with the idea that drugs were likely to interfere with the bacteriological examination decided upon at the time. In the meanwhile two other practitioners ushered into the field, one in the role of a friend and well-wisher and the other as a consultant not brought by the *friend doctor* but suggested by another esteemed friend outside the medical fraternity. The *friend doctor* actually treats perhaps apprehending delay may be dangerous and likely to tell upon his dear friend's health. When the other consultant arrived, some physical signs were seen and, as luck will have it, made the work of this consultant very easy. He commences treatment too of course expressing his opinion of the case. Being an eminent member of the profession the consultant did not fail to get a complete history of the case and in the course of the history he knew that two other practitioners were treating the patient, one as a doctor who had suspended treatment for reasons referred to above and the other as a *friend doctor*. He was also informed that another consultant of much the same status and position as himself could not come to any definite conclusion and that the results of bacteriological examination were awaited.

Patients naturally like to know the diagnosis of their diseases on the spot and those who tell them something at once catch their imagination more than the one who wants to be surer and hence nearer the truth. Many a time signs of the disease appear at a later stage. Consequently in such a case the patient naturally feels it safer to be under a doctor who tells them something on the spot. Those who were on the scene at an earlier stage are likely to fall lower in the estimation of the patient for no fault of such doctors who on the other hand do not wish to harm the patients with drugs unless they were sure of what they were doing. Can it be said that doctors on the British Register have to be taught Ethics by those in the local Register? The idea looks as heinous as it is real from all points of view.

We crave the indulgence of our readers if we were to mention about yet another case. It is a good old custom that patients usually prefer to consult a hospital specialist before they seek admission in the City Hospitals. So far so good. The existence of nursing home are at times annoying though the patients are informed that they will have personal care and attention by the presiding specialist, which facilities could not be commanded in a State Hospital as the patients were too many for one specialist to attend to. Many a time to escape larger expenditure in the nursing homes patients are rather silent about the state of their purse or even identity. In such a dilemma a child was operated upon in the hospital and it was said the child had fever at the time. The patient was brought home a few hours after the operation as is usually done in such cases. The child got high fever attendant with other symptoms and they said it was due to sepsis. The idea of larger expenditure in a nursing home or something else would not permit those in charge of the patient to send for the concerned specialist though it was suggested. A general practitioner was sent for and under his care temperature came down and the child was declared free from danger though some fear was lurking if all that could be done had been done especially because the attending practitioner was not a specialist in charge of a hospital. At such a juncture a medical student came to the rescue. It was reported so in this case. The specialist was introduced once

(*Continued on page 173.*)

SPECIAL CONTRIBUTION TO THE MEDICAL PROFESSION

Treatment of Asthma

When speaking of Asthma one usually has in mind the acute attack of Bronchial Asthma. Whoever had many occasions to treat such cases knows how difficult it often is to solve the question and which of the many formulae should be used in each specific case. If the cardiac system is intact, the first thought usually turns to Morphin injections as they usually seem to relieve the asthmatic symptoms promptly. Unfortunately, however, there are many cases which react to Morphin only for a while, besides there is inherent danger in the continued use of Morphin.

Therefore, we doubly welcome a preparation which possesses to quality to check like Morphin without the dangers of the latter, and which may be administered not only when the heart is in good condition, but, especially in cases were cardiac disturbances exist.

The preparation I refer to is "Felsol," a powder. "Felsol" is administered internally with a little water. It may be given to any patient any length of time, as its action is not cumulative and the continued use of it has never shown any bad by-or after-effects.

"Felsol" contains Phenazon, Anilipyrin, Iodopyrin, Caffeine, Susc. alb., Extr. Brachycladii.

With "Felsol," I have so far not had a single failure. Although my experience with the preparation covers a comparatively short time, and the patients who have used "Felsol" are, as yet, few in number, the results obtained are so remarkable that I would like to cite a few:

Case 1. P. N., 55 years old, came into my care suffering from severe general bronchitis, cyanosis and dispnea but no fever. The pulse was a little rapid and edema existed at the lower parts of both legs, so I did not care to give Morphin. I prescribed one "Felsol" powder three times a day and results were obtained in a few days which neither I nor my patient had anticipated. Within a few hours the patient's respiratory difficulties ceased, and after the fourth day the edema disappeared. The man, who before considered his end near, got it of bed on the fifth day. The chronic bronchitis, of course, only healed after three weeks to such extent that P. N. could resume his occupation. He has now been working for a year as a cement worker whereas before he began taking "Felsol" he had to lay off regularly about every three months. P. N. still uses about a box of "Felsol" of 12 powders every six weeks and so far has not complained of nor manifested any bad by-effects. At present P.N. is still afflicted with an emphysematous thorax, but there are to all appearances no more bronchial troubles.

Case 2. The second case, N. K., a retired minor, 62 years old, suddenly had asthmatic attacks, caused by chronic bronchitis and myocarditis. Here I first treated with digital is and morphium at the same time. This reduced the respiratory troubles to some extent, but after a few days due to decreased action of the heart, heavy edema appeared on both legs. I now gave "Felsol" at shorter or longer periods of time, 1 to 3 powders daily for about three months. Every time I stopped, the patient would request "Felsol" again as he felt that it kept the asthmatic attacks away, which otherwise would return. These attacks have now stopped altogether, although the bronchitis still exists. On account of arterio sclerosis the patient has not again been able to follow an occupation.

Case 3. A. J., coal minor, 35 years old, for many years a sufferer from chronic bronchitis, suddenly developed severe asthmatic attacks. The examination disclosed bronchial rales over the whole of both lungs, with loud wheezing and whistling, severe dispnea and a good pulse. The heart was evidently in good order. I first gave "Felsol" at 10 p.m. During the same night the asthmatic attack subsided. Soon thereafter the bronchial difficulties which had existed for a long period of time disappeared. The patient used one box of "Felsol," and to this day has been free from attacks.

Case 4. Mrs. K., nearly 60 years old, for some time past suffering with chronic nephritis and myocarditis, received sudden and severe attacks of Asthma. After taking a few "Felsol" powders, there resulted such improvement that the patient imagined she was fully restored. Asthma and cardiac troubles really had disappeared but not the kidney disturbances. These later necessitated the transfer of the patient to the hospital. So I lost my contact with the case.

Case 5. O. S., coal miner, although but 37 years old was practically an invalid on account of chronic bronchitis and Asthma. He developed severe attacks of Bronchial Asthma with very threatening manifestations. After administering one "Felsol" powder the patient was relieved as never before with any other preparation. After three more days O. S. returned to work, but still uses "Felsol" from time to time.

These cases may suffice to demonstrate the sure effect of "Felsol." In my opinion the remedy is very commendable for general practice and for the busy physician, on account of its contents and the simplicity of administering it. It gives the physician a handy, convenient and harmless remedy for any kind of bronchial, or cardiac Asthma. I consider "Felsol" a valuable addition to our treasure of remedies not only for its qualities to check the asthmatic attack itself. as also for its quality to act on the underlying causes of the Asthma, at least in a very favourable way.

Dr. D.

Physical and Chemical Properties of Felsol

" Felsol " is a colourless crystalline powder of acid reaction and somewhat bitter but not of unpleasant taste, easily dissolved in warm water and a little harder in cold water. The melting point is 110 degrees C.

" Felsol " consists of (Phenazon 0.25, Anilipyrin 0.4, Iodopyrin 0.25) Caffeine 0.1, Susc. alb. 0.01 and Extr. Brachycladii 0.01.

Indications

In the treatment of Bronchial Asthma, Cardiac Asthma " Felsol " is unsurpassed, and statistics show that it is successful in 80% of the Asthma cases in which it is used. Chronic Bronchitis and convulsive Cough have also been found to yield favourably to " Felsol."

The outstanding features of " Felsol " and the reasons which have given it its well-deserved place in the treatement of Asthma are summed up in the following:—

" Felsol "—contains no morphia or other narcotics, yet it possesses the power to promptly check or relieve the asthmatic attack peculiar to the former.

" Felsol "—can be used in cases of cardiac affections.

" Felsol "—is reliable in its action even in chronic cases of longstanding.

" Felsol "—is adapted for the prophylaxis of the attack, and if taken in time, or as soon as symptoms of the approaching attack are perceived will, as a rule, prevent it.

" Felsol "—is not cumulative in its action and the dose does not have to be increased even with extended use over a long period.

"Felsol"—does not produce bad after-effects, such as headache, vomitting, exhaustion, etc.

"Felsol"—is packed in a convenient form for the patient's use at home, when at work or travelling. It is easily administered by placing the powder on the tongue and swallowing with a drink of water. These two points are of special importance to the general practitioner and busy Physician.

"Felsol"—is very carefully compounded, and will keep indefinitely.

Directions

To check an attack of Asthma one or two powders are generally required, the second powder to be given from two to three hours after the first. In rare cases a third powder may be found necessary. It is always advisable to continue taking a few powders a day for several days after the attack.

Where the Physician has no special reason to prescribe otherwise the following general directions are given:—

First week:—One powder three times daily one hour after meals.

Second week:—One powder morning and evening.

Third week:—One powder every morning

After the patient has sufficiently recovered, the dosage may be still further reduced and a powder twice a week has proved sufficient in many cases to maintain the patient's well-being. In less severe cases the dosage may be reduced from the beginning, while in severe cases of longstanding it may have to be increased.

Where it is not deemed necessary to use "Felsol" continuously the patient should be advised in case symptoms of an approaching attack are perceived—such as nervous excitation, headache, itching of the nose or the skin, severe sneezing, yawning and other subjective symptoms—to start taking from one or two powders during the day. In this way the actual spasm is usually to a great extent, and very often completely, prevented.

For children from 2 to 10 years of age the dose may be reduced from ¼ to ½ the full dose.

The most convenient way to take "Felsol" and the one followed by most patients is to sprinkle the powder on the tongue and swallow with a drink of water.

Syphilis

Extracts from Standard Literature.

"The Therapeutic of Venereal Diseases" by Doctor Carles, Physician to the Sanitary Service of the City of Lyons, Doin, Paris, 1925.

TREATMENT BY ARSENICAL DERIVATIVES GIVEN HYPODERMICALLY

Page 271:—Sulfarsenol:—This salt is evidently the one which is tolerated best of the different derivatives of this class, whether given subcutaneously or intramuscularly. As with the preceding substance, numerous and similar attempts have been made toward still further diminution of the local reaction, which is usually very slight in any event. Following subcutaneous injections, the reaction is hardly appreciable except with very nervous patients, even when made with pure distilled water. With intramuscular injections, the sensation of local wounding and gluteal pain is slightly more marked, without ever being intolerable or capable of interfering with the patients' occupations. The addition of glucose, stovain or novocain does not seem to me to have accomplished any material diminution in the sensations produced by the injections.

" Audry and Chatellier have studied the best manner of administering Sulfarsenol intra-muscularly (see also the Gallonier Thesis, Toulouse, 1920). They favour a minimum quantity, such as 1 cc., of the diluting agent. The initial injection should be of 12 to 18 centigrams, in order to determine the patient's susceptibility, and the dosage is then increased as rapidly as possible. These writers advise this method which should succeed in reaching a single weekly injection of 60 centigrams, made alternately in the gluteal regions of each side. During the period of progressively increasing dosage, the single weekly dose of 60 centigrams is approached by injections made every three days. The total dosage of Sulfarsenol thus reaches 3, 4 to 5 grams, on an average. By following these general rules, any physician can readily formulate and apply hypodermic treatment with Sulfarsenol.

Among the various substances employed hypodermically, and which are tolerated variably and according to the susceptibility of the individual patient Sulfarsenol remains the substance which is tolerated the best and during the most prolonged treatment of all those used subcutaneously.

Hereditary Syphilis-Medicinal Substances Employed

Page 435:—Among the different arsenobenzenes, Sulfarsenol is one of those most perfectly tolerated in hypodermic injection, as we have already remarked. It is also the substance which is least easily decomposed on exposure to the air. These valuable qualities have caused it to be adopted by a number of physicians for hypodermic treatment employed with children. Any of the several vehicles mentioned may be utilized, but simple solutions in distilled water are sufficiently painless to permit treatment given in regular series. Marcel Pinard, Leredde and many others think that Sulfarsenol is the preparation most clearly and completely indicated for employing arsenical treatment under the ordinary conditions surrounding the practitioner.

Gonorrheal Vaccines.

The vaccine treatment of Gonorrhea is intended to provoke a reaction against the infection as well as to increase the opsonic index against the pathogenic bacteria.

Foreign proteins of any kind can induce the necessary aspecific reaction. Of course one foreign protein may give a better effect than another, and the amount of ths dose may be an important point.

Generally, the time a vaccine takes to act will show whether the effect is due to specific or aspecific protein action. An aspecific protein effect may take place within two or three days, while a specific effect involving the elaboration of antibodies must take at least seven to twelve days.

Whatever the kind of effect produced, whether it be specific, or aspecific, the products of the reactions require to be oxidised to allow of their final disposal.

To intensify this oxidizing effect, a useful addition to our armamentarium is found in Pharmasol Trimine containing colloid forms of Zinc 0·01 percent., Manganese 0·1 per cent and Iron 0·01 per cent.

Alternate injections of Gonococcus Vaccine with Pharmasol Trimine approximately doubles the efficacy of the former, by stimulating the oxidation of the products of the metabolism special to this curative process.

Is Cough Always A Chronic Symptom ?

Usually a cough develops, not in the first two days of a "Cold", but after the febrile period is abated, that is, after the calcium metabolism has been disturbed by an acute infection. The first thing would then be to restore the calcium balance, while at the same time some suitable antiseptic healing agent should be prescribed.

These two purposes can very well be served by Syrup Creosal, which contains Calcium Guaiacol Phosphate in a delicious form.

Syrup Creosal is particularly valuable in children, where the atonic condition resulting from disturbed calcium balance is more critical, and where the expedient of giving something pleasant to take rather than a nasty medicine, may make such a difference to the facility of giving treatment.

In the chronic bronchitis of the aged, Syrup Creosal is also particularly worth prescribing, exhibiting as it does a myotonic effect on the relaxed siliary muscles.

For Diagnostic Purposes

Where there are no symptoms of active syphilis, and we wish to determine whether or not latent lues exists, we have recourse to the Wassermann or Khan tests.

This may be preceded by a provocative dose of Sulfarsenol or other arsenical.

Where there are active symptoms (not primary) regarding which we wish to know whether or not they are luetic, the cheapest and usually the quickest method is to give one or two injections of Benzo Bismuth. External symptoms of late syphilis begin to clear up so quickly that for mofussil practice at least the results are visible before a reply can be received stating the results of the blood test. Symptoms originating in the central nervous system may often require three ampoules before the improvement can be called diagnostic, but here the expectation of a positive test is so large that the time of waiting for the report might as well be utilised in pressing forward the specific treatment.

Nothing is more irksome to the patient than to feel that nothing can be done for him meanwhile.

In the case of primary sores of doubtful diagnosis, a smear should be prepared on a glass slide always. To prepare this slide first rub down a little Chinese ink with a drop of water till the solution is black. Wash the sore till the raw surface is visible, then press a clean new glass slide (3" x 1") on to the raw surface and so pick up a little of the fluid. Now gently mix the Chinese ink with the material on the slide, being particular to incorporate that which was collected from the edge of the sore. Allow to dry at room temperature and when completely dry it may be fixed by any of the ordinary fixing agents. If the slide is to be examined at once, fixation is unnecessary. In any case it is better to arrange for the slide to be examined as early as convenient and the result recorded in such a way that it may be referred to at any time during future years.

NOTICE

A file of papers containing a lot of communications from the Medical practitioners has been mislaid in our office. Consequently we are not in a position to reply to them. We beg such of our customers who might have written to us two or three weeks prior to 10—2—31 to excuse us in case they did'nt till now get replies to their communications and request them to write to us again.

MANAGER,
THE MEDICIAL PRACTITIONERS' SERVICE BUREAU.
Vepery, Madras.

PRACTICAL MEDICINE

Elixir Bromo Valerianate (Gabail)

COMPOSITION

Formula :—

Extract of Valerian	...	10 grammes
Acid Valerianic	...	3 ,,
Ammonium Carbonate	...	q. s.
Strontium Bromide	...	6 grammes.
Chloral Hydrate (Fr. Cx.)		7 ,,
Syrup Aurantii	...	125 ,,
Distilled Water	...	150 ,,

Each table-spoonful contains 50 centigrammes (8 grains) of Valerian extract and 24 centigrammes (4 grains) of pure Strontium Bromide in an agreeable form both as regards odour and taste.

Dosage :—Adults: One tablespoonful twice or thrice daily in a little water before or after meals. Children: One teaspoonful twice daily, with a little water before or after meals.

Painful Menstruation

Probably ninety-nine cases of Dysmenorrhea out of every hundred are more or less spasmodic in character. This should indicate an antispasmodic remedy as the best treatment for the majority of cases of this complaint.

Elixir Bromo Valerianate (Gabail) has been tried in thousands of cases of painful menstruation, and in every case the pain was reduced to normal, or nearly so, and in many cases the quantity of Menstrual fluids was restored to normal also. In inflammatory cases the inflammation is sometimes reduced, but obstructive cases require local attention.

In chronic cases advise the patient to take two teaspoonfuls of Elixir Bromo Valerianate (Gabail) three times a day, beginning a day or two previous to the expected disturbance. If necessary the dose may be increased subsequently to a table spoonful.

After Alcohol

After an alocholic excess the nerves always require a sedative, and for this purpose Elixir Bromo Valerianate (Gabail) gives very satisfactory results. The patient who is subject to periods of excessive drinking should be advised to keep always handy a bottle of this Elixir. After a mild bout a table-spoonful in the morning may be enough, or it may be repeated until equilibrium is established and the headache completely disappears. In severe cases or where Delirium Tremens supervenes one or two table-spoonfuls or more may be repeated every hour or according to symptoms.

Whooping Cough

The spasmodic nature of this complaint at once indicates Elixir Bromo Valerianate (Gabail).

The number and severity of the spasms are both reduced in a satisfactory manner.

Chronic Hepatitis

Owing to the diminished lung metabolism, richer food and less active habits, " tropical liver " or chronic Hepatitis is especially common in Europeans who have been in India only for a short time.

The patient is usually irritable and mentally depressed, and complains of headache, giddiness, bad taste in mouth, no appetite in the morning and the bowels are irregular and constipated.

On examination, the liver is found to be uniformly enlarged and rather painful on pressure. The complexion is usually sallow with dark rims round the eyes, and the tongue is always thickly furred especially in the mornings.

It is interesting to note that the alkaloid Boldine, obtained from the leaves of the shrub (Boldoa fragans) indigenous to Chili and Bolivia, has a very definite diuretic and stimulating action on the liver.

The most convenient method of administering the alkaloid is by giving Boldine Pills A.F.D. which are available in the market. Each granule contains one milligramme of the pure alkaloid.

The efficacy of these pills have been verified by numerous clinical observations both in the continent and in tropical countries, proving that their effects are characterised by a gradual disappearance of headache, constipation and of all morbid and irritable symptoms. The liver diminishes in size and loses its tenderness on manipulation and the patient once more enjoys his usual health and strength.

It appears, therefore, that Boldine Pills A. F. D. are definitely worth a trial.

(*Continued from page 172.*)

again to see the child hale and healthy. He could not but condemn what was done by the attending practitioner, as he had nothing more to do. This piece of service is reported to be free and he is thanked for all the more. We are afraid whether the specialist knows even this day the identity of the patient he had to deal with.

So long those in service are allowed unrestricted private practice the code of Medical Ethics at least in this city cannot be what is found in other civilized countries and there may be a need for two codes one for the members of the independent medical profession and the other for service men.

Madras Medical Association : On 24—1—31 Dr. A. Lakshmanaswami Mudaliar, M.D., delivered the inaugural address before a gathering consisting mainly of members of Provincial Medical Service. This Association came into existence in 1915 with a threefold object : (1) promoting the cause of medicine (2) maintaining the honour and interests of the medical profession in general and of the Madras Medical Service in particular and (3) of maintaining an '*espirit de corps*' among the members of the Association. The membership to this Association is restricted to service people in the provincial service and the rules have since been modified so as to admit the gazetted officers in the Public Health Department.

Dr. Lakshmanaswami Mudaliar who has been chosen to succeed Dr. M. Kesava Pai as the President of the association gave expression to sound and healthy ideals which if worked with the same zeal with which they were uttered will certainly go a great way in improving the Madras Medical Service on very sound lines. Dr. Lakshmanaswami Mudaliar did not forget the responsibilities of his Association towards the Indian systems of medicine with which he advocated hearty co-operation. He realised the most difficult situation of the members of the independent medical profession and admitted that their existence was essential to cater to the needs of the very large body of the general public and he hoped it was possible to have "a harmonious body and not a vivisected, disorganised, disunited and almost lifeless skeleton in the medical profession." We appreciate the genuine views, but how far is it possible to bring about this harmony is a problem to all interested in such co-operation when there exists a large gulf of difference of interests between the two groups which is widening more and more on account of variety of causes, the chief and the most glaring amongst them being the misuse of the right of private practice by some service men, especially a few at the top, not to mention about the unequal and unwholesome competition in private practice. The only practical solution to bring about union between the two classes seems to be to restrict the practice of the service men to hospitals only for which they are paid amply by the State and the private practitioners who are "filling the difficult and none the less most essential role" being allowed to cater to the needs of the general public unhampered. Regarding the promotion of better understanding and a more hearty co-operation between the Allopathic doctors and those who practise the Indian systems of medicine, Dr. Lakshmanaswami Mudaliar merely gave expression to his sentiments that it was inevitable and advantageous to the country at large that the votaries of both systems worked without conflict of ideals and interests, but he did not lead his hearers how such a harmony could be brought about practically. The practitioners of other systems do associate and are associating themselves with their brethren in the allopathic system without any difficulty and the latter accomodate them as well when it serves their purposes, but what they claim from their allopathic brethren is a recognition of such harmony by a statute. We could say with some authority that none of the members of the Madras Medical Association who represent them in the Madras Medical Council did relish this idea much less others in the allopathic system including amongst them a Patron of the Association of Students of the School of Indian Medicine. Perhaps if Dr. Lakshmanaswami Mudaliar was in the Madras Medical Council, matters would have been otherwise and we have tangible proofs of the sincerity of purpose of Dr. Lakshmanaswami Mudaliar, who later in his address touched upon the necessity of abolishing the existing grades in the medical education which he said in strong terms was bound to be "detrimental to the best interests of the profession at large". We are glad

to mention that at the instance of Dr. Lakshmanaswami Mudaliar, the Board of Studies of Medicine of the Madras University of which Dr. Guruswami Mudaliar is the Chairman at present, is considering the solution of this very difficult and urgent problem which did not attract the attention of others in similar positions in the Madras University years ago. It is a most happy coincidence that the views expressed by us in these columns and elsewhere that the universities in this country should allow facilities to the Medical Licentiates to qualify themselves for University degrees at least in the way it is being done in England ever since the Licentiates came into existence, are being given effect to. We trust the Madras University authorities will accept the proposals of Dr. Lakshmanaswami Mudaliar and bring about the necessary reforms in the interests of Licentiates who are now forced to go to foreign countries and spend large amount of money. By the way we expect that this piece of reform will not deter those concerned and slacken the speed in bringing about the much more needed reform of increasing the course of studies in the Medical Schools from 4 to 5 years.

Dr. Lakshmanaswami Mudaliar's proposals in the field of development of the medical profession in this country are as sound as they are praise-worthy. He is for introducing tutorial system in the teaching institutions which is sure to benefit the weaker section of the student population. For the benefit of those who have already entered the profession, he advocates the much needed post-graduate studies. To stimulate research he appeals to Government to establish scholarships and suggests to the University the necessity of introducing Ph. D. and D. Sc. degrees which he opines and rightly so, will serve as "an incentive for our young men to enter the field of medical research."

Ethics did not escape the attention of Dr. Lakshmanaswami Mudaliar. He said that high ethical standards were as much in the interests of the individual as that of the profession. We will go a step further and say what we have been repeatedly pointing out in the columns of this journal that the observance of rules of Medical Ethics are more to the interests of the patients than those of the medical profession. This and other items which were the subjects of Dr. Lakshmanaswami Mudaliar's theme, have been and will continue to interest "The Medical Practitioner" and he and others like him will have our unstinted support. All the same we wish to point out to Dr. Lakshmanaswami Mudaliar and his Association that there are as many and even more other items requiring solution, the most important and glaring amongst these being the policy of supression adopted by the successive heads of the medical department under the plea of efficiency.

If such a policy of indiscriminate supersession were to continue unchecked and unnoticed it will certainly have undesired effects and retard progress and harmony among the members of the Madras Medical Association. Appeals from individuals aggrieved to the proper authorities are likely to have adverse effects, for instances are not wanting when those who complained even indirectly were declared unfit after the date of supersession. It is the legitimate duty of the Madras Medical Association to guard the interests of its members in the true co-operative spirit "one for all and all for one."

The more we think the more we are convinced that even the future of the independent medical profession depends in a way on service men. The good will, influence and patronage they are able to command while in charge of State Hospitals cannot fade away and may as well be counted upon even after retirement from service. The South Indian Medical Union owes its birth to a retired Civil Surgeon Dr. C. B. Rama Rau who continued to be its President till he left Madras for good. The present President is Dr. S. Rangachari, yet another retired Civil Surgeon who is the tower of strength to the independent medical profession in this city. After the 55th year every member of the Madras Medical Association automatically becomes a member of the independent medical profession and *ipso facto* ceases to be a member of the Madras Medical Association. The larger interests of the country require that not only the water-tight compartments in service and outside should be put an end to but also that the curative side of the medicine should be controlled entirely by the members of the independent medical profession.

Under the circumstances will it be too much for us to appeal to the Madras Medical Association to join hands with

their brethren outside the service till both the sections of the profession in one voice request the Government to stop further recruitment to medical service on the curative side. Then only the high ideals inculcated in the thought-provoking inaugural address of Dr. Lakshmanaswami Mudaliar can be realised. Such a step in the right direction will not in any way interfere with the prosperity of those who are already in service and who are members of the Madras Medical Association.

Two Wrongs to Right one: Supersessions seem to be the order of the day in the Madras Medical Department. While several are perhaps in contemplation in addition to past ones, the Fort St. George Gazette publishes the promotion of an Asst. Surgeon to the rank of a Civil Surgeon superseding nearly 17 Asst. Surgeons above him. The ostensible grounds that have been very likely put forth, must be Military Service but the fact seems us to be that this new Civil Surgeon's claims were overlooked when some transformations of young Asst. Surgeons to Civil Surgeons took place soon after the Vizag. Medical College came into existence, on the theory that Asst. Surgeons as such cannot teach unless they are ranked as Civil Surgeons. So, in 1926 an Asst. Surgeon of only one year's standing was made a Civil Surgeon to teach Chemistry in Vizag. Medical College as he happened to be a graduate in Chemistry. It was not possible for those who were in Surgeon-General's Office in 1926 to find out in the Civil Medical List that there was another Asst. Surgeon who was also a graduate in Chemistry and who entered service as Asst. Surgeon in 1912 and hence, of 13 years service. To set right this injustice yet another supersession takes place though this cannot be as glaring as several others that have taken place, the present incumbent having put in at least 18 years of meritorious service in the Civil Medical Department. In no other Departments of Government service such supersessions are in vogue. Any number of superior or additional qualifications do not count for promotion except merit and service. When two candidates of equal merit and service compete for a higher appointment when it is due and if one of them possesses higher qualifications or has done meritorious work in other fields, then only should his higher qualifications be taken into consideration.

A Lady Asst. Director of Public Health has become an accomplished fact. Though this is one more item to a deficit budget for the next official year. It is a distinct victory of which the Indian Women Association can be glad. The Madras Corporation or at least the Child Welfare Department of it will naturally be proud that their old Superintendent is the first lady to enter the Public Health Department of the Government. This lady was exerting such an influence while under Corporation service that the Head of her Department, the Health Officer was eclipsed. Abruptly she chose to be a tutor to the lady students in the Madras Medical College an appointment newly created at the time. She resigned this appointment and went to Ceylon and became once again a member of the Child Welfare Department in that country, which appointment also she did not like after some time and came back to Madras. In the meanwhile, the Madras Government was very anxious to get a right sort of person for this unique appointment. They had more than one lady doctors in service with public health qualifications one of them a Fellow of the Royal College of Surgeons and was specially deputed by Government to study ante natal and child welfare work. Yet they thought it necessary to advertise for the new job of the Lady Asst. Director of Public Health. We learn that there were more than 50 applications out of which a good number possessed foreign qualifications of high order. It appears to us from our experience of other appointments in the Medical Department that the final choice did not rest with the Surgeon-General. Whatever might have been the antecedents of the new Lady Asst. Director as the once Superintendent of the Maternity and Child Welfare Scheme of the Madras Corporation, the experience gained by her under Corporation service as seen in the Corporation reports must have weighed most with those who were responsible to make the final choice at the Secretariat. It is said that the Lady Asst. Director of Public Health will have very little executive work. Her only business seems to be to advise the local bodies. Will this advice go through the Director of Public Health or direct it is too early to say now.

Infant Mortality in the City of Madras: Dr. Lakshmanaswami Mudaliar read a paper on some aspects of the

infant mortality in the city of Madras at the last Provincial Health Conference, Madras, and with the help of statistics proved that the maternity and child welfare work in the city has not been responsible in cutting down the infant mortality as in other civilised countries and that the reduction of infant death rate has been only about 4%. He also pointed out that in well organised centres of work in the West the infant mortality was less only in places where scrupulous care was taken about sanitation and in the improvement of the social and economic conditions of the people all of which he said were in a very unsatisfactory condition in the city and consequently the child welfare work did not yield good results so far. He advocated the immediate necessity of improving housing conditions, necessity of good and wholesome supply of milk by the Corporation, a better control over markets and foodstuffs. The Corporation is yearly spending over Rs. 2.00,000 on maternity and child welfare work and even this work is not as well organised as it ought to be. From the point of view of the public, this and other similar schemes are the white elephants thrust on local bodies by well meaning and rather fussy women in high position. If the Madras Corporation spend Rs. 2,00,000 every year in dwelling houses for the poor with all comforts of modern sanitation, municipalised markets, organized dairy farms for the supply of milk, improved water supply and conservancy, infant as well as general mortality would have been much less than what it is to-day. In Western countries maternity and child welfare work came last as a means of lessening infant mortality, after everything has been done regarding sanitation and other allied items, but in our country we are neglecting the elementary needs of sanitation and keep the white elephant schemes in prominence so as not to displease anybody in Government houses where these schemes serve the purpose of a pastime.

An Announcement : Elsewhere in this journal is published an announcement regarding the opening of an X-Ray department which will also include all up-to-date appliances necessary for Electric-Therapy. We trust that Dr. M. K. Sambasivan, M.B.B.S., will not charge us for unfaithfulness if we release further news regarding this plaudible venture of a member of the independent medical profession who, in spite of inherent difficulties now existing against progress and prosperity due to the existence of another separate yet powerful rival entity in the form of Government-paid private practitioners, has been able to push himself to the forefront and that in a moffusal station within a brief period of seven years. Our readers, at least will, we hope, appreciate our purpose in divulging the authorship of this announcement which we do much against the wishes of Dr. Sambasivan. Dr. Sambasivan will certainly serve as an example to the rising younger generation in the profession who are struggling hard to get into Government service. We trust that the members of the profession in southern districts will co-operate with Dr. Sambasivan and benefit themselves and their patients by availing themselves of his services in this his special venture and we on our part congratulate this young, energetic rising doctor and send him our goodwishes in advance.

Cross and Downward Puzzle : May we refer the kind attention of our readers to a table exhibited elsewhere in this journal which will interest them during their leisure hours and bring the luckier amongst them prizes of no small value including a Sight Testing trial case etc. and smaller consolation prizes. Entry into the field of competition costs them only a rupee, an amount worth risking, as apart from the hopes of getting prizes, the solution of the puzzle is sure to refresh their memory regarding many medical terms in vogue in the profession. We wish all who enter the field of competition luck and shall announce the result in these columns as stated in the announcement elsewhere regarding this puzzle.

The New Chief Medical & Sanitary Officer, Cochin State : Dr. D. Raghavendra Rao, M. R. C. S., L. R. C. P., succeeds Diwan Bahadur Dr. V. Verghese, L.M. & S., as the Chief Medical and Sanitary officer, Cochin State. Dr Rao is an old boy of the Royapuram Medical School and passed out with a brilliant career. Being one who received stipends from the Madras Government, he had to serve the Madras Government which he did for a brief period and got into Cochin State service as a Sub-Asst. Surgeon. Dr. Coombes, the then chief Medical Officer of the

Cochin State took a fancy for Dr. Rao for his abilities all round and encouraged him to go to England for higher studies which Dr. Rao did at his own cost. After his return from England where he qualified himself for the Diploma of M.R.C.S. and L.R.C.P., he served as an Assistant Surgeon and later as Civil Surgeon, Trichur. It has to be said that Rao and the retiring chief Medical Officer were not pulling on well and Dr. Rao had his own troubles. After all merit and service cannot but be recognised at least by those with an unbaised mind and we congratulate Mr. Herbert the new Dewan of Cochin more than Dr. Rao himself in promoting Dr. Rao as the chief Medical and Sanitary Officer, a position which was long overdue to Dr. Rao but for the intervening period of Dr. Verghese's regime. Dr. Verghese after serving the British Government and retiring as Civil Surgeon had enough vigour and health to be at the helm of the medical department in Cochin which responsibility he must have discharged to the entire satisfaction of the State and the public in Cochin. We hope Dr. Rao will steer clear out of Cochin politics minding nothing else excepting the most onerous duties of relieving human sufferings in his dual capacity as a curative as well as a preventive officer.

Sub-Assistant Surgeons as Assistant Surgeons : The members of the I.M.S. are solely responsible for the creation of this grade of medical men who outside service are now styled as L.M.Ps., both sections being called till a few years ago as the Hospital Assistants. It is to be said to the credit of I. M. S. service in general that they alone more than others in service or outside appreciate the merit of this hard working and useful members of the profession. The two special institutions in the city of Madras, the Government Ophthalmic Hospital and the Government Hospital for Women and Children presided over distinguished members of the I. M. S. could see what was inside the humble frame of the Sub-Assistant Surgeons. They have been giving practical proof of their vision by recommending to the authorities the necessity of recognising their services—both to the state and to the public—by promoting them to the rank of Assistant Surgeons. Our readers must be aware that Dr. T. Venkatarangam Naidu who spent the major portion of his service in the Government Ophthalmic Hospital has been recently promoted as Assistant Surgeon in the same hospital. Only a couple of years ago Dr. Muthiah was the recipient of a similar distinction but—alas! he did not live long to enjoy the benefit of his hard labours in the same institution. The members of the Provincial Medical Service who are now occupying the positions formerly reserved for the I. M. S. only, all of whom our own countrymen, will, we trust, follow the noble example of those whom they have been lucky to succeed and recommend to those concerned the advisability and the necessity of recognising merit in the Sub Assistant Surgeon even without additional qualifications.

Dr. Lakshmanaswami Mudaliar has given a lead as referred to elsewhere though in another field. He is against the existence of water-tight compartments. Practical demonstrations will be appreciated most gratefully. By the way the postman puts on our table the January issue of "The Madras Medical Journal" which we hastened to open and read. Our theme of work being of different order in medical journalism we are naturally attracted to matters such as "Association Notes" and we were glad to observe that the term Madras Medical Service "shall mean and include all Civil Apothecaries, Civil Assistant Surgeons and Civil Surgeons (Provincial) in Government employ and gazetted officers of the Public Health Department. May we suggest to those who govern the destinies of the Madras Medical Association that the exclusion of the Sub-Assistant Surgeons in the new category is not in keeping with the spirit of the times and certainly against the sentiments expressed by their President in his inaugural address. It looks as if these untouchables got themselves sanctified, the moment they become Asst.-Surgeons as does a Hindu Pariah if he gives up his faith in which he was born and takes to Christianity or Muhammadanism. Medical Societies can certainly shine better by examples than precepts.

Legitimate Grievances : We have been addressed by a large number of L. M. Ps. requesting us to bring to the notice of the authorities through these columns that the period of service of rural medical practitioners should be recognised *in lieu* of the House Surgeon and House Physician courses required by the Madras

Services Commission for appointment to the posts of Sub-Assistant Surgeons. It would have been most apt that in the matter of selection to technical services such as Medical, Engineering, etc. the co-option of a member having the knowledge in the particular lines, was made possible. If it were so, the Madras Services Commission would have had the sagacity of allowing subsidised rural medical practitioner's amongst the L. M. Ps. to apply for the post of Sub-Assistant Surgeons. We did suggest to the Secretary of the Madras Provincial Rural Medical Practitioners' Association to make this a subject of discussion at the last Provincial Conference of the rural medical practitioners at Madras and we are at a loss to understand why this subject escaped the notice of those concerned.

We are informed of yet another grievance. The unemployment of a large number of medical graduates who are naturally nervous to start private practice in the present state of the profession, has naturally forced many of them to apply for the post of Sub-Assistant Surgeons. Ordinarily preference is bound to be given to graduates. In the present state of medical education, for which the Government is more responsible than anybody else, it will be scandalous to open the water-tight compartment of L. M. Ps. to graduates. Both the above grievances can be redressed by Surgeon-General Sprawson. He should guard the interests of all the existing sections in the profession and his dual authority as Head of the Medical Department and as the President of the Madras Medical Council will certainly be taken advantage of by those aggrieved directly or indirectly and we appeal to Major General Sprawson to give this matter his sympathetic attention.

The All India Medical Licentiates' Association : It is most regrettable that the Annual Conference of this Association was not held anywhere after 1929 in which year they met at Lahore in March. "The important information about the Conference in 1930," in the pen of the General Secretary and appearing in the December issue of the official journal of this Association, shows that the General Secretary Rai Saheb Dr. Ram Narain Lall has done his portion of the work in this direction quite satisfactorily ; but we cannot absolve the members of the Representative Committee of their callous attitude in not providing funds to hold the Conference in Mussorie as suggested by the General Secretary as a last resource for fulfilling the obligation under the rules of the Association, which make it obligatory on this body to call in a Conference at Bombay in case the same was not invited by any of the provincial branches. The present political situation instead of being used as a barrier to shield their responsibilities, ought to have stimulated this responsible and representative body to hold the Conference at any cost especially at a time when the prestige, if not the life, of the medical licentiates is at stake, as all concerned thought it fit to exclude their representation in the proposed All India Medical Council.

We trust the members of the representative Committee who should have the interests of the future prosperity of the Licentiates at their heart, should rise to the occasion and celebrate the Silver Jubilee of the Association in whatever place convenient, in a most fitting manner, so that it might not be said at a future date that the cause of the Licentiates failed for want of agitation which cannot be done more efficiently and effectively than by the united efforts of the whole Association.

Graduates as Sub-Asst. Surgeons : After we have gone to the press, we received a communication on this subject from the Surgeon-General which is published on page 185 of this issue.

MENTAL EXERCISE FOR MEDICOS.

FIRST PRIZE FOR THE FIRST CORRECT ENTRY OPENED.

Optical goods for refraction work consisting of a Trial Case, an Ophthalmoscope (Electric) Test Charts, etc.—One set.

Consolation prizes will be given for others also who send correct solutions, according circumstances. The decision of the undersigned is final regarding prizes and other details.

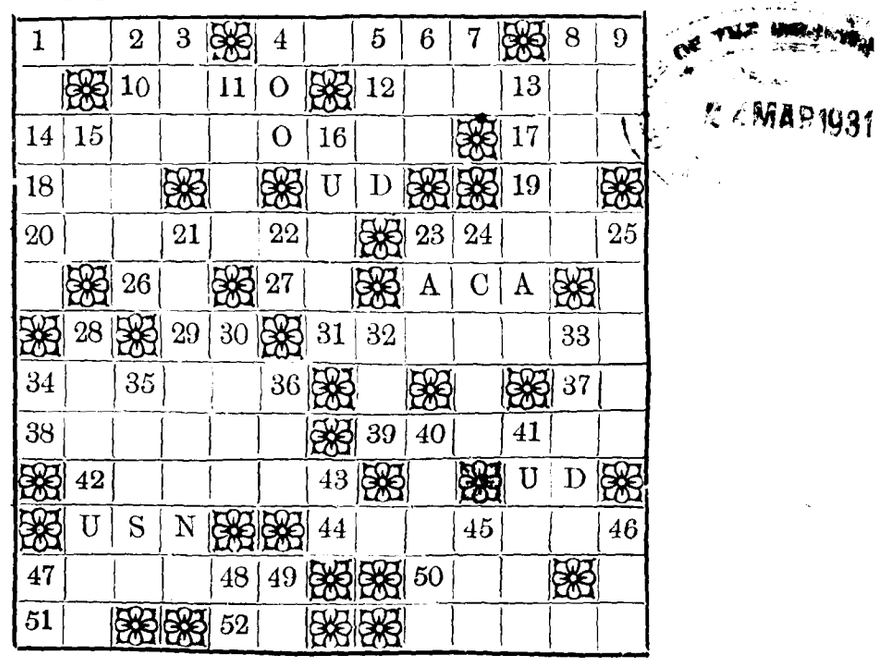
One Rupee per entry.

Closing date 31—3—31. Results will be published in the April issue of this journal.

Reference: Gould's Practitioners' Medical Dictionary.

Entries and remittances to be addressed to :—

THE MANAGER, MEDICO-SURGICAL HALL, KARUR, S. I. RAILWAY.



Across.

1. The phenomenon preceding an attack of Epilepsy.
4. A branch especially of a vein, artery or nerve.
8. Abbreviation for hora somni.
10. A prefix denoting within, inside.
12. Synonym of fasting.
14. The production of permanent colours in the skin by the introduction of foreign substances.
17. To corrode.
18. A prefix signifying upon.
19. Abbreviation for Registered Nurse.
20. Name of a strong pair of forceps for breaking off pieces of bone, especially in enlarging a trephine opening.
23. Relating to, due to, or consisting of vapour. (Reversed)
26. Abbreviation used in prescriptions to denote repetition of the same quantity for each item.
27. Same as 26.
29. Chemical Symbol for Niton.
31. A tubular channel or passage.
34. A pricking or stinging sensation.
37. Abbreviation for Master of Arts.
38. A preparation containing mercury and sodium amido-oxybutyrate.
39. A proprietary preparation used as a sedative and hypnotic.
42. A trembling of the voluntary muscles.
44. Any rounded eminence such as occurs in the joints of many of the bones, especially the femur; Humerus etc. (Reversed)
47. The buttocks.
50. A wry mouth, grimace.
51. Chemical symbol of samarium.
52. Non-secretion or imperfect secretion of milk after child birth.

Down.

1. One of the tube like vessels through which the blood is propelled by the heart to all parts of the body.
2. The delicate membrane of the eye representing the terminal expansion of the optic nerve.
3. Prefix to compound words signifying opposed to, against etc.
5. The understanding.
6. Abbreviation for unguentum.
7. Chemical symbol of selenium.
8. Yawning, gaping, opening by a fissure.
9. Abbreviation for saturated.
11. The normal state of tension of a part or of the body.
13. Pertaining to the skin.
15. A prefix denoting from, away separation.
16. Medical name for caraway (Reversed)
21. *Mortification or death of a part of the body* from failure in nutrition.
22. Chemical symbol of gold (Reversed)
23. A vessel for holding or carrying liquids with a handle over the top, generally made of tinned iron.
24. An ordeal poison with action similar to Nux Vomica obtained from the stem of strychnos Ieaja.
25. An organic arsenic preparation consisting of vegetable protein with about 4 per cent. of arsenic.
28. A mixture.
30. To shed or cast, as the skin, feather, or hair (Reversed)
32. An enlargement at the end opposite the ampulla of a bony canal of the labyrinth of the internal ear.
33. A prefix denoting an Imide.
34. Chemical symbol of Tantalum.
35. To care for the sick or for an infant.
36. The planter surface of the foot. (Reversed & head cut off.)
40. Abbreviation of Amygdala (Reversed)
41. A spectacle lens.
43. Abbreviation for right eye.
45. A species of fish from the liver of which a medicinal oil is extracted (Reversed)
46. Abbreviation for Anodal closure contraction (Reversed)
47. Abbreviation for Bachelor of Surgery.
48. Chemical symbol of calcium.
49. Chemical symbol of mercury.

Correspondence, Reports, etc.

LETTERS TO THE EDITOR

THE BRITISH MEDICAL QUALIFICATIONS AND LICENSED MEDICAL PRACTITIONERS

BY

DR. D. SIVASUBRAHMANIAM, M.R.C.S. (*Eng.*), L.R.C.P. (*Lond.*),
Medical College, Vizagapatam.

Ever since I returned from England I have been answering a lot of queries regarding this subject from medical men passed from the Royapuram Medical School, a large number of whom being my own students. A few days ago, Dr. V. Rama Kamath our enthusiastic representative in the Madras Medical Council, sent me an urgent request to put in writing all the necessary information which is likely to be useful to such of the Licensed Medical Practitioners either in service or outside, who intend going to England for higher medical studies. I am thankful to Dr. Kamath for giving me this opportunity of letting know my brethren my experiences in England in a comprehensive way which I trust will be useful to them. While in England, I have noticed some of the Licensed Practitioners undergoing considerable amount of difficulties and inconveniences, a few actually drifting on account of their going there without correct and reliable information, especially regarding entrance. I have ventured to narrate as briefly as possible all the necessary details regarding entrance, study, cost of passage, living, etc.

EXAMINING BODIES: I must straightway acknowledge the various facilities afforded for the L.M.Ps. by the various Licensing bodies in England (denied to them in their native land) and particularly the Conjoint Board of Examiners for the Royal College of Surgeons of England and the Royal College of Physicians of London. All L.M.Ps. and others who wish to proceed to England for higher studies should beforehand, communicate with "The Secretary, The Conjoint Board of Examiners, 8–11, Queen Square, Bloomsbury, London, W.C. 1." There is no use of simply proceeding abroad with the hope of I will manage somehow." However reasonable and accommodating the Board may be, which they are always are there is a limit beyond which they cannot go, and it will be very annoying if one gets stranded in a foreign land.

The regulations are constantly changing and as far as I am aware the latest regulations are as under:—

PRELIMINARY EDUCATIONAL QUALIFICATIONS: All L.M.Ps. should take a preliminary educational qualification if they are not already Intermediates of any of the recognised Indian Universities and the following are some of the recognised examinations which could be passed with a certain amount of exertion and coaching wherever necessary: (1) Cambridge School Certificate (Higher) examination, (2) Oxford School Certificate examination, (3) The College of Perceptors Senior examination. The details about these examinations can be had either from the Director of Public Instruction, Madras, or from the District Educational Officer, Madras. It is always desirable and economical if these examinations are passed in India prior to sailing as otherwise it would mean an additional stay in a costly city like London which many of us cannot afford.

COURSE OF STUDY: After passing the required preliminary examination, an L.M.P. is expected to pass an examination in Anatomy, Physiology, and Pharmocology, (Anatomy includes Embryology and Histology, Physiology includes Bio-Chemistry and Histology). Anatomy and Physiology constitute Part I, and Pharmacology Part II. The two parts can be taken separately. As the regulations stand to-day, from the date of passing Part I, two years' attendance, at a recognised hospital and medical school, is absolutely necessary before the final examination is completed. Within this period Pharmocology can be finished. The final examination includes Pathology written and practical, Medicine including Medical Jurisprudence, Hygiene and Public Health, Diseases of children, Medical Pathology and Medical applied Anatomy; Surgery including Surgical Anatomy, Surgical Pathology, Ophthalmology and venereal diseases; Midwifery including Gynæcology and Gynæcological Pathology For those medical students who commenced their studies in any medical school before 1923, no separate examination in Pathology need be passed, but they will have however to pass in Medicien Surgery and Midwifery.

It was the practice till lately that L. C. P. Ss. were allowed to put in only one year's hospital attendance (instead of two years) and sit for the final examinations, *but this concession has since been withdrawn* and both L. M. Ps. and L. C. P. Ss. get the same concession at present. The final examination subjects can be taken either separately or in groups, depending upon the capacity of the student. The fees for all the examinations are £ 42.

I would like to warn all regarding the preliminary examination. The Secretary of the Conjoint Board should be written to before hand about the various 'subjects-combinations' proposed by the candidate and he should approve of the same. It is in cases of vernacular this difficulty particularly arises and very often the board is accommodating.

ADMISSION IN A MEDICAL SCHOOL: Having made myself clear so far, the next point I wish to stress is the admission in a Medical School. Let me emphasise that it is not at all necessary that the course should be put in only in a London Hospital. The same could be completed in any of the hospitals with a medical school attached, in any part of the British Isles. Though I was fortunate enough to secure admission in one of the biggest hospitals in the British Empire "The London Hospital Medical College, London"—thanks to the very generous Dean Professor, William Wright, M. B., D. Sc., F. R. C. S. The largest number of Indian students will be seen in this College—many of my friends have been, and are still prosecuting their studies in the Provinces. Every hospital has got its own big man and one cannot possibly 'pick and choose'. Pecuniarily it is advantageous if a seat is secured in a medical school in the Provinces—Birmingham, New-Castle-on-Tyne, Manchester, and Leeds are very obliging regarding accommodation of coloured students.

All the hospitals in England are managed by private donations and there is absolutely no obligation that they should accommodate any coloured student. It is only a moral obligation and to the great credit of the Britisher, it must be said, that whenever accomodation is available, it is never refused. My information is 2 per cent. of the total number of seats are reserved for coloured students which of course include various nationalities, Indians, Japanese, Chinese, Egyptians, etc. As there is a large number of students pouring in every year, and as the admission is restricted, it is getting more and more difficult to secure admission in the medical schools. In this connection, I was talking to the late General L. B. Smith, I. M. S, the former Medical Adviser to the Secretary of State for India in the India Office, London, and he was telling me that he could not secure admission in London for his own nephew, whom he had to send to the Provinces. I am writing this to point out that there is absolutely no racial bias in the matter of admissions, but only paucity of seats available. Every vacancy caused when an Indian student qualifies, is reserved again only for an Indian student. Soon as a candidate decides to go abroad, he must communicate with the Dean of several medical schools in London and in the Provinces. Some may refuse straight, while some others may register the applications, but no one will promise a seat beforehand. It all depends upon the candidate's personal interview with the Dean or the Selection Committee as the case may be, and should the interview prove satisfactory, admission will be granted. This is a handicap to L. M. Ps. in Government service as one of the conditions for the grant of the study leave, is said to be that admission should be secured beforehand. As per the rules current in London no seat is assured in advance. Even when an applicant proceeds through the High Commissioner for India, all that could be gained is a very courteous reply registering the application and nothing more. I am aware this rule is very sympathetically observed by all the Surgeons-General in Madras and the Sub-Assistant Surgeons should be grateful to them. These are all the essential points and none can be possibly ignored. Ample facilities are afforded for the students when once admission is obtained. There is absolutely no difference in treatment between an Indian student and an English student. Everyone is treated alike whether in the Wards or in the Lecture theatre or in the common room. If anyone says otherwise, I can only say that he is talking 'through the hat.' The Indian student who goes to England should realise that he has to be on his best behaviour, for through him is judged the rest of his community. I can confidently say that so far every Indian student has been known for his politeness, courtesy and gentlemanly behaviour.

COST OF LIVING: This is a very important item and one should cut his coat according to the cloth. For a comfortable living (not a luxurious living), in London, including an occasional cinema and theatre, the expenses will work out to about £16 to 17 per month in London, and £2 to 3 less in the Provinces. This is quite a moderate estimate consistent with the necessary comforts for preserving health in a foreign cold climate. This does not include college fees which will be £40 to 50 depending on the hospitals. I give below details for a year in London:

Boarding and lodging	...	£	210
Hospital fees	...	,,	50
3 Holiday trips in a year	...	,,	15
Renewal of clothing and miscellaneous	...	,,	5
	Total...	£	280
For two years	...	£	560
Examination fees	...	£	42
	Total...	£	602

Working it at Rs. 13-8-0 per pound, it will be Rs. 8,127 or Rs. 8,200 roughly. As I already said, a stay in the Provinces will be a few pounds less which when worked out for 2 years will effect considerable savings in the budget. I would suggest that a minimum of Rs. 8,000 for 2 years stay in England, exclusive of passage, is absolutely essential (I have taken these figures from my own experience and am open to correction.)

PASSAGE: Very many students are not aware that there is a third class service to England. (This 3rd class service should not be confused with the 3rd class deck service of the Rangoon and the Strait mail steamers. This consists of a regular cabin accommodation with either 2, 3 or 4 berths in a cabin. It is quite comfortable and I am sure every L.M.P. or any Indian student unless he has money to throw about can comfortably travel in 3rd class to London. Not being aware of the existence of a 3rd class service, I had very nearly booked 2nd, which I subsequently converted into third and thereby effected a saving of about Rs. 200 each way. The Oriental, Commonwealth the Rotterdam Line Steamers, etc., all carry third class cabin passengers. Details may be had from Messrs. Thomas Cook & Son Ltd., Madras, or any Shipping Agents. The cost of a single 3rd class passage to London varies from £27 to £32, inclusive of board. Whereas a 2nd class, varies from £48 upwards. There is an educational supplement published by the High Commissioner for India every year giving very many particulars (available in Higginbothams, Madras.) and I will in a subsequent communication give an account of the facilities rendered by the High Commissioner for India for students abroad, and a few odds and ends useful for prospective students.

Besides the L. R. C. P. and M. R. C. S. qualifications there is the L. M. S., S. A. of London which is also a registrable qualification and equally entitling the holder for promotion as Civil Assistant Surgeon. Regulations are more or less on the same lines as for the L. R. C. P. and M.R.C.S. and particulars can be had from the Master, the Society of Apothecaries of London, London, E.C.

Antistreptococi Serum in Puerperal Sepsis

BY

DR. G. RAMASWAMY, L. M. & S.

174, Greek Street, Rangoon,

Patient Mrs. R., aged 23 years, 3rd para.

PAST HISTORY:—Previous confinements normally sprue for the last 2 years off and on.

PRESENT HISTORY:—Prolonged labour, Second stage about 6 hours; attended by a qualified midwife; healthy female child delivered. Nothing unusual. Complaining of much exhaution.

SYMPTOMS:—The patient complained of a severe rigor on the second day at 9 P. M. and the temperature was 103° F with a pulse rate of 140. There was profuse sweating and the thirst was very severe. As soon as I saw the patient Pituitrin 1 c. c. was administered and for weakness camphor in oil 1 c. c. was given hypodermically. The patient complained of much pain in the hypogastrium and pent up lochia was suspected. It was deemed expedient not to interfere with the patient at night. So a copius warm douche was given (weak condy's). The next morning the temperature was 102.4; the vaginal examination showed slight cervical tears and much bruising (as the second

stage of labour was prolonged). There was very slight discharge, still vaginal douche was given three times a day. The quantity of lochia was appreciably small and the patient looked very ill with the face pinched and jaundiced, eyes sunken, and the angles of the mouth drawn. The evening temperature was 105°F; immediately 10 c. c. Anti-Strepto-coccus serum was administered, and ice applied to head. The patient was put on the usual quinine and ergot mixture. After 2 hours, the temperature came down to 103, and the patient slept well. Next morning, temperature was 102; but it went up to 105 with rigor and sweatings. Malaria was suspected and 10 grs. quinine bihydrochlr, was administered intramuscularly. The temperature fell to 103 but was steady. Next morning, a mild dose of sulfarsenol (18 ctgr) was given intramuscularly ; and after this injection, the patient was normal for two days, and when the temperature again shot up to 106° F. in the evening, Anti-strepto Coccus Serum 20 c. c. was given and after this injection, the temperature came down to 102—in three hours.

In view of the rise of temperature on alternate days, I thought it better to give 10 c. c. Anti-Strepto Coccus Serum every day for the next 2 days. The patient rallied under this treatment and now she is in normal health.

On a reference to the literature on the subject, the above picture is typical of puerperal septicaemia or lymphatic sepsis. There are many views as to how the polyvalent Serum acts in these cases. This case clearly shows it is anti-toxic, as the temperature invariably comes down to 102 in 2 to 3 hours, after administering serum. This agrees with Foulerton's views with regard to Serum treatment.

A word is necessary about sulfarsenol. In two of my previous cases, Burmese ladies who suffered from puerperal fever, this drug had a marked action, and in those cases polyvalent serum was not resorted to. But an element of venereal disease was surely present in those cases. I am of opinion, that in venereal patients who are suffering from puerperal fever, sulfarsenol acts wonderfully ; whereas in other cases of sepsis especially when the endo-metrium is infected by strepto-coccus, it is not of much value.

The Typhoid problem as it affects, Egypt

REPORT IN "LA BOURSE EGYPTIENNE"

BY

DR. MAURICE GELET.

With the approach of the warm season typhoid and paratyphoid fevers, endemical to Egypt, take the form of an epidemic sometimes capable of attaining alarming proportions. Moreover the sources of infection in Egypt are numerous, and often in spite of all the measures of individual hygiene, practised after all only in certain places, the malady has a constant tendency to spread. The general hygiene, such as imposed and practised by the state, does not exist, so to speak ; there is little or nothing of supervision in alimentary matters, no control on itinerant dealers: in short there is no general prophylaxis.

Then in spite of all the attention which can be taken by one who wishes to live hygienically, nothing or next to nothing, protects one against the imprudence, the uncleanliness, or the negligence of others, You can, in your home pay attention to everything, wash your fruit, boil your milk and salad, exercise on your servants a scrupulous supervision ; but nothing will protect you against your bakers or your milkman, to mention only the most ordinary examples. You will tell me that the bread is baked, and that it allows of no risk. A mistake: You know that there are germ carriers and to what point they threaten our existence. The baker's boy who carries your bread each morning has just had fever. He has scarcely recovered, but, to earn his living, he re-commences his work. If we analyse his stools to-day, we will find them full of typhoid germs. And you know his habits: He goes to stool like everyone else, but generally he forgets to wash his hands. And with his dirty hands he handles the bread which he delivers to his customers, and which you eat with every confidence with your eyes shut, because you say it is baked and that it is purified by the fire. And thus it is that the baker's boy can, without knowing it himself and without wishing it, carry typhoid germs into a hundred or so of houses. I have been

told by a colleague of a case of a milkman having two children infected with tyhoid, and who, in continuing to deliver his milk infected the whole of a small locality.

I assure you that these examples are not uncommon, and that they constitute without doubt the most important factors of infection. And when one thinks of the dangers of Typhoid fever, of the very great risks which accompany the malady of this affection of which the issue is always doubtful, it seems, that our duty as doctors is to inform the public of this genuine prophylactic. I shall not speak to you of general hygiene ; I have often said already how far we are behind other nations and how difficult the work of our sanitary service is where cleanliness is a relative thing and often impossible.

It remains for me then to speak of individual and family Hygiene, about which I shall say only a few words ; It is necessary for each of us to try to live most cleanly in order to evade infection, to inspect our food more so in summer than in winter, a time when the tendency of intestinal infection is greatest. But this is not enough. The only really efficient way is anti-typhoid vaccination. It is with this vaccination that one can stop epidemics at their onset in schools, in barracks, in public establishments and above all, where there is an agglomeration of people. During the last war it was vaccination which prevented the African army from being destroyed by Typhoid.

Anti-typhoid Vaccination is used by two different methods, *i.e.*, by hypodermic and by mouth. In this article which is addressed to the public, I shall say that vaccination by injection depends upon the Physician, and that it rests with him to decide whether or not to use this method. I shall point out that the injections are followed by a local reaction consisting of several phenomena of congestion and by a general reaction in which fever may reach 39° to 40°. Is this general re-action absolutely without danger ? No. And it is precisely because of this that one never vaccinates anyone without first having minutely examined chiefly the lungs, heart and loins. And when one considers that the statistics of the two methods (Injection and by mouth) are exactly the same, one sees no reason not to accord preference to the method by mouth, the simple method, the one without danger and giving no trouble to everyday life. There exist several anti-typhoid vaccines administered by mouth, one of which, Enterovaccine-Anti-typhoid Polyvalent Lumiere, I have used upto date in more than two million vaccinations. Thus having this practise and experience I shall speak more readily yet by no means disputing the efficacy of other vaccines.

Entero Vaccine Lumiere consists of keratin coated pills, containing typhoid, paratyphoid and Colibacilla microbes. The dose of 28 pills, taken two twice daily for a period of seven days is a sufficient dose for the vaccination of an adult person. The duration of this immunisation is from 2 to 3 years. For infants under 7 years, 14 pills taken two twice a day over a period of 7 days is sufficient. Evidently vaccination of children is not possible when under three years of age. At the age of 3 they can swallow one pill. From my personal experience I find that it is preferable to give them only one pill a day for fourteen days, two hours before or after food. (Food should not be given for two hours before, nor two hours after a dose).

Certain people and alas, even certain doctors with little information on the subject, doubt the efficacy of Entero Vaccine and in general vaccination by mouth. If such doubts were justifiable, Vaccination by mouth would not hold such a high place in practical medicine to-day. After all, all the statistics published to-day show in a distinct manner the remarkable results obtained by this method. The most sceptic can be appeased with such evidence before them. I could quote a large number of epidemics checked by the use of Entero Vaccine, but I shall be pleased to mention that the point in question is that of a method officially sanctioned and adopted in France by the military office of health and by the Minister of the Colonies. Can one say that vaccination by Entero Vaccine can ward off for certain 100% typhoid fever? Affirmation would be equally erroneous: Exactly as for vaccination by injection, vaccination by Entero Vaccine does not immunise in the proportion of 100 for 100. It is the same for all methods of vaccination after all. Let us not forget it. The Doctor ignores the absolute. But the percentage of failures in general is so small that it is not worth mentioning. Still further the

uncommon cases who have been vaccinated and who have had Typhoid had it in a particularly mild form.

Why do I prefer the method by mouth; First, because from a scientific point of view, it is quite comprehensible and offers every security; secondly, because it is easily accepted by the public, which it does not inconvenience in any way neither in diet nor in their occupations. Further, it does not cause any reaction, and allows of no danger. One could not say so much of vaccination by hypodermic method, which has several very distinct contra indications.

There is yet another fact quite recently established. In order that a vaccination should be really efficacious it is necessary to give it in several doses. M.M.O. Crouzon and S. de Seze have just reported to the Medical Society of Hospitals the following fact: they observed in the staff of the Asylum for women, an epidemic of paratyphoid at the home of two young nurses vaccinated by injection a year previously. But they had received only one injection. The makers having discarded all the causes of failure, have agreed on the insufficiency of this method and of the necessity of using at least two injections. But with Entero Vaccine what happens? It produces exactly a series of vaccinations, for seven consecutive days with 28 pills, thus assuring to the individual the maximum chance of immunisation.

Moreover, to conclude I shall reprint this passage of a recent article on immunity: "It is interesting to recall that there exists a very convenient method for using Anti-typhoid vaccination several times without fearing any of the inconveniences which we have just mentioned. It is vaccination by mouth. Further, if one wishes to call to mind that this mode of vaccination is at least as efficient as vaccination by subcutaneous injection perhaps more efficient according to certain makers, one should reasonably make the best of the following conclusion. With a prolonged course of vaccines taken by mouth, and with this alone, can one safeguard the public without the pain and inconvenience of injections."

P.S.—The method prescribed by the French Military office of Health is for fourteen doses. No food being taken for two hours before, nor for two hours after each dose, and the form generally used is Anti-typhoid Entero-vaccine Lumiere where the dose is two pills.

Royapuram Medical School Sports

SIR,

As usual the Sports day came off, this month. The Superintendent of the school played the host instead of the boys of the school as was the case in days gone by. Some of the old boys in the city did complain that they were not invited. A large number to whom the invitations did go did not attend. They were gentlemen who had education outside the Royapuram Medical School. Naturally they cannot have as much interest in such functions as the old boys. But one relieving feature of this change was that the old boys had not necessity of putting their hands into their the pockets which in these days cannot be as full as one will wish. I could at least see one medical man who, though not an old boy of the Royapuram Medical School belonged to the L.M.P. fraternity and who was curious to see things in a Madras School as he belonged to Vizag. It must be said here that he came after tea. The lecturers of the Medical school at least a few of them were seen assisting the host-in-chief and all their attention could not go beyond a small section including His Excellency and few bigger gentry seated near about. In spite of compound walls of the size and dimensions of an uo-to-date penitentiary it was not possible for the police and the lecturers to control the rush of passers by belonging to all sorts of society who rushed through the tumbling chains to have a glimpse of His Excellencey and the aroma from the body of a few of such self invited guests made me runaway a few yards from the fiield of all attention in front of His Excellency. So, you will please excuse me if I could not narrate to you more of the Sports than what I actually saw.

At times I felt my companion from Vizag. a nuisance. He would keep me engaged in talks of all sorts. He happened to be a prohibitionist though a N. B. and was naturally shocked when the Host-in-chief took upon himself the pleasant duty of carrying wine glasses containing something which the host told a European member in the Assembly a "pleasant mixture". I do not know who this gentleman

was. He drank the mixture. They said he is a medical man. I was rather curious to see who all participated as there were our Ministers, for Ex-two and officiating two. This was an occasion to know, I thought, who were for prohibition, who for temperance and who for freedom. My companion was so happy that all said "thanks" except one already noted. Dear Editor, excuse me if I were a bit frank. I should say, drink in a wine glass, of whatever specific gravity was rather out of taste especially on the grounds of a medical school. Was the want of order and attention to details especially when His Excellency was the chief guest, due to freedom in spite of oneself? How can I be plainer than this?

After the distribution of prizes, His Excellency made a brief speech which was as sportful as the occasion demanded. It certainly disappointed a few as on such occasions we hear of some announcement or other. But later His Excellency was quite equal to the occasion as such high personages usually are when he announced a holiday to the boys, the following day which was received with applause both by the students and lecturers.

A Very old boy.

Graduate Sub-Asst. Surgeons.

R. No. 376 E. 81, MOUNT RD. MADRAS. *11th February, 1931.*

Dear Sir,

[Ref: *Your letter dated 30th January, 1931 regarding Selection of Sub-Assistant Surgeons in the Department.*]

I am directed by the Surgeon-General to inform you that the Government have ordered that the number of candidates with L.M.S. or higher qualification shall not exceed 10 per cent of the total number of candidates selected as Sub-Assistant Surgeons in the Madras Medical Department. Of the twenty candidates to be selected by the Madras Services Commission only two candidates with L.M.S. or higher qualifications can be selected for appointment as Sub-Assistant Surgeons in the Department and the rest will be L.M.P. candidates.

Yours sincerely,

P. K. WARRIER.

Personal Assistant to the Surgeon-General with the Government of Madras.

[ED.—We thank the Surgeon General for his prompt reply. Comments will follow in the next issue.]

Review

"HEALTH"—Edited by Drs. U. Rama Rau and U. Krishna Rao, January 1931. This journal has been in existence for the last nine years and that it has become popular among and serviceable to the public are clearly indicated by the increasingly large circulation the paper enjoys and the increase seen in the volume of the journal. Considering the very low subscription fixed for the journal, the public must be grateful to the Editors for the work they are doing.

JL
Lm 29, N30 MP N31. 2-4-6

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The Medical Practitioner

A Monthly Medical Journal

EDITED BY
Dr. M. S. Krishnamurthi Ayyar, M.B. & C.M.,
Retired Sanitary Commissioner, Travancore State.
AND
Dr. V. Rama Kamath,
Member, Madras Medical Council.

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Business Notice.

Scientific articles and notes of interest to the profession are solicited. Contributors of original articles will receive a copy of the journal in which they are published.

Communications on all matters connected with the journal, literary and business should be addressed to the Managing Editor, 147, Purasawalkam High Road, Vepery, Madras, as he alone is responsible for the conduct of the journal. Annual subscription to the journal is Rs. 1-8-0 including postage, payable in advance. Papers and articles forwarded for publication should be either typed or written legibly on only one side of the paper. They are understood to be offered to "The Medical Practitioner" alone and any breach of this rule will be followed by non-publication. When any such of the article appears in "The Medical Practitioner" the copyright automatically becomes the joint property of the author or authors and of the publishers. Papers and articles sent will be sent back to the contributors, if so desired, and postage sent for the purpose. The Editors of "The Medical Practitioner" cannot advise correspondents with regard to prescriptions, diagnosis, etc., nor can they recommend individual practitioner by name as such action would constitute a breach of professional etiquette.

THE

Medical Practitioner

Annual Subscription Rs. 1-8-0. **Single Copy As. 4**

VOL. II] MARCH, 1931. [NO. 6

THE MEDICAL BUDGET

The month of March is a very important one for those who are interested in the welfare of their country. The columns of the dailies are full dealing with the budgets. Every provincial newspaper naturally gives more prominence to the budget pertaining to its native province and one has glimpses of the budgets of other provinces also. As far as we could see, Deficit Budget has been the rule in all the provinces and the deficit in each province seems to be in direct proportion to the political sufferings of the people in such provinces. In the general discussion that followed the introduction of the budget by the member in charge of finance in each province, the non-official members of the council urged for retrenchment as they usually did in previous years even with surplus budgets. It is noteworthy in this province that the Finance Member who introduced the budget had pursued a new policy and has indicated to the satisfaction even of the opposition benches that he had grasped the situation correctly. The Finance Member, Madras did feel the necessity of retrenchment but would not apply the axe for fear of dissatisfaction of the servants of the Government. His apprehension cannot be imaginary in these days of non-co-operation which has taken a deep root in the hearts of the people.

It is unnatural to expect any initiation of retrenchment on sound lines from high salaried Government officials who are responsible for framing the budget, as it is against human instinct to advocate a policy which is suicidal to the prosperity of these officials. Retrenchment will be only effective if the salaries of these officials are cut down at least to bring it to the level obtaining in other countries. We trust our readers are aware that India poor as she is, pays those who govern her the highest salaries which no other country pays, yet she is most neglected. Mr. Yakub Hassan who was the first to speak on the budget in Madras, rightly observed that the general debate that usually took place on the budget was not of a character that would influence the re-shaping of the budget. He very aptly said that members may fret and fume over the budget, but it would not in the least affect the budget. It is very unfortunate that neither Mr. Yakub Hassan nor others that followed him could think of a department under the Government which spends fabulously large amounts of money in the name of medical relief. From what we read in the newspapers, the members of the Legislative Council in other provinces also had not a word to say about the all-heavy medical department. It cannot be said that the people's representatives in the councils are incapable of knowing the ins and outs of the medical department where there is a good scope for the inauguration of the policy of retrenchment without affecting the efficiency in the least and with maximum benefit to the public. In 1928 during the discussion of the budget Mr. A.B. Shetty made an elaborate speech and pointed out to the Government that more than half or even more of the medical budget is swallowed up in the pay of the establishment and made most practical suggestions to effect savings in this department. He advocated the employment of honoraries on a large scale

not as supernumeraries but to displace the paid officers of the Government. Mr. Shetty pointed out that it was not possible for any Government to establish an adequate paid service, when it was known that at least 24,000 medical men were required at the rate of 5 for rural and 10 for urban areas for every 10,000 population. In 1928, there were roughly about 2,500 practitioners, all told, both in Government service and outside and he brought to the notice of the Government that this number would not do, to look after the population in this province. The causes at work which hampered the growth of the independent medical profession were enumerated by him categorically which were the results of the abuse of the privilege of private practice by state-paid medical men. He pursued this matter by interpellations and direct communications with the Minister and as the result of his efforts was able to force the Government to issue a confidential circular through the Surgeon-General drawing the attention of medical men in service to the rules in Civil Medical Code and warning them that any infringement of those rules would be severely dealt with. This confidential circular had not the desired effect, nay the abuses took quite a different turn. Nursing homes came into existence which are run openly by members of I.M.S. Some of the members of the Provincial Service hired or more correctly had hired rooms close to the Chemist shops where they were running their business before the date of the confidential circular rather quietly, exposed signboards mentioning hours of business and are able to attract more patients by mentioning on the signboards the institutions to which they are attached.

Exactly a year later, in 1929, the prohibition of private practice by Government servants was the subject of a token cut by Mr. S. Satyamurthi. Mr. A. B. Shetty pointed out to the Government in this connection that an open order would have had better effects than the confidential circular referred to above, warning the medical men in service for the infringement of rules on private practice, as in the former case, public opinion might have prevented the transgression of rules more effectively. Mr. Shetty very forcibly pressed on the Government the need of putting a stop to these abuses which directly affected the growth of the independent medical profession. His plea was that in case the independent medical practitioners were encouraged to grow in large numbers they might be made entirely responsible for medical relief as in other civilised countries, the Government taking charge of the Public Health Department only.

In 1930, Mr. A.B. Shetty reiterated all what he said the previous two years regarding the disabilities of the members of the independent medical profession and brought to the notice of the Minister, the hard lot of another set of practitioners brought into existence by the late Rajah of Panagal, we mean the rural medical practitioners, and vividly described the hardships suffered by this class of practitioners at the hands of the Taluk Board Presidents. The redeeming feature of Mr. A.B. Shetty's championing the cause of the independent medical profession was, that the then Minister, Mr. Muthiah Mudaliar, did not controvert any of the statements made by Mr. A. B. Shetty, but was on the other hand sympathetic though he shelved the issues by mentioning that time was not ripe to bring about the reforms advocated by Mr. Shetty. We mean no disparagement to the other Honourable members of the Legislative Council; some of whom did espouse the cause of the members of the independent medical profession as effectively as did Mr. Shetty. All the same it is neither flattery nor exaggeration when we say that none did this work so methodically. If other members did not speak as much it was not because they were indifferent but they wanted information. Members of the independent medical profession both in the city and outside, have friends in the Legislative Council and if some of these doctors take pains, they can certainly do a lot in the matter of voicing their grievances and bringing about the long desired reform in hospital administration. The honorary and voluntary system of medical relief is the ideal followed in other civilised countries where the Government spend proportionately much smaller amounts for the purpose; yet it has been possible in such countries to afford medical relief to the public more abundantly and effectively. In the country of our rulers, autocratic control is considered to be a real danger in any organisation of hospitals or any other voluntary social services, as is

evidenced in a book "Hospital Organization and Management" recently published in England. The fact that introduction to this book was written by the Hon'ble Sir Arthur Stanley, G.B.E., C.B M.V.O. (now His Excellency the Governor of this Province) is a hopeful feature and likely to make our path of reform smoother.

Members of the public or legislative councils and local bodies who believe that the hospitals and such charaitable institutions exist for the sake of the poor, will, we hope, not think otherwise of the members of the independent medical profession if they clamour for honorary appointments in the hospitals and displace the paid doctors. We trust it is possible for others outside the medical profession to believe that the practitioners are as anxious, if not more to effect highest possible retrenchment in the medical department and this can only be done if the members of the independent medical profession volunteer to serve free in hospitals.

The total number of beds available in all the hospitals in this Province are 9390 for a population of 42½ millions, *i.e.*, two beds for every 10,000 population. In the United States of America which is one of the richest countries and where there are 127 practitioners for every 100,000 of population there is one bed for every 270 population. In this province at this ratio there ought to be proportionately more beds as the number of practitioners is far below the ratio obtaining in that and similar advanced countries. As seen from the last administration report submitted by the Surgeon-General, about 17 lakhs of rupees are spent on salaries to officers. To this must be added at least 3 lakhs as pensionary contributions, making a total of 20 lakhs which would certainly provide for 12,500 more beds at the rate of Rs. 160 per year per in-patient.

There is yet another way where retrenchment could be effected. The unit of medical relief should be made a hospital and not an out-patient dispensary. We can say without any fear of contradiction that in the way the out-patients are being attended to in the out-patients' department at the rate of on an average about 150 in two hours by one doctor, *i.e.*, one patient for less than a minute, can never be said to be satisfactory at all. It is only among the in-patients the treatment can be done satisfactorily both in the interests of the patient and for the advancement of medical science. If such a system is possible in the Federated Malay States where conditions of life are similar to those obtained in this country or at least this province, why not inaugurate such a system here, entrusting the out-patient work to private practitioners.

There are many other items of waste and luxury by way of new appointments which requires the scrutiny by the non-official members of the legislature. A new theory has been advocated that the professors of the Medical College cannot teach the students effectively if they are of the rank of Asst. Surgeons though they have the necessary academic qualifications, unless they are transformed as civil surgeons. With this plea many new civil surgeons have been created and quite a good number of junior Asst. Surgeons are promoted as civil surgeons. This has necessarily increased the expenditure materially. There is absolutely no justification for such transformations. Asst. Surgeons can certainly teach as such and for this work they may be paid an additional allowance depending upon the onerous nature of the work in the teaching institutions. This is being done in Mysore Province where professors in the medical college are from the rank of Asst. Surgeons.

Advantage seems to have been taken of the findings of the Committee on Medical Education by the medical department for the creation of some new special posts with very high salaries, such as professors of Anatomy, Physiology, Pathology etc. There exist in provincial service to-day officers with the highest medical qualifications such as M. D., M. S.. F.R.C.S., M.R.C.P. Government has been spending large amounts of money by way of study leave etc., and get their officers additional qualifications at public cost. Instead of getting outsiders for the special posts mentioned above the Government must appoint their own officers which would cost them much less. This is certainly a retrograde step towards Indianisation of services apart from being unnecessarily costly. Only a few years ago the Government brougt into existence two cadres for the teaching of Anatomy and Physiology and at the time these cadres were brought into existence, there was no talk of bringing for the higher posts in these cadres, officers outside the department.

Consequently many young and bright members of the Provincial Service joined these cadres not minding the large income they might have earned in private practice which is denied to both these cadres. Some went to England and got qualified for the highest posts in these cadres but only to be disappointed. The Government is certainly guilty of breach of faith which though not questioned by those affected, will certainly have a demoralising effect. Economy and fairplay demand that no new blood is introduced into these cadres till such time at least when all those who have joined these cadres retire. A hue and cry would have been raised by all concerned if the members of the I.M.S. were disturbed in the way those in Provincial Service are now being treated.

As was mentioned by Mr. Yakub Hassan and referred to above, the budget speeches cannot serve the purpose of construction, but this is an occasion to criticise the Government for their acts of commission and omission and we earnestly appeal to all non-official members that they should be kind enough to devote a good deal of their attention to bring about the necessary reform in the matter of medical relief in this province. We wish the Hon'ble members press the Government to introduce reform in medical schools and increase the standard and course of studies to bring the same to the level of university education so that there may be uniformity in medical services and medical profession and the water-tight compartments now existing are done away with. The Committee on medical education had strongly recommended to the Government this reform. Expenditure on this account will certainly be much less than that required for the new special appointments referred to above and reform in medical education must certainly be introduced without further delay.

Of late supersessions in Madras Provincial Medical Service have been so glaring to escape the notice of right thinking men. A year ago, an Asst. Surgeon who returned from England specialising in diseases of Ear, Nose and Throat has been made a Civil Surgeon to do this duty superseding many other Asst. Surgeons in the department. A couple of months ago, another Asst. Surgeon was converted into a Civil Surgeon and appointed as the third obstetric physician in the Govt. Hospital for Women and Children and quite recently another Asst. Surgeon, scarcely two years in service, has been made Professor of Pathology, the special qualifications possessed by these being made the cause of such preferential treatment. Those who have been responsible to recommend to the Government of such transformations, however good their intention may be, ought not to have forgotten the most important principle which governs promotion in service, *i.e.*, merit and seniority. Additional qualifications possessed by those after entering the service should not be made a plea for supersession. This will certainly bring about discontent with the resulting demoralisation in service. In no other department of the Government such supersessions are brought about as a result of higher academic qualifications, be it be in the Judicial, Engineering or any other technical departments of the Government where even this day merit and seniority alone count. In the Judicial Department the minimum qualification that is demanded of a candidate is B. L., for the post of District Munsiff and such a B. L., can aspire to be a Judge of the High Court in the ordinary course of events and an M.L., or a Bar-at-law or even an L. L. D., of London who joins the District Munsiff cadre later than the B.L. has not superseded and cannot supersede an ordinary B.L., because of his higher academic qualification. So also in the Engineering and other departments of the Government service. Such being the case, we ask the Hon'ble members of the Legislative Council with all seriousness at our command whether such supersessions in the medical department alone could be tolerated? Is it not possible for those possessing special qualifications to do the special work as Asst. Surgeons. Apart from the demoralising effect of such appointments, these have certainly increased the financial burden of the medical department. As was mentioned by us earlier in this connection, in Mysore Province where the State sends its medical officers for specialising in the various branches of medical science, they are made to work in the same cadre on their return for the same pay they have been getting in that cadre and they are never promoted to a higher rank unless they finish the number of years in service required for such promotion. There is yet another aspect which should engage the serious attention of the representatives of the people in the Council and that is that such of the Asst. Surgeons who, though junior, are made civil surgeons on account of special foreign qualifications, got such qualifications with the help of public funds and the moment they are made civil surgeons they necessarily claim a higher fee for consultation from the public and are not as easily accessible as they would have been if they remained as Asst. Surgeons. It is therefore plain that such transformations apart from being costly do not help the public in the matter of medical relief.

The Madras Services Commission has done a great disservice to Medical Licentiates otherwise known as L.M.Ps. by admitting applications of medical graduates for appointment as Sub-Asst. Surgeons. Practitioners of the L.M.P. class came into existence on account of the special cadre—the Sub-Asst. Surgeon. Medical schools came into existence for such class of people. After the passing of the Madras Medical Registration Act theoretically all practitioners having been put in one register the castes in the medical profession must have disappeared. But the ways of the Government are mysterious as they are unreasonable. The castes still remain and a registered practitioner with L.M.P. qualification is not allowed to compete for the post of Asst. Surgeon. But the Madras Services Commission is now allowing the graduates to compete with L.M.Ps. for the post of Sub-Asst. Surgeons which was specially meant for the latter class. Is it not a hardship on this class of practitioners who once a Sub-Asst. Surgeon has to remain as such?

Rural reconstruction has been considered by the lovers of our country as the first step for Swaraj, yet it remains most neglected at least in the matter of medical relief. We wish our political leaders to realise that a popular and capable rural practitioner is a necessity for this reconstruction work. It is therefore essential that ways and means are found out to make the rural medical relief scheme popular and efficient. Space does not permit us to touch on other items requiring reform in the medical department such as provincialisation of Health Officers cadre who though treated as Gazetted officers are not classed either in provincial or District Board service though technically they belong to District Board or Municipal Service. The Local Fund Sub. Assistant Surgeons is another class of medical officers who demand provincialisation. Such questions ought to have been dealt with by the framers of the Local Boards Act which has been recently revised. All the above items have been the subjects of discussion in these columns here and elsewhere and will continue to be so till we get Medical Swaraj.

THE ANNUAL REPORT OF THE PUBLIC HEALTH DEPARTMENT AND THE REPORT OF THE NATIONAL HEALTH & BABY WEEK FOR THE YEAR 1929.

The improvement noted in the first report is that for the first time the report of the working of the Public Health Department and that of vaccination are combined and presented in a single report. We wish the report of the National Health and Baby Week which forms a portion of the duties of the Public Health Department, will also be combined with the Public Health and Vaccination report and all published in one report, so that all the activities of the Department may be presented in a single publication.

Vital Statistics : Correct vital statistics constitutes as stated in the report the very foundation of all public health activities and have their use in the several branches of administration. It should be made compulsory throughout the province. For small villages each having a population of 2000 and below the Village Munsiffs must be made responsible for the collection and registration of the vital statistics. Bigger villages each with a population of between 2000 and 5000 should be constituted into minor Unions and for each a combined Registrar of Vital Statistics and Vaccinator be appointed to be in charge, not only of vital statistics and vaccination but sanitation also, as in the case of the Conservancy towns in the Travancore State. For major Unions a combined Registrar and Vaccinator should be appointed to work under the Sanitary Inspector of the Union. Any dereliction of duty observed in the working of the Registrar even in the small villages, Unions or Municipalities should

be severely dealt with. In order that the vital statistics figures may be made use of in gauging the social and economic condition of the people, additional columns to note "the age of mother" and "the order of birth" should be opened in the Birth Register, and in the case of death of infants, a column to note the financial condition of the parents of the deceased infants should be opened in the Death Register. There is nothing impracticable in this as similar additions have been made in the Vital Statistics registers in the Travancore State. As long as communal representation has become established in all departments and public bodies etc., it is but necessary that the vital statistics figures also should be tabulated and given for each community as Brahmins non-Brahmins. Adi-dravidas etc.

Births: The number of still births registered during the year was 24,435 which works at the rate of 15.1 per 1000 live births. Still this figure is considered to be low and is attributed to the gross neglect of the registration of still births. Even as it is, the rate of 15.1 is rather high and requires investigation. If only "the age of mother" and "order of birth" are noted in the Birth Register, the relation between the early age of mothers and still births may be easily found out.

Deaths: The deaths of females between the ages of 10 and 30 is higher in India than in other countries and show that maternity which generally occurs earlier in the females of India than in other countries is the chief cause of the high rate of mortality. Death from child birth is also high and has risen from 3788 in 1925 to 11087 in 1929. The number is reported to be low and considered to be caused by defective registration and it is estimated that 20 per mile of live births will be nearer the actual fact. Even the rate now obtained 7.13 in rural areas and 15.56 in municipalities is very high in comparison with that obtaining in other countries of the world where it is only one third of these rates. The infant mortality rate in the year under report is 179.5 and from 1920 to 1929 it ranged from 161.3 to 179.5. The writer of the report, Surgeon-General Sprawson, says that "there is no definite trend of the decline in the mortality. This is in striking contrast with the results achieved in western countries where intensive attention devoted in recent years to maternity and infant welfare has brought about a progressive and steady decline in the infant mortality rate which at the present time is 1/3 to 1/2 of what it is in the Madras Presidency." It is clear from the above that the maternity and infant welfare scheme as at present worked in this province is not of much use and that, therefore, the line of work must be changed to suit the conditions and habits of the people before centres are opened in other places. In the special survey conducted in 1928 in connection with the maternal mortality, it was found out that the earlier the age of mother and the birth order, the greater the incidence of the maternal and infantile mortality. In order that such statistics may be made available always without resorting to the institution of the special survey, the opening of the two columns in the birth register to note the age of mother and order of birth as suggested above will be useful as has been found to be the case in Travancore.

Propaganda: The object of propaganda by means of lectures, exhibitions, etc., is to make the people realise the importance of health and act on the lines which contribute towards its improvement. In the matter of health education including maternity and child welfare, the results of the propaganda measures have to be gauged by the health of the people, the decrease of the maternal and infantile mortality rates and not on the number of lectures given and the number of people that had assembled during those occasions. It has been stated in the report itself that there has been no appreciable improvement. So it is clear that the propaganda as at present conducted is not of much use. If some of the municipalities had not done any propaganda work in the year they should be congratulated in having acted according to their conviction that the propaganda had been of very little use and not to be blamed for not sheepishly following other towns in the propaganda work as it is now in operation. The Surgeon-General is perfectly right when he says in para 131 of the report and it is in agreement with the views of the Hon'ble Dr. Hoops, the President of the Far-Eastern Tropical Medicine Conference held at Singapore. The latter said "Further having once raised the really and properly educational body of medical men in a country the next essential step is the diffusion of knowledge concerning the origin, mode of prevention and spread of diseases to the population at large. The adult as a rule is too case-hardened to benefit; but the school boy is still impressionable. Hygiene should be a subject in every school and should be so taught that the subject becomes interesting and is liked." It is necessary, therefore, that Hygiene and also Physiology should be made compulsory subjects in all schools and medical men are appointed to teach these subjects if the pupils are to be benefited by such teaching. tohese medical men may be entrusted with the duty of medical inspection of the schools to which they are attached. It will, eventually, be the most economical arrangement.

Medical Inspection of Schools: The existing practice of restricting medical inspection to secondary schools and colleges is of course an anomaly. It is only in early life that pre-disposition to diseases may be easily detected and satisfactorily remedied. The inspection of elementary schools is, therefore, absolutely necessary. The mere fact that no separate report on medical inspection of schools has been published this year though it was published before, proves that the subject of medical inspection is not receiving proper attention at the hands of the authorities concerned. Physical education comes after health and in order to determine the kind and extent of physical training required by each pupil, they have to be determined by medical inspection. That physical education which is subordinate to medical inspection is made compulsory and a regular department has been organised, reveals the want of sense of proportion obtaining among the administrative authorities. There are, according to the report of the Director of Public Instruction for the year 1929-30, 239,645 students (male and female, reading in colleges, secondary middle and special schools. For the medical inspection of these students at the rate of 12 annas for the first inspection and 6 annas for the second inspection or say at an average 8 annas for each inspection Rs. 119,822 are spent. If a 1st class Health Officer on Rs. 250 per month be appointed for each district, the expenses will come to, including travelling allowance and a small office establishment, about Rs. 4,000 a year and for the 25 districts Rs. 100,000 will be required. Thus it will be seen that without extra expenditure the special staff may be entertained. In case, however, inspection is made compulsory in elementary schools, one officer for each district is not sufficient. The best thing then would be to appoint medical men as teachers for teaching Hygiene and Physiology in each school or a group of schools in the same place and entrust him with the duty of medical inspection of schools to which he is attached. The Director of Public Instruction rightly says in his report that "the inadequacy of facilities for the treatment of ailments detected in the course of inspection and the lack of intelligent and ready response on the part of the parents and managment to the findings of the school medical inspection detract to some extent from the efficiency of the scheme." If, as suggested above, medical men are appointed as teachers they can institute a medical clinics in each school and arrange for the treatment of the pupils requiring it. These medical teachers need not be appointed as full time employees and may be recruited from among the private practitioners either independent or attached to the rural medical scheme. By this arrangement not only medical inspection of schools, teaching of Hygiene and Physiology, but rural medical relief may also be satisfactorily, efficiently and economically done.

Assistant Directors of Public Health: The anomaly of requiring all Assistant Directors of Public Health to squat in Madras and go out in the districts for inspection, one for vaccination, another for fares and festivals, the third for sanitation, etc., is only found in the Public Health Department. The Health officers of the districts and municipalities attend to all these works, vaccination, vital statistics, fares and festivals, epidemics, etc., which form part of the public health duty and that for each item one special Asst. Director should inspect is rather strange and unheard of anywhere else. The province may be divided into 3 or 4 centres as before and for each one an Asst. Director appointed in charge of all these duties. The inspection can then be done efficiently and with less cost involved in travelling. For the working of the maternity and child welfare schemes as at present obtained, how far the services of the newly appointed Lady Asst. Director will be useful remains to be seen.

Diploma in Public Health and B. S. Sc., Course : It is satisfactory to note that both graduates and L. M. Ps. are now given the same training and required to pass the same examination conducted by a Board of Examiners and given the same Diploma . As regards the B. S. Sc., the solitary student who joined the class last year has failed in the examination and it remains to be seen whether anyone will seek admission this year. Col. Russell is reported to have said that the training given to the B.S.Scs., here is better than that given in other parts of India and even in Western countries. If that is so, why even during his time, the B.S.Scs , had been sent for training to Calcutta and D.P.H. qualification of the Western countries had been given preference for the appointment of Asst. Directors. Beyond the inconsistency of his statement and the actual practice obtaining even during his time, the establishment in Calcutta of an up-to-date school of Tropical Medicine with the assistance and co-operation of the Rockfeller Institute must certainly enhance the value of the instruction imparted there. It would, therefore, be in the best interests of public health and to avoid the periodical deputation of Health Officers to Calcutta as is now being followed, if the students are trained in Calcutta and obtain Diploma granted there and make them eligible for the appointment of first class Health Officers.

THE ALL-INDIA MEDICAL COUNCIL

AND

The Medical Licentiates.

In accordance with a resolution passed by the Standing Committee of the All India Medical Licentiates' Association at their meeting on 18th January, 1931, the representatives of this Association, led by Dr. Rai Bahadur Khazan Chand, Vice-President of the Association met Major-General J.W.D. Megaw, Director-General of Medical Service who is also the would-be President of the proposed All-India Medical Council, to represent their grievance regarding the elimination of the medical licentiates from the purview of the proposed bill. The deputation dealt upon the achievements of this class of practitioners especially in Government service in all fields of medical science where their services were recognised both by the Government and the public. The reply of the Director-General is published elsewhere in the correspondence columns of this issue and speaks for itself. The deputation did certainly carry coal to Newcastle by enumerating to Major-General Megaw who knew all about this most useful and hard working class of Government servants for thirty years of his life in Government service during which period he served in different capacities and was in close touch with this class of medical subordinates. As we have pointed out more than once in these columns, if there is a class of medical men, existing today as Sub-Asst. Surgeons and if they are recognised as medical men, the credit is all due to the members of Indian Medical Service. They know their wants, their limitations, their hardships, their disabilities and their legitimate ambitions too. The reply of Major-General Megaw is a direct evidence to verify our statement. With a person of the nature of Major-General Megaw, the representation ought to have been based on quite different lines. The General Medical Council of Great Britain came into existence in 1858 for the purpose of guiding and controlling the medical education and registration of qualified medical men with the sole purpose of enabling the public to distinguish qualified from unqualified practitioners. But in 1931 in India an All India Medical Council is to be brought into existence not for the purpose for which such a Council was started 73 years ago in Great Britain but to satisfy the General Medical Council regarding the standard of medical education only of graduates. Yet it is to be misnamed as All India Medical Council which certainly does not indicate the purpose of its functions. The medical licentiates being now in provincial medical registers cannot but be called medical men and if these are to be excluded from the scope of the All India Medical Council, the natural implication would be that they cannot be recognised as medical men at least for the purpose of All India Medical Council. Is it not a slur ? Do the Licentitates for whom Major-General Megaw and the rest in the I.M.S. service have a warm heart deserve this stigma ? It looks as if those who felt the need of an All India Council to satisfy the whims of the General Medical Council were not aware of the existence of Provincial Medical Councils which were brought into existence by the Medical Registration Acts in these Provinces. The Provincial Medical Registration Acts are a copy of the English Medical Registration Act of 1858 and there is a section in the Provincial acts which runs as follows :—

"The Council shall have power to call on the governing body or authorities of any University, Medical College or School included in or desirous of being included in the Schedule".

"(*a*) to furnish such reports, returns or other information as the Council may require to enable it to judge of the efficiency of the instruction given there in Medicine and Surgery and Midwifery, and

"(*b*) to provide facilities to enable any member of the Council deputed by the Council in this behalf to be present at the examinations held by such University College or School".

"If the said body or authorities refuse to comply with any such demand, the Governor-in-Council may, upon report by the Council, remove such University, College or School from the Schedule or refuse to include it in the Schedule."

All the provincial medical councils without exception are presided over by a European member of I. M. S., who is the Surgeon-General in major provinces and Inspector General of Civil Hospitals in the minor ones and there are in this Council nominated members of the I.M.S., who usually count more than elected members. Is it not possible we ask, for the General Medical Council to be in communication with all the Provincial Councils and get whatever information they want regarding the standard of medical education in the Universities and in case the General Medical Council found the standard defective could they not suggest improvements in this direction through the Provincial Councils ? If necessary, yearly conferences could be held of representatives of the Universities from all the Provincial Councils under the Chairmanship of the Director of Medical Services to exchange views and bring about a uniform standard. Why all this unnecessary fuss which while not serving any good purpose casts a slur though indirectly on a class of medical men in this country who form the largest group. If in spite of all good and reasonable arguments there should be a statutary body to control and guide the university medical education such a body need not be called an All India Medical Council. All India Medical Graduates Council will be the most suitable name under the circumstances.

The deputation ought to have argued out the objections for their entry in the All India Medical Council instead of giving an opportunity to the Major-General to express such objections. The plea put forth by the Major-General was that the Licentiates should patiently wait to claim recognition of equal terms with University graduates till the standard of education is raised in medical schools, cannot convince us at all. May we point out to him that in his own country in 1858 when there existed medical universities and other bodies granting membership and fellowship diplomas, the framers of the Medical Registration Act found it necessary to add a section which ran as follows :—

"Any person who was actually practising medicine in England before the "1st day of August, 1815, shall, on payment of a fee to be fixed by the General Council, be entitled to be registered on producing to the registrar of the branch council for England, Scotland or Ireland a declaration according to the form in Schedule (B) to this Act signed by him, or upon transmitting to such registrar information of his name and address, enclosing such declaration as aforesaid".

(This section was in force till 1875)

The declaration referred to ran as follows :—

I, ...residing at..... in the county of .....hereby declare that I was practising as a medical practitioner at..... in the country of .....

(Signed) (Name)

Dated this day of 18

When such practitioners who did not undergo any course in any institution were allowed to be registered in the British Register, no one, including the General Medical Council can raise any objection to include the medical licentiates and other non-university diploma-holders in the contemplated All India Register. In the British Medical Register even today all the practitioners do not possess qualifications of the same standard which is insisted upon by the proposed All India Medical Council. If the licentiates of the Society of Apothecaries can find a place in

the British Register which contains not only University graduates but also holders of diplomas granted by the non-university faculties—the latter being considered to be higher in the matter of educational equipment—why not the licentiates in India who are in no way inferior to the licentiates in England get into the All India Medical Register?

The Major-General referred to the part played by him as the Surgeon-General to the Government of Madras with regard to the findings of the Committee on Medical Education of which he was the Chairman. This will only serve the purpose of merely indicating sympathies to the class of medical men represented by the deputation and can never be an argument against their inclusion in the All India Medical Register. So far, his successor in Office in Madras has not been able to push through the reform of a 5 years' course in the medical schools, and preference has been given to the more costly items of the Committee's findings such as the appointment of professors of Anatomy, Physiology, Pathology etc., from outside the Government Medical Department with the plea of improving university medical education. Is it not a strange irony!

Nobody, much less the deputation claimed recognition by artificial means as referred to by the Major-General in his reply nor is it possible. If the licentiates could be grouped along with graduates and the holders of European diplomas in the provincial medical registers why not they be grouped along with these in the All-India Medical Register? It has been made possible for our rulers to change their angle of vision regarding politics and it will be certainly less risky and more conducive to the harmonious growth of the medical profession if they permit the licentiates in the All-India Medical Council. Then and then only it will be possible to raise the standard and course of medical education in schools; for, none could fight for the Licentiates more than they themselves as implied by the Major-General at the end of his reply. Pious hopes and utterances from the highest quarters has been moonshine in this country in other fields of public life. It cannot be otherwise in the medical profession. If the medical licentiates have not been recognised to the extent they deserve, the fault is certainly their own. Even person like Major-General Megaw who today occupies the most enviable and highest position as the Director-General of Medical service in India and who has been 'a real friend of the medical licentiates of India' and claimed them as his 'own brothers' could not help them, who else could? The answer is found in the concluding sentence in the reply to the deputation which runs thus :—

My advice then is, concentrate all your efforts on raising the status of the licentiates in every respect. Do not rest satisfied with a mere imitation for the university standards but aim at something which will be recognised as being sounder and more practical. When you have succeeded in this, the recognition of the licenses will follow as a matter of course". Nothing can be plainer. Will the medical licentiates and others who are anxious to bring about in this country a medical profession worthy of the changed conditions (now on the horizon) strike iron when it is hot before it is too late to mend? Times are certainly propitious. Let optimism prevail as a result of self-help and let all concerned catch time by the forelock. The All India Licentiates' Association has the necessary sinews of war, be it money or men. Let them bestir by all possible ways We have a 'Lord Irwin—the man' and our representatives in the Legislative Assembly will certainly rise to the occasion if they are posted with the necessary information in time before the All India Medical Council Bill is placed on the anvil in the Legislative Assembly.

Original Articles

ENDOCRINOLOGY

BY

DR. M. S. KRISHNAMURTHY AYYAR,
M. B. & C. M.

XVII

Other Glands: The important Endocrine glands whose internal secretions have been investigated and largerly used in therapeutics have already been dealt with. There are other glands some of which are, in addition to their external secretions, considered to have internal secretions also, though the latter have not been isolated, but are still practically used in the treatment of diseases. They will be discussed below:

Placenta: Born with the pregnancy, its life is terminated with pregnancy, for, it is expelled in labour as the after-birth. The placenta is created by the fusion of the top-most enlarged cells of the uterine surface and the most advanced cells constituting the van-guard of the growing and multiplying ovum. It serves as lung, stomach and kidney of the embryo. The internal secretion of the placenta is named "meno-form," similar to that of the follicles of the ovary. It stimulates the action of the corpus luteum in the efforts on the mammary development during pregnancy. It acts as a break upon the post pituitary until at least something happens that puts the placenta out of commission in this function of restraint and the bottled up post-pituitary secretion explodes the crisis apparent as the process of labour. It stimulates growth of the fetus and according to some, increases the secretion of the milk. It has got an anti-toxic action and converts the toxic protein products of intermediary metabolism into harmless metabolites for excretion. In eclampsia the function of the placenta is altered so that this normal synthesis of toxic products into non-toxic is interfered with and eclampsia is caused. For clinical use the placenta extract is given combined with mammary extract and corpus luteum to increase the lactation and also in vomiting of pregnancy.

Mammary Glands: The mammary glands are typical glands of external secretion, yet there is evidence to conclude that they are also glands of internal secretion and that this secretion substitutes to a certain extent for the loss of that of the placenta. They make for a persistence of the state of equilibrium among the endocrines attained during pregnancy after the expulsion of the placenta. With the prolonged activity of the corpus luteum during pregnancy prolonged stimulation of the breasts occurs. The secretion of the post-pitutrin would now cause the change from the internal cell secretion to milk. But it is inhibited from doing so by the placenta. When the placenta is removed after labour the post-pituitary can act and free flow of milk is established. However to counterbalance this and to prevent the post-pituitary from overacting the breasts secrete a harmone with an action like that of the placenta but not so strong which tends to inhibit the ovary. So is put off the imposition of a pregnancy upon the period of lactation obviously bad for the mother, infant and embryo. Mammary gland extracts are used to increase lactation and to stop metrorrhagia and menorrhagia and oozing from the uterus.

Duodenum and Gastric Mucosa: Bayliss and Starling demonstrated the internal secretion of the duodenum and it is called "secretin." The increase of the red and white cells of the blood which follows the taking of food is said to be caused by the stimulation of this secretin on the bone-marrow and lymph glands. The close similarity, if not the identity of the secretin with the anti-neuritic vitamin has been suggested. Secretin can be obtained in largest quantity from the duodenum. It is present in small quantity in jegunum, hardly at all in the Ileum and is almost absent in the salivary glands, liver, spleen, pancreas and kidneys. However, some observers have isolated it from other tissues of the body, though in small amounts.

Another internal secretion similar in many respects to secretin was discovered in the gastric mucosa and is called "gastrin" or "gastric secretin." The action of secretin consists in the stimulation of bile, intestinal juice and pancreatic secretion and stimulate the contraction of the intestines. It is given in intestinal toxemia, in various types of indigestion arising as a result of faulty pancreatic and intestinal secretion. It is given also for constipation. Two preparations are in

use, one in the form of tablets which contains dessicated substance from the duodenum and the other the elixir prepared from the mucus membrane of the stomach. The latter is indicated in atony of the stomach, dilatation, fermentive dyspepsia, chronic gastric catarrh of the asthenic type.

Pancreas : The well-known insulin obtained from the islands of Langerhans of the pancreas by Dr. Banting is the internal secretion of the pancreas. By its action the glucose is used up by the muscles and tissues of the body. The absence or diminished amount of it causes diabetes mellitus.

Liver : During the last few years the liver which inspired Claude Bernard to invent the word "internal secretion" and failed to be even included among the major endocrine glands has now been restored to its pristine position, as three or more hormones having the greatest importance in maintaining the normal equilibrium of the body have been discovered. One of the hormones is that which reduces the blood-pressure and extract of liver is now given for high blood-pressure. The second is that which has to do with the manufacture of red blood cells in the bone marrow and it may be called "hemopoetin" and is used in cases of pernicious anaemia. The third is called "cardiasin" which strengthens the heart. The fourth has something to do with the glycogenic function of the liver. *i.e*, the conversion of glucose into glycogen for storing it in the liver and reconversion of glycogen into glucose when sugar is required by the cells of the body and muscle.

Spleen : The spleen is credited with three harmones, the first increases the fragithe of the red cells and hence removal of lity spleen has cured certain cases of anæmia due to excessive destruction of red cells and also certain cases of excessive and incontrollable bleeding. The internal secretion of the spleen sensitizes to destructive agencies, the blood platelets which are normally required for blood co-agulation and the red blood cells. The second hormone is named "peristaltin" and has the power to stimulate the movement of the bowels. Extract of the spleen has been found, in consequence, useful in the treat, ment of chronic constipation. The third hormone affects the calcium content of the blood and it is probable that the spleen acts as a store-house for the parathyroid hormone. Extract of the spleen is thus used in the treatment of tuberculosis.

Heart : It is found that from a portion of the heart known as the "sinus" or "pacemaker" which sets the pace for the action of the heart, because of its peculiar irritability, a substance may be extracted which accelarates and strengthens the beats of the isolated heart even after the heart has been beating alone outside the body in an artificial solution. An extract of the heart particularly the portion containing the "sinus" and the "bundle of His" has been used in diseases of the heart.

Kidney : As far back as 1879 the famous Brown Sequard expressed the belief that the kidneys produced an internal secretion and in 1892 reported a series of experiments which showed that the administration of renal extracts in uremic manifestations, prolonged the lives of nephrectomised animals. The secretion is believed to be obtained from the renal glomeruli and it enhances the renal permeability. By taking the extracts the albumen in Bright's disease is disminished and headache and vomiting cease.

Prostate Gland : It is extremely small in childhood but progressively becomes greater in size with the onset of puberty and tends to enlarge during the period of sexual activity, to atrophy after the onset of masculine climactric. The internal secretion of the prostate influences the production of spermetazoa and if the prostate is removed atrophy of the testes occurs. The secretion of the prostate influences the growth and development of the body and the skilled movements. Thus there is no doubt that prostate is a gland which produces an internal secretion which is important for the efficiency of the muscular system, nervous system and sexual life of the male.

Skin : It is well known of late that when the sun-light or ultra-violet light acts upon the skin, a chemical substance is produced which through the blood is transported to other parts of the body and exerts its influence upon the growth and proper nutrition of the body. Certain writers are referring to it as the hormone of the skin This substance is found to be "ergosterol" or a close relation of it, which when acted upon by ultra violet light is transformed to Vitamin D. Dr. Berman suggests that it may be named "Dermosterol."

The Chorioid Gland : The chorioid gland in the brain has a great deal to do with the secretion of the cerebro spinal fluid and nutrition of the cells of the nervous system. The chorioid is related to the function of that part of the brain known as the "Thalamus" which plays the central role in the emotional making of the personality. The secretion of the chorioid by its action on the Thalamus, influences the behaviour. The chorioid may specially condition those reactions which are of fundamental significance in the understanding of personality and therefore of those disturbances of personality which are named as neuroses and psychoses.

EPILEPSY AS SEEN IN MADRAS MENTAL HOSPITAL

BY

CAPT. G.R. PARASURAM,B.A., M.R.C P. (E);
DIPL. PSYCH.,
MEMBER, ROYAL MEDICO-PSYCHOLOGICAL ASSOCIATION,
DEPUTY SUPERINTENDENT,
GOVT. MENTAL HOSPITAL, MADRAS.

There are about 50 epileptics onthe male side and over 20 on the female side. I am not going to stress very much on the physical aspect of Epilepsy but I will try and give the readers a little information about the mental aspect of these patients. Hughlins Jackson after whom Jacksonian Epilepsy was named, describes Epilepsy as a disease characterised by sudden, rapid, occasional, excessive local discharges of the Cerebral Cortex. I don't thing anybody could give a better definition of Epilepsy. The words explain themselves.

Aetiology : It is a common enough disease found all the world over. Any statistics of this hospital will not give you an idea of the extent of the prevalence of epilepsy. There are more cases of epilepsy outside than inside the hospital probably in the proportion of 4 to 1. Ordinary epileptics do not come to this hospital unless there is the accompanying mental trouble. Often there is a hereditary history in the family. Males seem more affected than females—I may mention subject to correction that Epilepsy is a disease usually found in all classes of people and in all walks of life. The age of onset usually is some where about 15 to 20. There are a few cases which begin after 20 practically none above 30. It may begin in very, very early childhood. Some of these patients show some stigmata of degeneration such as a deformed ear, a microcephalic head, deformity of the spine, a high arched palate, an elongated face or other congenital abnormalities. I am sure general practitioners know more about the actual fit than myself. The fit has got a definite pre-paroxysmal stage in which the most noticeable thing is a change in the patient's mental condition. Often in this hospital, the staff will be able to foresee that so and so is going to get a fit. In this stage, the patient becomes either irritable or morose, has a tendency to keep much to himself. Some get restless; some mutter to themselves; and some of them complain about bad food, the ill-treatment and some have definite delusions of persecution. This stage lasts for a day or two. Just before the fit in some cases, there is an aura or warning. The aura may be sensory or motor. The sensory aura is generally visual and the patient gets a hallucination. Generally the hallucination is of a frightful nature, seeing somebody coming to attack—seeing demons and so forth. In a few cases the hallucinations are of a pleasing nature where angels come to minister. It is rarely auditory—somebody hurling abuse on the patient. One patient gets a burning sensation over the buttock as though being set on fire. These various sensory aura indicate to us that sensation in other regions of the body have already disappeared and that this area which has hyper-acute sensation is the last to lose, sensation. It is a fact that when sensation in other parts of the body is at a low ebb, the parts retaining sensation are hyper-sensitive. The man who has got peripheral anasthesia and has got sensation in tact in the region of the groin fiddles about with his genitalia. Similarly when the aura is motor, it only means that the fits have already begun. One patient before a fit feels that he is being whirled round and round. Another patient feels that somebody from below is trying to pull him down to the sitting posture. There is one patient who knowing

that he is going to get a fit, retires to a convenient place to fall down, so that he may not hurt himself. In the majority of cases there is no cry. But in a few there is a cry before the patient drops. Practically all the patients drop down suddenly unconscious. It is to be noted that though the falling process is different with each individual, it is the same in any individual patient in all subsequent fits. They hurt themselves in the same identical place. Some fall straight on their backs, some fall on their sides, some fall on their face. One patient hurts his left ear continuously; one patient constantly hurts himself over the big toe of the right foot. One patient hurts the top of his forehead and his injury is not healed so far; while yet another patient always hurts his left eye, so much so that he constantly keeps that eye closed with his hand. The tonic stage begins when every muscle in the body is rigid. This lasts a few seconds; the muscles momentarily relax and again go into contraction. Gradually the contractions become less and the relaxations become more (this is the Clonic stage) until there is no more contraction. The patients may pass urine in this stage; froth comes on the mouth; and some have emission also. Some people roll about on the ground and cause injuries all over the body. One man beats the ground with his heels. After the convulsions, they go to sleep for a variable limit of time—some for few minutes, some for 3 and 4 hours—usually less than half an hour. There are one or two cases who get up immedialely after a fit, totter about a few steps and lie down. A few get so much exhausted by the fit that they have to be helped to their bed where they stay for hours together, the exhaustion being so severe that in one man though he wants to eat, he says he could not eat. The characteristic changes to be noted in epileptics occur after the fit. Usually the mental picture is one of confusion. A dazed appearance not knowing his bearings—perception at a low ebb, not able to recognise his surroundings—not having a good idea of time, place and person—a confused memory retarded ideation and a disordered judgment. The mental picture can be any type of mental disorder, confusion being the commonest with plenty of hallucinations. They may be maniacal—having a good opinion of themselves, talkative, giving out a world of information, mischievous and interfering with practical jokes and so forth. Others are gloomy, moody, morose, retire to a place where they can indulge in their own thoughts, easily irritable. Some are indifferent to their personal wants. Some sit in a corner like a a log of wood, doing nothing but physiological functions and that too, indifferently well (Stupor). Some have a wild look which will frighten away anybody. They are impulsive, aggressive, abusive, noisy, dirty, filthy, destructive and we have to take particular care of them lest they should assault others. In spite of vigilant care, we do have rather severe assaults leading to pretty severe injuries which outside this hospital would have landed the assailant in jail. There are one or two patients who are extraordinarily quiet, polite and very useful to their companions after a fit. Some of these assaulting patients do so only on provocation which may not be severe but once provoked they go for the same individual again and again. Many of these patients after the fit have delusions. Some are relgious—one man is religious, extraordinarily devotional and repeatedly prays to God not only to help himself but the whole universe. Some have got delusions of persecution often accompanied by hallucinations that are primarily responsible for their conduct. One man after a fit has got a delusion that his marriage is being arranged for, sees his girl coming, escorted by the Superintendent with 84 warders and all other paraphernalia. One main characteristic in all these cases is that the power of initiation is generally affected and their ideation is very much restrictive. In some cases, the retardation of ideation is so great that there seems to be definite inertia. They want to say something they think, the idea does not come up and they repeat the same thing over and over again. One lady takes nearly five minutes to express the idea" "I thank you for your present."

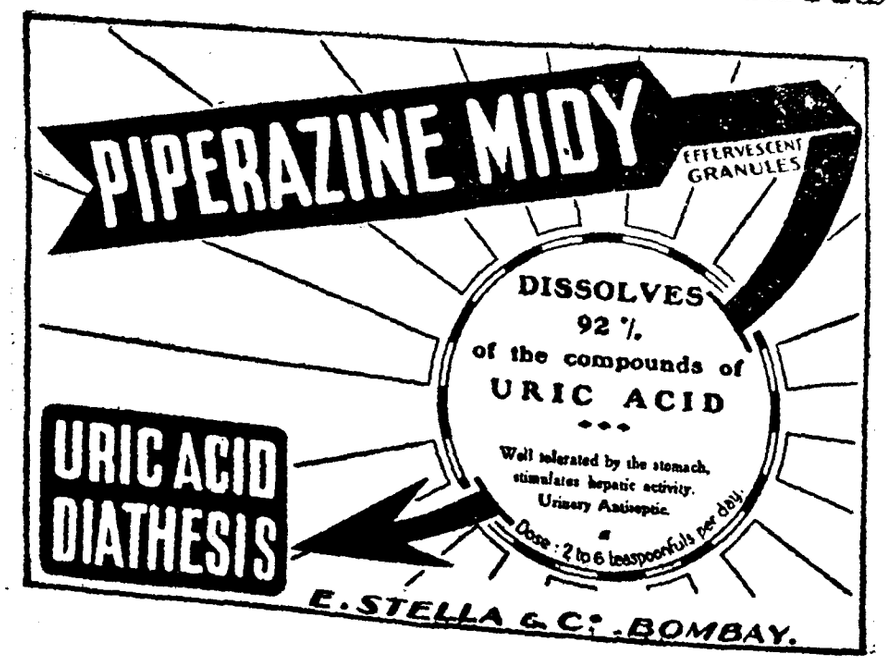
It is not all cases that get these typical fits; there are some patients who get minor Epilepsy or Petit Mal. There is great variation both in the frequency and the intensity of the fits. Some get only a few fits while others get frequent fits but less severe. In cases of petit mal there are only a few twitchings, the person does not lose, the person has got only momentary hallucinations and one or two twitchings and he does not fall down. All the same the mental changes are there. There are some whose fits are so trivial that they have not been noticed. There are cases where the fit is entirely replaced by some impulsive act. The term "Epileptic Equivalent" is applied to this. After the fit there are some who perform some automatic movements which has no meaning to us. One man goes on spinning cotton; another man is found catching at something or somebody. One woman goes round and round a place. This is Post Epileptic Automatism. Epileptic equivalent is important from medico-legal aspect. It is very difficult to prove it. Sometimes there is what is called "Dual personality" in these cases. The patient altogether changes his personality. One of our patients so far lost his identity that he went and claimed a perfect stranger as his uncle. This man, in his ordinary movements, is a quiet-going decent man; but when he is off-colour the change in his personality is great. He forgets Kuppuraj 1 and becomes Kuppuraj 2. He gets wild in his appearance, takes to meat and beaf diet (a change from his usual vegetarian diet), is impulsive, aggressive and when given the chance he will assault. He has a complaint against everybody and loses his respect for the Superintendent and the other staff. The memory of every patient suffering from epilepsy to the events of his fit and its sequlae is a total blank. The patients have only heard that they have got epilepsy; they do not know that they have epilepsy.

Now, coming to the question of Pathology, there are two schools of thought, one sticking to the theory that epilepsy is purely an organic disease; while the extrimists of the other school hold that it is purely psychological. Something has to be said for both. One experienced Superintendant of a Mental Hospital goes to the extent of saying that there is a cerebral tumour however small in every case of epilepsy. Some of the constant changes found in the brains of these cases are, any immaturity of the cells, certain loss of cells, increase of nuroglia, thickening of the durameter and some increased cerebro-spinal fluid. In some there is thickening of the skull and adhesion of the membrane. There are some changes in urine as well. Nobody can deny the existence of organic changes in the brain of some of these people; but it is very difficult to say whether the organic changes are the cause or the effect of the disease. Taking the psychological aspect of this disease there are some constant factors. There is what we call the epileptic character. It is on subjects with this character that epilepsy takes a hold. Throughout life these patients exhibit a certain amount of mental infantilism. It is a childish mind with a childish outlook of life. With some their vocabulary is small, and their ideas are few. Many of them are as easily suggestible as children. Their instincts often get the upper hand of them. They are extremely selfish; they cannot brook interference; everything has a special reference to them. They have often complaints of a silly nature. In their anxiety to get sympathy for them they often complain about the ill-treatment by the staff. Many of them show sexual perversities and according to modern psychology the adult sexual instinct is one of slow evolution. The various sexual perversities shown by these patients is an indication of the childish sexual instincts, which are polymorph-perverse. It is the childish instinct that makes many of these strip themselves naked, that make them play about their genetalia without attaching any sexual perversities which happen among these people. Again many of these people want to go back to their childhood days. The attitude of universal flexion with some of them put on, indicates that they are unconsciously wishing to go back to the mother's womb. The tendency on the part of some of these to go, hide, and make themselves invisible, is indicative again of child mentality. The secretive habits of some of these is another indication. The extra religiosity of some of these people is a request, all unconcsious, to seek some support from a Father (God) from whom they seek protection—another childish trait. Some psychologists point out that the fit in an epileptic is indicative of the gratification of the childish sexual instinct unconsciously *via* the medium of the musculature and the consequent unconsciousness being the indication of the infantile wish to retire from the world of reality going back to the mother's womb. The findings of an immature brain together with congenital physical anomalies also point in the same direction. Therefore it is very difficult to say whether idiopathic epilepsy is organic or psycogenetic and what exactly the

relationship is between the psychical and mental characteristics of epilepsy and which of these is responsible for the other. According to the psychical theory, the disease occurs in persons with an immature cerebral cortex. Due to an autotoximia there is intra vascular clotting and arterial spasm, the vascular supply is cut off which gives rise to convulsions. The convulsions resulting in elimination of toxines. According to the psychological theory the essential mental peculiarities, the affective immaturity especially in the the psycho-sexual sphere, the psychical meaning of the fits or their equivalents are strivings of the unconscious or the fulfilment of unconscious wishes just as much as dreams are.

Epilepsy in children, gives rise to mental deficiency, the extent of the deficiency corresponding to the age of onset of the disease. The ultimate result of mental disease in the epileptic is a profound Dementia. As for prognosis, all told, it is not very satisfactory. Treatment of epilepsy is very unsatisfactory and therefore I don't propose to say anything about it.

Every case has to be treated on its own merit. We had not so far any specific treatment nor is it perhaps possible as the causes of epilepsy are as divergent as its course.



Abstracts

PRINCIPLES OF MEDICAL ETHICS OF THE AMERICAN MEDICAL ASSOCIATION

(Continued from February Issue)

CHAPTER II.

THE DUTIES OF PHYSICIANS TO EACH OTHER AND TO THE PROFESSION AT LARGE.

ARTICLE I

DUTIES TO THE PROFESSION

Uphold Honour of profession : Section 1.—The obligation assumed on entering the profession requires the physician to comport himself as a gentleman and demands that he use every honourable means to uphold the dignity and honour of his vocation, to exalt its standards and to extend its sphere of usefulness. A physician should not base his practice on an exclusive dogma or sectarian system, for "sects are implacable despots; to accept their thraldom is to take away all liberty from one's action and thought". (Nicon, father of Galen.)

Medical Societies : Section 2.—In order that the dignity and honour of the medical profession may be upheld, its standards exalted, its sphere of usefulness extended, and the advancement of medical science promoted, a physician should associate himself with medical societies and contribute his time, energy and means in order that these societies may represent the ideals of the profession.

Deportment : Section 3.—A physician should be "an upright man, instructed in the art of healing." Consequently, he must keep himself pure in character and conform to a high standard of morals, and must be diligent and conscientious in his studies. "He should also be modest sober, patient, prompt to do his whole duty without anxiety; pious without going so far as superstition, conducting himself with propriety in his profession and in all the actions of his life." (Hippocrates)

Advertising : Section 4.—Solicitation of patients by physicians as individuals, or collectively in groups by whatsoever name these be called, or by institutions or organizations whether by circulars or advertisements, or by personal communications, is unprofessional. This does not prohibit ethical institutions from a legitimate advertisement of location, physical surroundings and special class—if any—of patients accommodated. It is equally unprofessional to procure patients by indirection through solicitors or agents of any kind, or by direct advertisement, or by furnishing inspiring newspaper or magazine comments concerning cases in which the physician has been or is concerned. All other like self-laudations defy the traditions and lower the tone of any profession and so are intolerable. The most worthy and effective advertisement possible, even for a young physician, and especially with his brother physicians, is the establishment of a well merited reputation for professional ability and fidelity. This cannot be forced but must be the outcome of character and conduct. The publication or circulation of ordinary simple business cards, being a matter of personal taste or local custom, and some times of convenience, is not *per se* improper. As implied, it is unprofessional to disregard local customs and offend recognized ideals in publishing or circulating such cards.

It is unprofessional to promise radical cures; to boast of cures and secret methods of treatment or remedies; to exhibit certificates of skill or of success in the treatment of diseases; or to employ any methods to gain the attention of the public for the purpose of obtaining patients.

Patents and Perquisites : Section 5.—It is unprofessional to receive remuneration from patents for surgical instruments or medicines; to accept rebates on prescriptions or surgical appliances, or perquisites from attendants who aid in the care of patients.

Medical Laws—Secret Remedies : Section 6.—It is uprofessional for a physician to assist unqualified persons to evade legal restrictions governing the practice of medicine. It is equally unethical to prescribe, or dispense secret medicines or other secret remedial agents, or manufacture or promote their use in any way.

Safeguarding the Profession : Section 7.—Physicians should expose without fear or favour before the proper medical or legal tribunals, corrupt or dishonest conduct of members of the profession. All questions affecting the professional reputation or standing of a member or members

of the medical profession should be considered only before proper medical tribunals in executive sessions or by special or duly appointed committees on ethical relations. Every physician should aid in safeguarding the profession against the admission to its ranks of those who are unfit or unqualified because deficient either in moral character or education.

ARTICLE II

PROFESSIONAL SERVICES OF PHYSICIANS TO EACH OTHER

Physicians Dependent on each other: Section 1.—Experience teaches that it is unwise for a physician to treat members of his own family or himself. Consequently, a physician should always cheerfully and gratuitously respond with his professional services to the call of any physician practising in his vicinity, or of the immediate family dependents of physicians.

Compensation for Expenses: Section. 2.—When a physician from a distance is called on to advise another physician or one of his family dependents, and the physician to whom the service is rendered is in easy financial circumstances, a compensation that will at least meet the travelling expenses of the visiting physician should be proffered. When such a service requires an absence from the accustomed field of professional work of the visitor that might reasonably be expected to entail a pecuniary loss, such loss should, in part at least, be provided for in the compensation offered.

One Physician to Take Charge: Section. 3.—When a physician or a member of his dependent family is seriously ill, he, or his family should select a physician from among his neighbouring colleagues to take charge of the case. Other physicians may be associated in the care of the patient as consultants.

ARTICLE III

DUTIES OF PHYSICIAN IN CONSULTATIONS

Consultations should be Encouraged: Section 1.—In serious illness, especially in doubtful or difficult conditions, the physician should request consultations.

Consultation for Patient's Benefit: Section. 2.—In every consultation, the benefit to be derived by the patient is of firstimportance. All the physicians interested in the case should be frank and candid with the patient and his family. There never is occasion for insincerity, rivalry or envy and these should never be permitted between consultants.

Punctuality: Section 3.—It is the duty of a physician, particularly in the instance of a consultation, to be punctual in attendance. When, however, the consultant or the physician in charge is unvoidably delayed, the one who first arrives should wait for the other for a reasonable time, after which the consultation should be considered postponed. When the consultant has come from a distance, or when for any reason it will be difficult to meet the physician in charge at another time or if the case is urgent, or if it be the desire of the patient, he may examine the patient and mail his written opinion, or see that it is delivered under seal, to the physician in charge. Under these conditions, the consultant's conduct must be especially tactful; he must remember that he is framing an opinion without the aid of the physician who has observed the course of the disease.

Patient Referred to Specialist: Section 4 —When a patient is sent to one specially skilled in the care of the condition from which he is thought to be suffering, and for any reason it is impracticable for the physician in charge of the case to accompany the patient, the physician in charge should send to the consultant by mail, or in the care of the patient under seal, a history of the case, together with the physician's opinion and an outline of the treatment, or so much of this as may possibly be of service to the consultant; and as soon as possible after the case has been seen and studied, the consultant should address the physician in charge and advise him of the results of the consultant's investigation of the case. Both these opinions are confidential and must be so regarded by the consultant and by the physician in charge.

Discussions in Consultation: Section 5.—After the physicians called in consultation have completed their investigations of the case, they should meet by themselves to discuss conditions and determine the course to be followed in the treatment of the patient. No statement or discussion of the case should take place before the patient or friends, except in the presence of all the physicians attending or by their common consent, and no opinions

or prognostications should be delivered as a result of the deliberations of the consultants, which have not been concurred in by the consultants at their conference.

Attending Physician Responsible: Section. 6.—The physician in attendance is in charge of the case and is responsible for the treatment of the patient. Consequently, he may prescribe for the patient at any time and is privileged to vary the mode of treatment outlined and agreed on at a consultation whenever, in his opinion, such a change is warranted. However, at the next consultation, he should state his reasons for departing from the course decided on at the previous conference. When an emergency occurs during the absence of the attending physician, a consultant may provide for the emergency and subsequent care of the patient until the arrival of the physician in charge, but should do no more than this without the consent of the physician in charge.

Conflict of Opinion: Section 7.—Should the attending physician and the consultant find it impossible to agree in their view of a case another consultant should be called to the conference or the first consultant should withdraw. However, since the consultant was employed by the patient in order that his opinion might be obtained, he should be permitted to state the result of his study of the case to the patient, or his next friend in the presence of the physician in charge.

Consultant and Attendant: Section 8.—When a physician has attended a case as a consultant, he should not become the attendant of the patient during that illness except with the consent of the physician who was in charge at the time of the consultation.

ARTICLE IV

DUTIES OF PHYSICIANS IN CASES OF INTERFERENCE

Criticism to be Avoided: Section 1.—The physician, in his intercourse with a patient under the care of another physician, should observe the strictest caution and reserve; should give no disingenious hints relative to the nature and treatment of the patient's disorder; nor should the course of conduct of of the physician, directly or indirectly, tend to diminish the trust reposed in the attending physician. In embarrassing situations, or wherever there may seem to be a possibility of misunderstanding with a colleague, the physician should always seek a personal interview with his fellow.

Social Calls on Patient of Another Physician: Section 2.—A physician should avoid making social calls on those who are under the professional care of other physicians without the knowledge and consent of the attendant. Should such a friendly visit be made, there should be no enquiry relative to the nature of the disease or comment upon the treatment of the case, but the conversation should be on subjects other than the physical condition of the patient.

Services to Patient of Another Physician: Section 3.—A physician should never take charge of or prescribe for a patient who is under the care of another physician except in an emergency, until after the other physician has relinquished the case or has been properly dismissed.

Criticism to be Avoided: Section 4.—When a physician does succeed another physician in the charge of a case, he should not make comments on or insinuations regarding the practice of the one who preceded him. Such comments or insinuations tend to lower the esteem of the patient for the medical profession and so react against the critic.

Emergency Cases: Section 5.—When a physician is called in an emergency and finds that he has been sent for because the family attendant is not at hand, or when a physician is asked to see another physician's patient because of an aggravation of the disease, he should provide only for the patient's immediate need and should withdraw from the case on the arrival of the family physician after he has reported the condition found and the treatment administered.

When Several Physicians are Summoned: Section 6.—When several physicians have been summoned in a case of sudden illness or of accident, the first to arrive should be considered the physician in charge. However, as soon as the exigencies of the case permit, or on the arrival of the acknowledged family attendant or the physician the patient desires to serve him, the first physician should withdraw in favour of the chosen attendant; should the patient or his family wish some one other than the physician known to be the

family physician to take charge of the case the patient should advise the family physician of his desire. When, because of sudden illness or accident, a patient is taken to a hospital, the patient should be returned to the care of his known family physician as soon as the condition of the patient and the circumstances of the case warrant this transfer.

A Colleague's Patient: Section 7—When a physician is requested by a colleague to care for a patient during his temporary absence, or when, because of an emergency, he is asked to see a patient of a colleague, the physician should treat the patient in the same manner and with the same delicacy as he would have one of his own patients cared for under similar circumstances. The patient should be returned to the care of the attending physician as soon as possible.

Relinquishing Patient to Regular Attendant: Section 8.—When a physician is called to a patient of another physician during the enforced absence of that physician, the patient should be relinquished on the return of the latter.

Substituting in Obstetric Work: Section 9.—When a physician attends a woman in labor in the absence of another who has been engaged to attend, such physician should resign the patient to the one first engaged, upon his arrival; the physician is entitled to compensation for the professional services he may have rendered.

ARTICLE V

DIFFERENCES BETWEEN PHYSICIANS

Arbitration: Section 1.—Whenever there arises between physicians a grave difference of opinion which cannot be promptly adjusted, the dispute should be referred for arbitration to a committee of impartial physicians, preferably the Board of Censors of a component county society of the American Medical Association.

ARTICLE VI

COMPENSATION

Limits of Gratuitous Service: Section 1.—The poverty of a patient and the mutual professional obligation of physicians should command the gratuitous services of a physician. But endowed institutions and organizations for mutual benefit, or for accident, sickness and life insurance, or for analogous purposes, have no claim upon physicians for unremunerated services.

Contract Practice: Section 2.—It is unprofessional for a physician to dispose of his services under conditions that make it impossible to render adequate service to his patient or which interfere with reasonable competition among the physicians of a community. To do this is detrimental to the public and to the individual physician, and lowers the dignity of the profession.

Commissions: Section 3.—When a patient is referred by one physician to another for consultation or for treatment, whether the physician in charge accompanies the patient or not, it is unethical to give or to receive a commission by whatever term it may be called or under any guise or pretext whatsoever.

CHAPTER III

THE DUTIES OF THE PROFESSION TO THE PUBLIC

Physicians as Citizens: Section 1.—Physicians, as good citizens and because their professional training specially qualifies them to render this service, should give advice concerning the public health of the community. They should bear their full part in enforcing its laws and sustaining the institutions that advance the interests of humanity. They should co-operate especially with the proper authorities in the administration of sanitary laws and regulations. They should be ready to counsel the public on subjects relating to sanitary police, public hygiene and legal medicine.

Public Health: Section 2.—Physicians, especially those engaged in public health work, should enlighten the public regarding quarantine regulations; on the location, arrangement and dietaries of hospitals, asylums, schools, prisons and similar institutions; and concerning measures for the prevention of epidemic and contagious diseases. When an epidemic prevails, a physician must continue his labours for the alleviation of suffering people, without regard to the risk to his own health or life or to financial return. At all times, it is the duty of the physician to notify the properly constituted public health authorities of every case of communicable disease under his care, in accordance with the laws, rules and regulations of the health authorities of the locality in which the patient is.

Public Warned: Section 3.—Physicians should warn the public against the devices practiced and the false pretensions made by charlatans which may cause injury to health and loss of life.

Pharmacists: Section 4.—By legitimate patronage, physicans should recognize and promote the profession of pharmacy, but any pharmacist, unless he be qualified as a physician, who assumes to prescribe for the sick, should be denied such countenance and support. Moreover, whenever a druggist or pharmacist dispenses deteriorated or adulterated drugs, or substitutes one remedy for another designated in a prescription, he thereby forfeits all claims to the favourable consideration of the public and physicians.

Conclusion: While the foregoing statements express in a general way the duty of the physician to his patients, or to other members of the profession to the public, it is not to be supposed that they cover the whole field of medical ethics, or that the physician is not under many duties and obligations besides these herein set forth. In a word, it is incumbent on the physician that under all conditions, his bearing toward patients, the public and fellow practitioners should be characterized by a gentlemanly deportment and that he constantly should behave toward others as he desires them to deal with him. Finally, these principles are primarily for the good of the public, and their enforcement should be conducted in such a manner as shall deserve and receive the endorsement of the community.

Notes on Treatment of Diseases

N.B.—These notes are intended to supplement the treatment given in ordinary text books and neither to be expected nor possible to be exhaustive.

Constipation: In giving soap-water enema, it is better to add 3 or 4 drops of Ol. Eucalyptus (Leonard Williams).

(2) Mycol (A.F.D.) containing Bile Extract, Lactic ferments, Beer Yeast is a powerful intestinal disinfectant and bowel educator and rationally indicated for the treatment of constipation and alimentary toxemia.

(3) For chronic constipation the best medicine is paraffin oil, specific gravity 0.89; it should not be combined with active drugs like thymol. If it is found in stools the dose must be reduced or a calomel purge should be given.

(4) The best intestinal disinfectant is thymol, but as it is soluble in almost all oils, alcohol, ether and chloroform, it should not be given with them. It may be given in 10 gr. doses enclosed in capsules three times a day for about a month. The next best disinfectant is Benzonaphthol in 10 to 15 gr. doses 3 times a day. No special precaution is necessary as in the case of thymol; then only comes Salol Bismuth Salicylas and Quinine Salicylas.

(5) Of the several purgatives some act on certain organs while others in other organs. Mercury, Podophyllin, Euonymin act on the duodenum; Sodium and Mag. Sulphate on the Ileum; Colocynth on the large intestines and Aloes on the rectum (Keith).

(6) The seven drugs reported to act satisfactorily in chronic constipation are (1) Paraffin oil (2) Benzo-Naphthol (3) Cascara (4) Mercurial purge (5) Salines (6) Aloin in children and (7) Belladona in old persons (Leonard Williams).

(7) For enema in cases of venous congestion in the pelvis, Mag. Sulph. 2 ounces glycerine 1 ounce and water 4 ounces may be given.

(8) For habitual constipation nothing is better than Cascara Sagrada.

(9) For regulation of bowels both in children and in adults phosphate of sodium 5 to 10 grs. in milk in the case of children and 30 to 60 grs. for adults. In very young children who pass dry and friable stools like those of dogs, Tinct. Bryonia in 10 to 25 mms. doses is good. Phenolphthalein 1 to 10 grs. in capsules at bed time is useful (Hare).

(10) In atonic constipation with grey dry tools, Tinct. Lobelia mms. 10 with cascaras at bed time is useful. In constipation or otherwise when the stools are dark in colour, podophyllin is indicated, but when the colour is light, calomel should be given.

(11) In infants of 1 to 3 months old who passes stonyhard stools podophyllin is the best remedy. It should be given by dissolving 1 grain of the risin in 1 dram of alcohol and 2 or 3 drops of this in sugar once or twice a day.

(12) Among the insane, Hormonal to be injected into the glutoal muscles and to be continued for two months (Stoddart).

(13) Mag. Sulph., Soda Sulph. and Sodium phosphate may be given for a long time without any harm. For adults Liq. Paraffin is not advisable and for the old nothing is better than Belladona ¼ to ½ gr. every day or castor oil (Leonard Williams).

(14) In giving sterilised bran, it should be mixed with meals and not taken separately either before or after meals. The laxitive property is contained in phylin found in the bran (Kellog).

(15) The addition of thyroid to the medicines given for constipation is good (Endocrine Survey).

(16) Laxa which is a combination of bran and Agar-agar is good. This is in the form of biscuits and may be taken with or without food.

(17) Regulin which is a combination of Agar-agar and Cascara in the form of flakes is good.

(18) Sodium sulph. gram 100, Sodium Phosphate gr. 80 and Sodium Bicarb grs. 60, ½ a teaspoonful of this in a tumbler of water every morning.

(19) Habitual constipation is divided into 5 classes; on account of the part played by the vegetative nervous system in its production depending on the action of the Atrophy, Pilocarpy, Epinephrine, Pituitary or all of them by injection.

(20) For infants at breast, one teaspoonful of the milk of magnesia with one teaspoonful of paraffin oil or a piece of loaf sugar dissolved in tipid or oatmeal water and given before each nursing (Armitage).

(21) For bottle-fed infants a few drops of codliver oil each feed or a teaspoonful of cream to each feed or 5 grs. of Soda Sulph or Sodium phosphate or Mag. Carb or 1 gr. of Sulphur for alternate feed. (Armitage).

(22) Thyroid extract is good (Armitage).

Notes on Therapeutics, Diagnosis and other Medical Subjects

Amines and their uses: There are 18 amines of which only one Glycocoll is made in the body. The tryptophane is necessary for the development and maintenance of the thyroid gland. Tyrosine is necessary for the development and maintenance of the adrenal glands; Lysine, Cystine and Phenyalanine are required for growth and maintenance.

Malnutritional Edema: The transudation of the fluid from the tissues to the blood-vessels and *Vice Versa* is neither due to mere filtration nor to osmosis, but to the secretary activities of the vascular endothelium. The endothelial activity is paralysed by an excess of sodium ions and stimulated by a sufficiency of calcium ions. Organic acid affects the walls of the blood-vessels and cause swelling and hyaline de-generation. Diets containing large quantities and of inorganic salts causing acidosis contribute to edema by their action of the walls of the blood-vessels (Reginald Berge)

Crackling of Joints: The change underlying this condition is a fibrocitis involving the capsule of the joints, the ligaments and the joints and any tenden or fascia in the immediate region. These structures are made of fibrous connective tissue which when allowed to contract shortens and when stretched causes the peculiar crackling. After this crackling has been produced or at sometimes the tissue is stretched and further crackling does not occur until the structure is allowed to reshorten (J.A.M.A.)

Fecal Excretion: On an ordinary mixed diet the daily fecal excretion of an adult male averages between 100 to 150 grams with a solid content varying from 20 to 40 grams (Barker).

Urea and Creatinin stand in marked contrast to each other since the former is largely exogenous in origin while the latter is almost entirely endogenous formation; uric acid stands in an intermediate position 1/3rd. endogenous and ⅔ exogenous under ordinary conditions of the diet (Barker).

About Urine: The beneficial factor involved in the regulation of urinary acidity is the proportion between the acid sodium phosphate and the basic sodium phos phate the former raising the acidity and the latter lowering it.

The secretion of urine consists of two distinct processes differing not only in site but also in nature; the first of these is filtration and occurs in glomerulus and is purely physical and the second reabsorbtion occurs in the tubules and depends upon the vital activity of the epithelium. By the first process the protein colloids of the blood plasma are filtered off and by the second water and the so-called threshold bodies as chlorides and sugar are largely reabsorbed while non-threshold substances or urea are rejected and can only escape by the ureter (Barker).

The appearance of acetone bodies as in Diabetes merely indicates one form of acidosis sometimes designated Ketosis (Barker).

Osmosis or the passage of solvent through a substance permeable to it but not to the dissolved substance which occurs as a result of the diffusion pressure of the solvents. Diffusion is the movement of the molecules of solute to regions of lesser concentration. It may be considered as a major force concerned in the distribution of urea and other non-protein nitrogenous substances and is also concerned in the movement of electrolites and their ions. Diffusion influences both the movement of molecules through the membranes and in fluids where membranes are not concerned, (Barker).

Never with Arsenic: If, indeed, in any case of Diabetes an arsenical treatment can be indicated, the arsenic should never be combined in the same prescription with orally administered Pancreas. Apart from the fact that arsenic has a tendency to cause an increase in the deposition of fats—and a kind of fatty degeneration is an almost constant symptom of prediabetes, there are other reasons.

Fatty degeneration of the islands of Langerhans is one of the most frequent causes of diabetes. Strong minerals like arsenic have a tendency to change the molecular constitution of protein substance such as pancreatic tissue. It is most important that the pancreas tissue be administered in liberal quantity and that the treatment should not require to be interrupted on account of such accidents as arsenical intolerance, or the need to periodically give a rest from arsenical treatment. There should never be any

excuse to say "the patient cannot take this medicine now." This class of medicine is best in a completely harmless form. The only additional ingredient permissible in a Pancreas pill is Hepatic tissue, which undoubtedly serves a useful purpose.

Extracts from Standard Literature In Erysipelas.

"*Sulfarsenol in the Abortive Treatment of Erysipelas*", *Dr. Ch, Borde, Society of Medicine and Surgery of Bordeaux.*

Meeting of June 22nd, 1928.

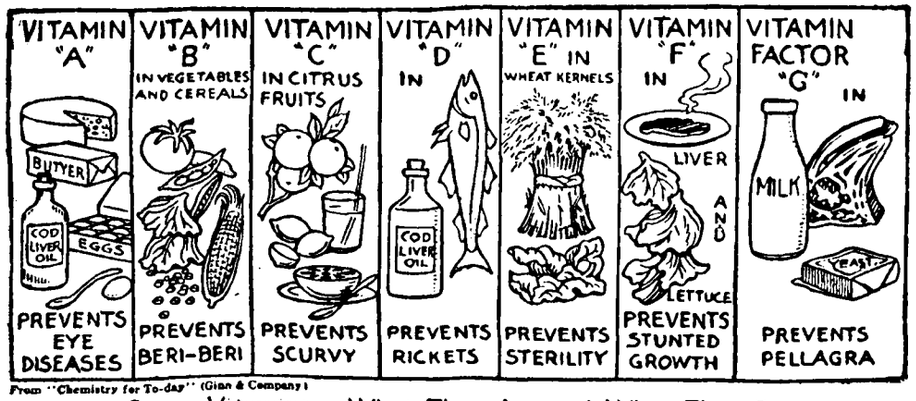
"Whether of medical or surgical type, erysipelas has known no really effective treatment up to the present time. Its treatment has been merely symptomatic. Accordingly, grave forms of this affection, which is usually rather benign, sometimes terminate fatally. I have therefore considered it useful to state that Sulfarsenol appears to be a remedy probably preventive, surely curative and even abortive, of erysipelas. While this opinion is based only upon eight cases, the latter are all conclusive, in view of the rapid results thus obtained."

"I use Sulfarsenol subcutaneously in the post-trochanteric region, in doses of 12 centigrams. Each dose is dissolved in an ampoule of dissolvarsan and injected every two days until cure occurs, which requires from one to four injections. I merely mention two benign cases".

Conclusions:—"I resorted to Sulfarsenol in the treatment of erysipelas because of the failures commonly attending customary treatment, also because of memories of death occurring in the case of two young patients, of whom one was treated with antistreptococcic serum while a fixation abscess failed of production three times with the other, and still further because of the excellent results, especially preventively, obtained by Riviere in treating puerperal fever with Sulfarsenol. Results seem to me still more notable in erysipelas, since they are excellent even after the affection is already present. This fact may be due to the circumstance that the streptococcus is the only bacterium present in erysipelas".

"I believe that physicians should test Sulfarsenol in erysipelas, it being a substance not hitherto employed for this purpose, as stated in a letter from the manufacturers of Sulfarsenol, dated February 2, 1928. It has given me unquestionable results, it is harmless, and it is readily applied.

For a long time I have used Sulfarsenol subcutaneously in the treatment of syphilis, always in the special solution indicated above, the maximal single dose being 30 centigrams. Thus far, I have had no complications whatever, even no malaise being produced. Neither advanced age nor marked obesity proved to be contraindications, in one of my cases of erysipelas published above.



Seven Vitamins. What They Are and What They Do

SPECIAL CONTRIBUTION TO THE MEDICAL PROFESSION.

Hysteria.

Nowhere else in Medicine does theory conflict so completely with fact, as in the theory and fact of Hysteria. It is almost time we dropped all consideration of theory in the treatment of the disease, and look at the patient What do you see during the attack? A nervous tension. What do you see between the attacks? A nervous tension of a different degree or sort. The more the experience a doctor has had in the effects of Elixir Bromo Valerianate (Gabail) the more obviously to him do these symptoms call for this one remedy. It meets the case most fully, doing an immense amount of good and no harm whatever. The patient may recover soon, or the treatment may take a long time, but Elixir Bromo Valerianate (Gabail) is perfectly safe to continue, for any length of time, and so long as these nerve tensions prevail in the least, there is no fear of depression. Besides, we have in Elixir Bromo Valerianate (Gabail) a Bromide prescription in which all depressive action is practically eliminated.

Epilepsy.

In the realm of medicine, the word Epilepsy may be considered as synonymous with Bromides.

Bromides however, (especially the potassium salt which is most in use) have a reputation for being depressing when continued for a long time.

And in cases of Epilepsy they are usually required for a very long time.

The two best measures available for reducing this tendency to depressive action are:—

(1) The adoption of the Strontium salt of Hydrobromic acid as we have in Elixir Bromo Valerianate (Gabail).

(2) The addition of Valerian to the prescription. Usually, Valerian has such a nasty flavour that the patient will not continue long to use it, but in Elixir Bromo Valerianate (Gabail) this is completely overcome by the special method of manufacture, by which the odour is not merely disguised but completely suppressed.

The taste of the Bromide cannot be completely covered, but if a little water be mixed with the Elixir before taking, it will be so reduced that no objections will be raised.

Neurasthenia.

When you are called on to treat a case of Neurasthenia, forget about your books for a while, and consider your patient.

Never mind the conflicting notions of how this "disease" is to be treated, at least until you have done all you can for the needs of your particular case, as you may find them. Find out the cause, and most likely it is either too much work or too much pleasure. It is not likely to be too much muscular work, unless mental effort or stress be also involved, and it is not likely to be too much walking or swimming. It might be shock.

Analyse the cause and you are sure to find that there have been too many nerve messages of one kind or another running along his nerves.

Either that or there have been nerve messages of such a severe kind that he has never recovered from their effect.

The next thing is surely to let him recover, if he can, by reducing the severity and frequency of future nerve messages. You may tell him to stop work or curtail the pleasure, but will his nerves and mind rest? Accustomed as they are to activity, they have the activity habit. To help cure that nervous activity habit nothing could be better than a little Elixir Bromo Valerianate, say half or one tablespoonful three times a day, according to the needs of the case. This will stop the exhausting process quickly and without doing any harm of any kind, and help materially towards recovery. There may be other matters also requiring your attention but in the majority of cases you will find that this meets the main cause of the trouble.

Palpitation

Nervous palpitation of the heart, especially in anaemic, neruasthenic, or overworked individuals can be much more correctly treated by means of Elixir Bromo Valerianate (Gabail) than by any other bromide prescription, because the strontium maintains the tone of the muscular system, including the heart, and reduces fatigue.

The reasons why Intramuscular Injections are preferred in the Treatment of Syphilis

(1) Less liability to shock. The latest theory regarding shock seems to point to a disturbance of the colloidal condition of the blood as the origin of this phenomenon. The slightest degree of flocculation or precipitation can induce this symptom.

(2) More sustained action. Absorption and excretion are both slower from intramusular than from intravenous injections. The effects therefore may be less immediate, but they are sustained.

(3) Chemical changes may occur.

In medication by arsenical compounds of the Salvarsan, Neosalvarsan and Sulfarsenol groups, it is well known that there must be some change in their chemical nature before they begin to exercise curative effects, because in a test tube, they fail to kill the parasites in many times the concentration reached in the human body.

The theory is that the arsenical compound unite with some protein in the tissues and in that new combination is parasiticidal.

Whatever the theory, the fact remains that some change has to take place, and that change requires time for its accomplishment.

In the case of 606 the change may take place in sufficiently short time. or there may be some detention by an intermediate reaction to slow down its excretion through the kidney, or there may be some other reason, but it is found that this chemical can exert a marked antisyphilitic action very rapidly in spite of the fact that it must be given intravenously.

It would seem that all the other antiluetic arsenicals fail to exert the full curative power when given intravenously. Certainly a very considerable portion of the dose is excreted by the kidneys within the first twelve hours after their intravenous injections. Still more is excreted within the first 24 hours. After that the excretion is slowed down and there appears to be a considerable degree of retention regarding the remainder of the dose absorbed. The retained quantity must be the only actively curative quantity.

When such compounds are injected into a muscle they come into close contact with the tissues with which the combination has to take place. The rate of excretion of arsenic shows that practically all of it becomes converted into the better retained spirillocidal compound.

It has its full effect.

That is the main argument for intramuscular use of the arsenical groups of antivenereal remedies.

Its principle is *economics*. Do not waste the good material. Put it into a muscle, or give it hypodermically, which is equally good.

It only remains to select the most suitable compound for use, and without doubt all the most reliable and completely confirmed experience points to Sulfarsenol, and to Sulfarsenol only. There may be others, more or less newly introduced, but where is the experience at the back of them ?

It has taken ten years to prove, by extended Wassermann tests, the superiority of this one compound. Are we to scrap all these tests and all that experience, because some one commercial firm or some other give it as their statement that the substitute is equal to the original ? Even if there some greater or smaller degree of chemical identity, has physiology nothing to say ?

There may be some utility in admixtures of 914 with glucose, dextrose etc, if they contain a sufficient quantity of the added material to completely prevent the pain. Some reports seem to point to the impossibility of the method being preventive in every case. Apart from the failure to prevent pain or perhaps abscess in some cases, it is essential that we should know the exact composition of such admixtures, because 45 centigrams of a mixture could not contain 45 centigrams of the medicament.

Most of us will abide by Sulfarsenol, because we know our old friends best.

Hay Fever

One of the most troublesome seasonal ailments, and one which causes extreme inconvenience to those who are susceptible, is Hay Fever.

The best method to attack the problem would be by vaccination, but unfortunately the pollens of India which cause the trouble have not yet been sufficiently studied.

The most reliable remedy so far found for Hay Fever in India is Hectine, either as Hectine injections or "Kinectine" (Hectine Compound) tablets.

Kinectine is the quinine salt of Hectine in tablet form, and is equally effective for Hay Fever, Coryza, cold in the head and Influenza.

The usual dosage of Kinectine is three tablets during the first day and two tablets each day for the next sixteen days. The tablets should be swallowed whole with a little water. In some cases of Hay Fever the trouble will disappear on the third or fourth day of the treatment.

Measles

Usually the safest treatment for Measles is to keep the patient warm in bed till all danger of complications are over.

Lately various antipyretic treatments have been advocated, but with most of these the diaphoretic action increases the danger of chills, and the urinary suppression which they originate also increases the danger of complications.

The safest of all antipyretic treatments for Measles is most certainly Cryogenine, which with its long maintained effect raises no difficulty of subsequent chills. Diaphoresis with Cryogenine is negligible and free renal function is rather encouraged than inhibited.

Under Cryogenine treatment the patient feels happier, while under other and more depressing antipyretics there may even be a tendency to weep.

PRACTICAL MEDICINE

Enterovaccin Lumiere

Antityphocolic Polyvalent Vaccine for Innoculation by the gastro-intestinal tract.

Typhoid fever is amongst epidemic diseases, one of those with a high morbidity and death-rate. In France alone, the deaths from this disease are about 20,000 annually.

In hot climates, and particularly where the public hygiene is imperfect, its ravages are still more extensive. In congested and crowded areas, in cases of over-strain, amongst troops on the field, and even in peace time, it takes a heavy toll.

In the French barracks during the last 20 years there have been 66,000 cases amongst which 10,000 were fatal. During the "Guerrde Cessation", where only 431,000 white troops were engaged, there were 27,056 deaths from typhoid. In the Transvaal War, the same disease caused about 8,000 deaths. In the Franco-Prussian War 1870, 74,205 Prussian soldiers were affected with typhoid of whom 8,904 cases were fatal. In Morocco during the 1914-1918 War, typhoid claimed many victims amongst the troops in the field before anti-typhoid vaccination was generally employed.

Formidable in its virulence, the Eberth Bacillus, microbic agent of typhoid, is still more formidable owing to the facility with which it propagates.

The blood, viscera, expectorations and particularly the urine and excretion of the patient contain the bacillus in abundance. It spreads by direct contact and may also be carried to a distance, having the faculty of retaining its vitality for a considerable time outside the organism. Drinking water, milk, fruit and vegetables from infected regions, oysters and various shell fish are all ordinary sources of the disease. Further, all those who have been infected, but who have apparently fully recovered, can frequently remain carriers for considerable periods.

These facts, show that it is almost impossible to prevent contagion by ordinary measures and explain also the serious effort made during these later years to ensure protection by the only effective means namely, immunisation by vaccination.

That it is effective is a well known fact. Several methods of anti-typhoid vaccination are to-day available. Nearly all offer the necessary guarantee of efficacy and it is merely a question of preference or convenience that favours one method from another.

The question of the method of administration is the principal factor.

The greater number of anti-typhoid vaccines have to be given subcutaneously. This has certain inconveniences; for many people have an aversion to hypodermic injections while others do not care to lose

the time necessarily taken up in two or three surgery visits. Further, apart from the local and general reactions which may result from the injections, the liquid vaccines, like all biological products, are subject to alteration, from which serious results may occur. There is also considerable difficulty in the safe transport of liquid vaccines over long distances and their conservation in hot climates.

The vaccination method of A. Lumiere and J. Chevrotier (**Enterovaccine Lumiere**) does away with the above inconveniences.

It is by placing the bacilli under quite special conditions, preventing action by the gastric secretions, by studying the action of exotoxins, endotoxins, dead bacilli and cultures, their age, the means of sterilisation, both physical and chemical, the dosage, the intervals between vaccination, etc., that Lumiere and Chevrotier succeeded in preparing polyvalent vaccines capable of conferring certain immunity by the gastro-intestinal tract, against the infectious conditions due to the Eberth bacillus, the paratyphoid and the bacterium coli communis.

The result of their investigations were given in the following communication to the Paris Academie des Sciences—*Polyvalence des Serums Antityphiques*—18th Nov. 1921';—*Toxicite des Vaccins Antityphiques*—2nd. June, 1913 ;—*Vaccination Antityphique par voie gastro-intestinale*—Jan. 19th 1914. In the last communication, Lumiere and Chevrotier gave the composition and method of preparation of their polyvalent antityphocolic vaccine. Many people have asked why Lumiere and Chevrotier did not recommend the addition of bile to their vaccine with a view to cleansing the mucuous membrane and thus facilitating absorption. They assert that the idea is quite erroneous as has been proved by experience.

The biliary extracts cannot be introduced directly into the stomach. They must be taken in keratin coated capsules or pills which are dissolved only in the intestines, and these capsules or pills gradually dissolving can only supply the small quantity of bile they contain over a large surface of the intestinal tract. According to Lumiere, experiments carried out "in vitro" and on animals, showed that it took 5 to 6 hours for the diffusion of the bile in this type of product. What then can be the use of a few centigrams of bile, slowly diffused throughout the intestines, which normally receives from 800 to 1000 centigrams of bile ?

Indications

Enterovaccine Antityphocolic Lumiere is not only unalterable, but extremely simple in administration. Its immunising power is very active as each pill contains 10 milliards of sterile micro-organisms, making a total of 300 milliards in the week's treatment. The liquid vaccines only contain one or two milliards in the 3 or 4 injections which comprise the fortnight's treatment.

It is further extremely polyvalent, and thus has the maximum chance of being effective as a prophylactic agent for immunisation. The use of Enterovaccine Antityphocolic Lumiere is advised for administration to every individual exposed to typhoid infection, whether directly, or indirectly to those who are likely to sojourn in districts where the disease is endemic or epidemic , and even to those who have to live in congested or over-populated are as, and are likely to come in contact with carriers of the infection, or consume the sources of infection-water, milk, fruit, shell fish etc.

Directions for Use

Four spherules of **Enterovaccine Antityphocolic Lumiere** should be taken daily, 2 morning and evening with a glass of water, for a period of 7 days.

For children under 7 years, half the above dosage. There are no contra-indications.

In no case is it necessary for persons undergoing treatment with Lumiere's Antityphocolic Vaccine to cease work or alter in any way their usual regime.

MEDICAL REPORTS ON FELSOL.

The originals of the following letters are on file at Felsol registered offices.

I

I thank you for your sample of "Felsol." I have used it on a case of Asthma and wish to say that it does you credit in achieving what you say with reference to promptly arresting the attack. It does so in a markedly efficient manner with no bad after effects at all. One particular patient had bad after effects following the usual injections, this never occurred after " Felsol." ... ...M.R.C.S. L.R.C.P.

II

I am in receipt of the samples of "Felsol" which you so kindly sent me. I tried it in the case of a patient who has had most severe asthmatic attacks for the past fortnight, necessitating hypodermic injections of morphia, atropine and adrenaln, and it acted like a charm.

... ... Dr. H. G.

III

Kindly send me sample of " Felsol " so that I may give it a good trial on myself. It has worked wonders with my niece.

... ... M.R.C.S.

IV

I have tried the sample of " Felsol " on the most obstinate case of Bronchial Asthma, that, at present, I have under my treatment. I am glad to say that the result was simply marvellous.

... ... M.D.

V

I have tried the " Felsol" samples with excellent results on a patient who has proved extremely resistent to vaccines for over twelve months.

... ... M.D., M.R.C.S., L.R.C.P.

VI

I tried two of the " Felsol " powders on a patient suffering from Cardiac Asthma of a severe character and am glad to say that he got great relief. Amyl nitrite has been unsuccessful in this case.

... ... M.B., B.Ch.

VII

You kindly sent me a short time ago a Physician's sample of the internal remedy for Asthma, " Felsol." I used 2 of the powders last Friday night in an old standing case of Bronchial Asthma ; *in 15 minutes there was very great relief after one powder only.* I have promised my patient I would write to you and ask you to send me some more ; he blesses me from the bottom of his heart since last Friday.

... ... M.D.

VIII

I have just tried the sample powders of your preparation, on an old gentleman of 70 years of age who has been suffering with Bronchial Asthma and who has tried almost every known remedy without any success. He now writes me that the powders have worked wonders, and he hopes, at last, he may have an easier and pleasanter time. I, therefore, have wired you to send me ½ dozen boxes.

..... L.R.C.P., L.R.C.S.

IX

I gave the sample of "Felsol" which you sent me to a middle aged woman who is a confirmed sufferer from chronic Bronchial Asthma. A single powder, she found, gave her rapid relief in an attack and helped to ward off further attacks. The powders indeed have given her far more relief than any other form of treatment she has tried —and their name is legion.

..... M.R.C.S., L.R.C.P.

X

Thanks for sample of "Felsol" received Saturday, June 5. I just happened to have a severe case of Asthma and casually thought that I would just try your powder on him. His breathing was very difficult before. I called in to see him this morning and I was delighted by his report. He said that half an hour after he took the powder his breathing improved and he slept all night. ..... M.D.

XI

Kindly send me one dozen boxes of "Felsol" as soon as possible. The sample six powders you kindly sent gave immediate and great relief to a man, a long sufferer from Bronchial Asthma and I wish to push on with the remedy and also try it in another chronic case.

.....M.R.C.S., L.R.C.P.

XII

Thank you very much for the samples you sent me. I gave them to a lady patient of mine suffering from Influenza, Acute Capillary Bronchitis, Pleurisy and Inflammation of the Kidneys. Her respirations were 44 to 46 a minute—in 36 hours they came down to 30 a minute and gave her great relief. She is now quite well and out again. I shall therefore be obliged if you will send me 24 powders to have by me.

..... L.R.C.P. (Lond.)

P.S.—I shall certainly recommend them to all my professional friends. The patient herself told me voluntarily that the powders had given her great relief.

XIII

The sample of "Felsol" came to hand on the 3rd instant, and on the following day, my patient commenced to take the powders.

The immediate result has been so satisfactory that I wish to continue with the treatment without any break.

..... M.B. Ch.B.

XIV

The samples of "Felsol" you sent me have, in the words of the patient "done magic." .....M.B., Ch. B.

XV

Kindly forward me a supply of "Felsol" 1 dozen boxes at once. I have tried the sample you sent me, in one of the most distressing cases of Bronchial Asthma, with excellent results.

..... M.D.

XVI

Would you please forward me by return 5 boxes of "Felsol" for which I enclose cheque. The patient for whom I require them has found more relief from "Felsol" than anything else so far tried for Bronchial Asthma. ..... M.B., B.S.

XVII

I thank you for the sample of "Felsol" you sent me; my patient is most grateful and says it relieved his attacks more than anything he has tried yet.

..... L.S.A., L.M., S.S.A.

XVIII

I am greatly obliged to you for the further samples of "Felsol" you were good enough to send to me; they have been a real "Godsend" to my poor patient, who has been a great sufferer from Asthma, until I got to know of your powders.

..... M.D.

XIX

Thank you for the sample "Felsol" you sent me recently. I have tested it as well as a sample you sent me previously, and think it splendid.

..... M.R.C.S., L.R.C.P.

XX

The sample of "Felsol" you sent me gave great satisfaction in one of my worst cases here. ..... M.B., C.M.

XXI

Would you please forward to me a quantity of "Felsol." I should like to give this product a thorough test, for already the sample which you forwarded to me has acted like a charm.

..... M.B., B.Ch.

XXII

Will you please send me 1 doz. boxes of "Felsol." They have achieved more than I expected, and my Asthma patients are more than grateful for the relief they obtain from "Felsol."

..... M.R.C.S., L.R.C.P. (Lond).

XXIII

Thank you for the sample of "Felsol" which has done one of my patients a lot of good. Last night he slept longer than he has done for six months.

Please send me a dozen boxes for which I enclose cheque.

..... M.D., B.Sc.

XXIV

In confirmation of this morning's telephone message, I should be glad if you would please send to Miss.....of..... 3 dozen "Felsol" powders. You will be pleased to know that this seems to be the only remedy that has given any relief to this patient.

..... M.R.C.S., L.R.C.P.

The Treatment of Insomnia and Nervous Diseases.

Insomnia from whatever cause is one of the first things to reduce one's stamina, and the person who is subject to sleeplessness for any length of time is very apt to become hypochondriacal, and his resistance against illness of any kind is very near to zero.

Insomnia is often the result of disordered digestion caused by indigestible food, or by food taken in excess just before going to bed. A course of Papyta Tablets, one after each meal soon rectifies matters, and normal sleep is once more enjoyed.

When sleeplessness is due to defective circulation a cardiac tonic, such as Digibaine may be indicated.

The majority of insomnia cases however, are usually of a purely psychical or nervous origin, and it is here that great care has to be exercised in choosing the correct remedy to prescribe for the patient.

There should be administered no specific which will interfere with the heart, kidneys or digestive functions: in fact all organic functions should be unaffected. Something is required which will produce a natural and refreshing sleep so that the patient may wake up with a feeling of fitness and well being.

According to the research of many Doctors, Dr. Marie and Dr. Bourilhet in particular, Veronidia A. F. D. answers the above requirements for emotional or neurasthenic insomnia, and its efficacy is

no less marked in sleeplessness caused by acute illness or pain such as toothache and neuralgia.

In many cases of insomnia of psychic or nervous origin the doctor may hesitate to prescribe a soporific while hopes remain of the possibility of controlling the trouble without the direct use of the "sleeping draught."

A remedy of this class which is worth a trial is Elixir Bromo Valerianate (Gabail).

The usual dose of this Elixir is a tablespoonful three times a day, and this quantity so quietens the nervous and psychic excitement, that usually no "sleeping draught" is necessary. After a few days the dose may be gradually reduced to half a tablespoonful, or even less. None of the depressing effects of potassium bromide are observed, because the Strontium salt is used in preparing this product. Sleep appears to come on at night as a natural phenomenon and the patient wakes up in a natural manner when rest is completed.

MENTAL EXERCISE FOR MEDICOS

(Continued from page X of the February issue)

TRY YOUR LUCK **RARE OPPORTUNITY**

The prizes may be increased or decreased at the discretion of the Manager whose decision in all matters must be accepted as final. A correct solution is one which agrees fully with the key solution deposited with the Editor of "The Medical Practitioner". The admission fee of Re. 1-0-0 per entry must be sent either by Money Order or in G. C. notes but not in stamps. The necessary fees must accompany the solutions without which the solutions will not be accepted. Entries will be accepted on plain paper. Competitors are requested to write their addresses in block letters both in the money order coupon and in the entry form. *Closing date has been extended to 30th April*, 1931. Results will be published in the May issue of "The Medical Practitioner." Entries and remittances to be addressed to

The Manager, MEDICO-SURGICAL HALL,
58, North Street, Karur (Trichy. Dt.) S. India.

[The table has been re-published as there was a slight error in the previous one; the rest of the matter remains the same as published in the February issue.]

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51		■	■	52								

News and Comments

The Gandhi-Irwin Peace Pact: The medical profession should rejoice with the rest of their brethren in other fields of life at the Gandhi-Irwin Peace Pact. The Civil Disobedience movement which fortunately ended after the treaty was of a nature unknown in the history of the world. A war was waged without weapons on one side and the lathies on the other side were considered to be most ignoble. All glory to Lord Irwin who acted the part of a true healer of wrongs and to Mahatma Gandhi who as an ideal devotee of God, suffered and preached others to suffer to bring about peace in the country which lost her two precious gems in the struggle Lala Lajpat Rai and Pandit Motilal Nehru. Members of the medical profession did not lag behind in this struggle either in this province or elsewhere and we welcome them all back from the prison. It is quite possible for members of the medical profession to do ideal national work, be it the propaganda for swadeshi goods onthe campaign against liquor. They could do very efficient propaganda without leaving their chairs in their consulting rooms. Yet jail life having lost its horror attracted many from among the profession. We are sure even in jails they were as useful as they were outside in treating human ills. There has been very little talk about medical relief in the National Congress so far. The fact that during this Congress war, hospitals came into existence as a part of the campaign will, we hope, not be lost sight of by our leaders who are now engaged in nation-building work.

Medical Registration in Mysore: A bill for the registration of qualified Allopathic Medical Practitioners in Mysore has been introduced in Mysore Legislative Council. It has passed the hands of the Select Committee and will come for discussion at the March session of the Legislative Council. The bill was a verbatim copy of the Madras Medical Registration Act (IV of 1914) when it was introduced but has since undergone some changes by the Select Committee. To make the scope of the measure clear, the words "practising Allopathic system of medicine and surgery and obstetrics" have been added in the preamble to indicate the class of practitioners which the Mysore bill deals with. The word 'Sanatorium' is added in the list of medical institutions coming under the purview of the bill. The Madras Act does not contain this word as this Provincial Government has been combating Tuberculosis without a Sanatorium. In sub-Section (2) of clause 4 of the bill 'or' appearing before 'Sanatorium' might as well come after 'Sanatorium' and following 'or' may be added "any other institution where Allopathic system is practised or taught" etc. The Medical Council is to consist of 10 members with the Senior Surgeon to the Government of Mysore as the nominated president, and out of the 9, 5 are to be elected and the remaining 4 are to be nominated by Government. In this respect, the Mysore Council is to be more democratic than the Madras Council which has 8 nominated members to the 7 elected, but in effect both cannot but be far from democratic as the state of the profession—we mean the independent medical profession—is in both the provinces. There is one notable feature in the formation of the Mysore Council that is seen in sub-clause (c) under clause 5 where it is mentioned that 2 members are to be elected by registered practitioners who are graduates of Mysore or any other universities named in the schedule thereto. In Madras, graduates of all other universities except of Madras and Andhra are grouped amongst the non-university diploma-holders. There is certainly more virtue in this change and it appears to us that the virtue was a necessity as almost all the existing medical officers of the Mysore State including the Senior Surgeon are graduates of the Madras University. There is no need of the sentence after 'Vice-President' in sub-clause (2) of Clause 5 "who shall preside at the meetings of the council" as such a clause might indirectly imply that other members of the council cannot preside during the absence of both the President and Vice-President. This function of the Vice-President may be advantageously mentioned in the rules to be framed for the 'conduct of meetings' provision being made also for any other member of the Council to preside at the meetings in the absence of both the President and Vice-President as it is quite possible both may be absent for a meeting due to unavoidable circumstances. Practitioners in the British Register have no representation at all in the proposed Mysore Council nor is there a need for such

special representation in a province ruled by an Indian Raja. This is as it ought to be. The five members to be elected ought to be from a general constituency which must be brought into existence under the general rules of election and we suggest to those who have control over the destinies of a future Mysore Medical Council that in this and other matters regarding this bill, they may rely on the British Medical Act of 1858 from which the Madras Act emanated in a much distorted form, the skeleton having no muscles and other component parts which make the British Council as elegant as it is useful in contrast to the Madras Council which is a discordant and lifeless body. The practitioners should be grouped together and not in three parts as in Madras Register, all should exercise their votes in electing graduate and non-graduate representatives. As the non-graduates are more in number, we would suggest that this constituency should elect one graduate and four non-graduates on the basis of proportional representation. Clause 11 of the bill deals with the appointment of Registrar and we wish the framers of the bill realised the importance of this officer especially in a Council where the President of the Council is the Senior Surgeon who has naturally very little time to look after the affairs of the Medical Council as is the case in Madras and may have necessarily to condone the sins of omission and commission of his executive assistant, the Registrar. The practitioners in Madras Medical Register are too familar with the 'negative powers' of the Registrar of the Medical Council. It looks as if the framers of the bill did anticipate such 'negative powers' in the would-be Registrar of the Mysore Council and they have added a clause regarding this appointment making it subject to approval of the Government. True it is that such a clause is against democratic principles but when the strings of democracy are in the hands of bureaucrats such a clause cannot but be wholesome. We feel it is our duty to point out that it will be disastrous to have a practising doctor as the Registrar as is the case in Madras. The Council has invariably to sit in judgment over the infamous conduct of practitioners and it is quite possible that the practising Registrar may at any time come in conflict with another practitioner who will be very much hampered in case he wishes to complain against the practising Registrar as in all such cases the proceedings have to be initiated by the Registrar. The Madras Council have not as yet realised the importance of the functions of the Council much less those of the Registrar. A large majority of them are persons in Government service and naturally the affairs of the Council cannot but be a pastime to them. It is therefore essential that the Registrar is not a medical man as is the case in Great Britain and the majority of the Councils in India. In case out of professional sympathy due to unemployment, the Mysore Council chooses a medical man, let him not have the privilege of private practice. In Clause 15 there is an omission of stamp duty of annas twelve for registration which is in the Madras Act and we trust it is a desirable omission. Power to make rules by Government and bye-laws by the Medical Council also find a place in the last clause of the bill. As these rules are not framed and the bye-laws have to be passed by the future council we shall deal with this subject in a subsequent issue. In the meanwhile we wish our readers read the opinion of Dr. H.B. Mylvaganam, F.R.C.S., (Eng.), who is one of the members of the Select Committee. Dr. Mylvaganam's remarks deserve the serious consideration not only of the members of the Mysore Legislative Council but of the whole profession. He is one of the most prominent members of the medical profession in India who served the Mysore Government in various capacities and retired as the Senior Surgeon. He is in touch with Indian and foreign conditions regarding the profession as his experience is as ripe as it is fresh. We agree with him that a Medical Registration Act in the form proposed by the Mysore Government will be of no benefit either to the public or the profession. Dr. Mylvaganam's minute as addressed to the Secretary of the Select Committee appears in the correspondence columns of this issue.

No More Unqualified Compounders in Mysore State: Native States are much in advance of British India in many respects. As an instance, a bill to amend the Mysore Municipal Regulation, 1906, will come for discussion at the next session of the Mysore Legislative Council. If the bill is accepted, which is very likely, unqualified compounders will cease to exist in the Mysore Province. The bill entails registration on shops dealing with drugs recognised by British Pharmacopoeia and the person entrusted with the duties of the compounder should possess a certificate of his qualification A fine not exceeding Rs. 100 is imposed for not registering a chemist shop, not exceeding Rs. 50 if compounding is done by non-qualified person and a fine not exceeding Rs. 10 for not producing a certificate by a compounder when demanded by a Magistrate or Medical Officer not below the rank of Asst. Surgeon or a Health Officer. We are bound to point out the defects in this small yet very useful piece of legislation. There are many European drugs outside the scope of the British Pharmacopoeia, largely used by the profession. So instead of saying 'drugs recognised by British Pharmacopoeia,' 'drugs used in the allopathic system of medicine both official and non-official' may be inserted. The framers of the bill would have popularised its scope by including all registered practitioners among persons who could demand the production of certificates by the compounders engaged in chemist shops. Now that Mysore is to have a medical registration regulation, such invidious distinctions in the profession should be as far as possible avoided in the interests of the profession as well as the public.

Government Nullifies their own Order: Our readers might remember that the Government quite recently passed orders that no rural dispensary should be started in a village where a qualified practitioner had settled without the help of the Government subsidy and in case a taluk board wish to have a rural dispensary in a place, the practitioner of the place should be appointed to run such a dispensary. Hardly two months have passed when those in authority were forced to rescind their own order regarding such a dispensary at Kaup, a village in Udipi, South Kanara. The fact that the D.M.O., S. Kanara, did not get any official communication regarding the latest order from the Surgeon-General till 25-2-31 the date when the rural dispensary came into existence at Kaup makes us believe that the Surgeon-General was not consulted at all before the Government thought it fit to nullify their order No.2923 P.H. dated 21-11-1930 referred to in these columns in December last. We learn also that the Government have passed a general order to the effect that in future no rural dispensary Allopathic or of other system should be brought into existence in a village where a registered practitioner had settled and that taluk boards should obtain a certificate from the Surgeon-General about the non-existence of qualified practitioners in the village where they intend to start a rural dispensary. This order makes the situation still worse. General orders seem to depend upon persons more than upon principle or principles. At least it has been so in this case. When Government cannot uphold their own action, the public morals necessarily undergo degeneration. It seems the Government do not realise this aspect when individuals are concerned. This is neither democracy nor autocracy. Shall we coin a word 'favouritocracy' to put the Government's action under this heading.

Bombay Government turns down the five Years' Course For Medical Licentiates: The College of Physicians and Surgeons of Bombay laid down a five years' course for the L. C. P. S. Diploma quite recently under the new regulations. They also insisted on the medical school authorities that the science course should be finished within 60 lectures in a period of only six months instead of spreading the whole course for a period of one year. Deducting holidays and treating Saturdays as working days, there are available only 62 days in six months which period was rightly considered by the school authorities to be hardly sufficient for this purpose as in this case science lectures had to be given every day. The College of Physicians and Surgeons would not budge an inch and insisted that the course should be finished within the time fixed by them. The Government seems to have taken advantage of this difference between the College of Physicians and Surgeons and the Superintendents of schools and made the present deficit finance as the immediate cause to disapprove of the proposal of a five years' course.

It is very unfortunate that the Bombay Government has taken a very retrograde step and done a great disservice to the cause of medical education in Bombay. This Government as well as others in other provinces can as well close the medical institutions where medical licentiates are being trained as those sent out of the schools are more than the number

required by the Government for service purposes. In Bombay, only five Sub-Asst. Surgeons are needed on an average per year and on a percentage calculation 95% of medical licentiates get absorbed in the independent medical profession.

Is the Government in Bombay and elsewhere justified in supplying to the public, medical men of different standards when no difference could be made in the methods of treatment adopted by medical men of all grades in teaching human ills? They seem to have plenty of money for other purposes such as creating new appointments, starting new institutions, appointing committees for inter-university conferences and other items of expenditure in the name of medical relief, not excluding the proposed All India Medical Council and the pertaining committees and sub-committees and conferences of Surgeons-General etc., but not for bringing about a uniform and high standard of medical education. Large and fabulous amounts of money are being spent every year for the committees and sub-committees etc. As pointed out by us elsewhere in this issue and many other past issues of this journal, the remedy to improve the lot of medical licentiates whether it be regarding education or anything else lies in their own hands, and that is persistent agitation through the length and breadth of India. If the medical licentiates who are the largest group of medical men both in service and private practice do not realise this, the blame will be theirs.

Hospital Committees: The system of Advisory Committees for assisting the management in state hospitals has been introduced in the moffusil also and we learn from several medical men that the Government have not put into these committees several types of men of experience as in England where similar committees function. We dealt with this subject in detail last year in the September issue of this journal when we saw seven such committees brought into existence in the Madras city. Those who wish to represent to the Government about any defects in the moffusil committees will do well to refer to our comments on this subject as the same were based on the system prevailing in the land of our Rulers as mentioned in a book 'Hospital Organisation and Management' recently pulished in England with an introduction by His Excellency the Governor of this province (then the Hon'ble Sir Arthur Stanley.) Apart from members representing various other experiences there is special representation in these committees for members of the independent medical profession in addition to the medical men in those hospitals who are all members of the independent medical profession unlike in this country.

It should not look as if these committees brought specially into existence by the Government not by election but by nomination, are meant to certify the actions of those who run the Government charitable institutions and whose doings are usually criticised and resented by those who take shelter in such institutions.

Local Fund Sub-Asst. Surgeons: Apart from Sub-Asst. Surgeons in Government service there is a class of these medical men recruited for service by the district boards to serve in taluk board dispensaries. In days gone by, a few of the district boards such as of S. Kanara used to train their own medical subordinates then known as Hospital Assistants and all the taluk board dispensaries in the district were manned by medical subordinates of this cadre. It is so in S. Kanara even to this day and in a few local fund dispensaries graduates have stepped into the shoes of the Sub-Asst. Surgeons. In other districts there is a mixture in the work of local fund Sub-Asst. Surgeons,—some are pucca district board servants, others are Sub-Asst. Surgeons in Government service lent to these local bodies. A few of the local fund Sub-Asst. Surgeons have been complaining to us about the hardships *viz* (1) insufficient pay, the start and increases being much smaller than that of Government Sub-Asst. Surgeons. (2) desire for transfers at least once in five years and to be placed under the disciplinary control of the Surgeon-General (3) need for post-graduate course in Dt. Headquarters hospitals at least once in 10 years of their service (4) promotion as Government Sub-Asst. Surgeons in the proportion of 10 per cent. of those in Government service.

Our advice to those practitioners under local fund service is, that it is too much for them to expect that the Government will do anything in the direction of redressing their grievances mentioned above which are being expressed by them as such. Conditions of a particular service should not be confounded as grievances.

The Sub-Asst. Surgeons knew when they joined the service what their lot would be. If there be any infringement of rules in their service as such it is grievance, but regarding the change in the service conditions nobody can set it right except the local fund Sub-Asst. Surgeons themselves. For this purpose we shall suggest to them to hold a conference in any important place and draft a memorial to the district boards for bringing about necessary reforms so as to cast them in much the same position as Government Sub-Asst. Surgeons. As mentioned by us elsewhere in this issue, the Government ought to have revised the Local Boards Act so as to keep this class of useful servants of district boards under control of a provincial nature though exercised by local bodies themselves. We on our part shall certainly help this class of practitioners to the best we can when they make up their minds to help themselves.

Treatment of Social Diseases: Mr. Donald Miller, Secretary of the Mission to Lepers, while opening a new operating theatre at Bankura Leper Home mentioned in the course of his address appealing to his Indian audience that they should regard leper work as a challenge to their patriotism. While politics, he said, touched a part of the nation's life, it did not touch all of it and a true patriot must not forget those other aspects in his absorption in the political side. He regretted that so much of the service of the lepers of India had been left to *friends from far away lands.* The care of the leper was of essential value in helping India to her fullest freedom."

We would add venereal diseases in this category. What applies to lepers who could be generally made out as such in a society is true doubly regarding those members of the public, suffering from venereal diseases who could not be detected as easily as lepers are, and hence greater vigilence and greater attention have to be bestowed by our patriots regarding the measures used for combating venereal diseases also.

What do we find in our country and in our own province when a Missionary in the person of a secretary of a Mission rightly criticises us as a nation that we leave the work of lepers to *friends from far away lands,* our local Minister who has a reputation of being a nationalist, though a leader of a communal federation, renews for another 5 years—a period more than that of his own office—the Missionary management of the Tirumani Leper settlement. We mean no offence to the Madras Church of Scotland Mission who are agents of the local Government to run the Lady Willingdon Leper Settlement at Tirumani.

Regarding venereal diseases, the report of the Ministry of Health in England, a huge organisation under the Government reveals that the work done in this direction is very unsatisfactory even in the methods employed in detecting venereal diseases, much more necessarily regarding the treatment of the victims. Yet the Madras Government under the advice of the Surgeon-General entrust this work to one individual who, though frank in his opinion that there is not scope for combating venereal diseases in the existing hospitals, has not suggested any practical ways to do this work more satisfactorily. The venereal specialist though imported to Madras from a free country could not shake off vested interests in the scope of medical relief in this country and is said to have recommended to train more medical officers and not *private medical practitioners.* This will mean more prosperity to medical officers and less recognition of the existence of members of the Iindependent medical profession and a need for apportioning larger amounts of money in the future medical budgets if this item has not been already included in this year's budget. It is never too late for our popular Minister to conceive that social diseases will be doing more havoc than ever unless the Government gets the help and cooperation of the general practitioners.

The All India Medical Licentiates Association: We regret we could not publish in the last issue, the proceedings of a meeting of the standing committee of the Association which took place at Delhi on the 17th and 18th January, 1931 as the same were sent to us after we went to the press.

15 members were present from different parts of India and Dr. Khan Chand, the Vice-President, presided. 16 resolutions were passed on various items pertaining to the work of the Association which we hope will be published in detail in the official organ of this body. The three main items of importance which were discussed were (1) Discrepancies in the accounts of the Treasurer and the office of the Editor

of "The Indian Medical Journal" (2) The All India Medical Council, and (3) Venue for the Jubilee Conference of the Association.

Regarding the discrepancies in the accounts which were objected to by the auditor, the standing committee expressed regret and piously hoped that the finance committee and the treasurer prevent a recurrence. The Editor of "The Indian Medical Journal" gave an assurance that he would explain the discrepancies with the help of his clerk at his Calcutta office and a committee of three members including the General Secretary was appointed to visit the Editor's office for the purpose. The report of this committee will be placed before the Jubilee Conference.

Doctors are usually bad accountants, but in cases where accounts are placed before public auditors, they would do well to be above blame. Objections in audit report have been a chronic disease and in eradicating this ailment, the remedy must be something more than pious hopes.

It is regrettable that some of the members of this responsible committee would not agree to hold the Jubilee Conference this year on *political grounds*. The political situation instead of being made an excuse for not holding the Conference ought to have been a stimulus for organising the same. The proposed All India Medical Council Bill if not anything else ought to have opened the eyes of all concerned in the prosperity and even the existence of medical licentiates. It was beyond the powers laid down in the existing rules to have the Conference elsewhere than in Bombay as no local branches invited the Conference. Under the circumstances, the decision of the committee is a preposterous as it is illegal. Those concerned to summon this Conference in Patna last year did fail miserably nor did they invite the Conference a second time.

A Nurses' Bureau: On 19—2—31 Mrs. M. Hannen-Angelo organised a gathering of select doctors, nurses, laymen and women interested in the nursing profession, at the Madras Nurses' Club, Egmore. Lt. Col. Pandalai I. M. S., presided. The object of the meeting was to concert measures to start a Nurses' Bureau. After an informal discussion about the advisability of having a Bureau in the city, a subcommittee was appointed consisting of Dr. P. V. Cherian, Mr. Wilfred Periera and Mrs. Hannen-Angelo for drawing up the necessary scheme. An advisory committee was also formed consisting of all the doctors present at the meeting that day with power to co-opt for the purpose of helping the sub-committee. We are rather doubtful if the proposed Bureau will be able to provide work for all the qualified nurses under the circumstances prevailing in the city. So the idea suggested at the meeting to include in the Bureau unqualified nurses cannot be acceptable. The existing numerous hospitals in the city are open to the rich and their gates narrow down as the poor try to get in. The nursing homes run by service and ex-service medical practitioners take the remaining few among the rich after their admission into the hospitals in the wards of at least a few who have not as yet conceived the idea of starting nursing homes. The Corporation Child Welfare centres cater to the wants of a large section of the public. The general practitioners in the city are too busy with their work in their dispensaries that very few of them could think of engaging nurses for their cases except under extraordinary circumstances. The net result has been so far unemployment to private nurses and private practitioners. All the same we wish luck to the proposed Bureau.

Dr. W. J. Fernandez has been created a knight: Knighthood is not the gift of only His Majesty the King Emperor. His Holiness the Pope confers also Knighthood and similar honours, which coming as they do from the highest spiritual head, has certainly a highter value in the eyes of those devoted to religion. Dr. W. J. Fernandez has been created a Knight of the order of St. Gregory the Great. His unostentatious services invariably rendered free both to the clergy and many Catholic institutions did not go unrewarded. Dr. Fernandez is a familar figure to the members of the medical profession in the city which was the only field of his activities. They know him first as the faithful assistant of that renowned Surgeon Col. Niblock and later as the third surgeon and the Resident Medical Officer of the Government General Hospital in the city, the duties of both these offices he discharged with credit to himself and to the profession. He gave up Government service and chose to be an independent medical practitioner and has been doing the work of a Surgical Consultant maintaining the dignity and prestige of the profession and though not quite old in years he is worthy of being followed by others like him in the profession. We congratulate him most heartily.

X-Ray Institute at Kumbakonam: As announced in the last issue, Kumbakonam can now be proud of an X-Ray Institute with all the up-to date scientific appliances, a brief description of which has been given in the advertisement appearing elsewhere. We congratulate Dr. Sambasivan on his splendid achievement. We trust that the public and the medical profession will co-operate and help this Institution and encourage this young doctor who has done a distinct service to Kumbakonam with a pretty heavy outlay.

A Correction: The cross and downward puzzle table has been published a second time as a mistake crept in the first one. As was mentioned by us last time the puzzle will be a relaxation to medical men. The fee for entry is certainly too small compared with the cost of the prizes offered. We have in our possession the key solution in a sealed cover. We kindly invite our readers to the announcement made on this subject elsewhere and hope they will encourage a pastime which will also bring them luck.

Admission of L. M. Ps. to M.B.B.S: At the instance of Dr. Guruswami Mudaliyar the Academic Council of the Madras University passed unanimously at their meeting on 14-3 31 a regulation making it possible for L. M. P. diploma holders to qualify for M.B.B.S. degree. The regulation runs thus:

"A candidate who holds the Diploma of L.M.P., or any other qualification accepted by the Syndicate as equivalent thereto, will be admitted to the Degree of M.B.B.S. provided—(a) he passed the Diploma examination at least five years before the date of application for the Final M.B.B.S. Degree Examination; (b) that he has passed the Intermediate in Arts of this University or an examination accepted by the Syndicate as equivalent thereto; (c) that he attends for two years in all special courses in a College of Medicine affiliated to or recognised by this University; and (d) that he passed Part II of the 1st, and the whole of 2nd and Final M.B. and B.S. Examinations of this University and that the above regulation to take effect forthwith".

The medical profession especially the L.M.P. section of it will be thankful to Dr. Guruswami Mudaliyar who initiated this much needed reform and to the other members of the Academic Council who gave their unanimous support to the proposal. We advocated the urgent need of such a reform in these columns in March last and we are glad that our suggestion came to pass though the existence of clause (b) in the regulation, will certainly make it appear that the reform is a half-hearted measure. It may be argued that the S.S.L.C. course is considered by the authorities in England, not sufficient for entrance to medical studies in that country and such of the L.M.Ps. who go to England for higher medical studies have to pass (1) Cambridge School certificate (higher) examination (2) Oxford school certificate examination or (3) the College of Preceptors senior examination. The L. M. Ps. who proceed to England finish the entrance examination within a couple of months at the most but in their own country they are made to sit with youngsters in intermediate classes who are much below the age of the L.M.P. practitioners of 5 years standing. The fact that the seconder of this regulation, Prof. K.V. Rangaswami Iyengar expressed that an L.M.P. who had five years practice and had undergone two years in the Medical College could be considered to possess sufficient general knowledge as to fit him for a higher degree and that to insist on a qualification in general knowledge would be unfair, will convince our readers that this aspect was considered. But, no body including the seconder was as much magnanimous as occasion deserved by not pressing that the Intermediate course was unnecessary. The Board of Medical Studies would have rendered real service if they published beforehand their recommendations in the press or at least in the medical journals of which we have enough number in our province. Reforms are brought about for public good. Secrecy even of a well-meaning nature and prompted by modesty, will at times frustrate the otherwise good purposes of healthy reforms. We appeal to our patriots who constitute the Board of Medical Studies to bring an amending

regulation at the next meeting of the Academic Council to do away with a two years entrance course to the L.M. P's and in case they are anxious to satisfy the British Medical Council, they may bring about an entrance examination of the nature now obtaining in England, which will enable the L.M.Ps. to go through this course in as small a period as it is in England. Imitations are many a time odious in the matter of reforms especially if they do not serve the purpose for which such reforms are brought about in a country like India where conditions are quite different. It looks as if Dr. Guruswami Mudaliyar in his anxiety to rush through the new regulation which was long over due, did not consider the very arguments offered by him in favour of this regulation. For he said that the propsed "regulation was intended to encourage the best talents in profession who unfortunately due to *poverty or other circumstances* were unable to take in the first instance the M. B. course." We ask Dr. Guruswami Mudaliyar with all earnestness whether the existence of clause (b) in the regulation is compatible with the kind spirit which prompted him and others to inaugurate this regulation.

Correspondence, Reports, etc.

THE BRITISH MEDICAL QUALIFICATIONS AND LICENSED MEDICAL PRACTITIONERS

BY

DR. D. SIVASUBRAHMANIAM, M.R.C.S. (*Eng.*), L.R.C.P. (*Lond.*), *Medical College, Vizagapatam.*

(Continued from February issue.)

Before a 'Licensed Medical Practitioner' or a Sub-Assistant Surgeon proceeds overseas he must obtain and take with him the following documents : 1. His (her) diploma, 2. Medical Registration certificate 3. A course certificate with the details of his Medical School course, with special reference to having personally conducted 20 labour cases (This can be had from the respective Medical Schools on payment of Rs. 5. 4. Age certificate. 5. A vaccination certificate. 6. A passport issued by the local Government or the Collector of the district as the case may be.

Only the first four certificates are required for the purpose of the Conjoint Board of Examiners and the other two are required only to enable the person to travel comfortably and for the purposes of passport regulations.

Though a post-graduate student can join the Medical Schools in England at the beginning of any quarter in the year, still it is advantageous from the point of view of the student, that admission is sought either for the summer session—which begins in April, or for the winter session which begins in October. I would personally prefer October as it also coincides with the beginning of their regular academic term. But there is this disadvantage in October ; it is at that time, many students rush in and consequently competition for seats is also greater. There is an erroneous tendency for some people to equip themselves with all sorts of sundry clothing and carry an enormous amount of luggage with them. This is not only not necessary but it is also uneconomical. Unless a student travels in the winter season (December to February) he can easily manage in his voyage with the ordinary suits and with one or two tweed suits he may have already with him. It is economical and more fashionable to go in for the necessary woollen clothing after arrival in London. One should take with him however a rain coat, which will have to be reinforced in addition by a regular woollen overcoat after arrival in England. About £20, I would consider quite sufficient as initial outlay for all the necessary woollen clothing including underwear, gloves etc. As I have already said before, one can spend any amount on anything he wants, and that too in London. But I am giving here only the figures necessary for a reasonable living for a student.

Before sailing from India it is always advisable to write to the Warden, the Indian Students' Union and Hostel, 112, Gower Street, London, W. C. 1., or to the Warden, The Indian Students' Hostel, 21, Cromwell Road, London, S. W., giving the probable date of arrival in London and asking, if possible, to reserve a room in either the one or the other. Every 'cabby' knows the two institutions very well and there is absolutely no trouble for a newcomer to find his bearings. Specially in the Gower Street Hostel, even if rooms are not available in the Hostel, the Secretary personally sees that accommodation is obtained in one of the nearby boarding houses known to him and renders every facility to make the 'fresher' at home. I cannot possibly thank the Secretaries of the Indian Students' Hostel, enough for the various amenities which they have provided and are providing for the Indian students abroad. One outstanding figure most loved and respected alike for his simplicity and sincerity is Mr. P. D. Ranganatham who was the Warden of the Institution from its inception till lately. (He was himself the originator of the scheme). Now he has shifted his activities to the Continent. The Cromwell Road Students' Home is also equally comfortable and in some respects better furnished. This is run, as a Quasi Government Institution under the auspices of the High Commissioner for India, London. This hostel also is invariably full up.

The office of the High Comissioner for India is now, I hear, shifted to the newly opened 'India House' in Aldwych. Every Indian student, whether he is a scholarship-holder, or a private student or a post-graduate on study leave, can have access to the secretaries of the various departments of the High Commissioner's Office, who are ever willing to render whatever

help they can for the fresher such as recommendatory letters to the Deans of colleges, facilities for apprentices in industrial or manufacturing concerns, letters to boarding houses, advice regarding banking etc. etc. There is a separate educational department which is most in demand, and from 10 A.M., to 6 P.M., interviews are given by the Secretary for the students seeking advice. Without exaggeration I may say that in the course of a day about 40 to 50 interviews are given. In some cases the officer himself corresponds and gets everything 'shipshape' for the candidate, but if in every case the High Commissioner's Office is unable to meet the Students' demands it is because of circumstances beyond their control. For all Government servants and scholarship-holders payments are quite promptly and regularly made into their respective banks by the accounts-section of the High Commissioner for India.

Before concluding, let me impress upon the readers that the difficulty of the English examinations should not be underestimated. Decades ago it might have been easy to pass. At any rate it is not so now. I can boldly say that the standard of the L R. C. P., M R. C. S., is decidedly a little more than the average M. B. B. S., standard. It is particularly more difficult for the L. M. Ps whose training, I am sorry to say, is deficient in so many respects due to a short course. The Editors of 'The Medical Practitioner' have been ventilating the grievances of the L. M. Ps. regarding their imperfect training and constantly pressing for a revision of their curriculam. Major V. Mahadevan, I. M. S., the present Superintendent, Royapuram Medical School is very enthusiastic in the matter of the revision of the curriculam and I am sure he will do his best to improve the lot of the students under his care. The present Surgeon-General, Major General C. A. Sprawson, I. M. S., has already expressed his sympathies in this respect when he inaugurated the Royapuram Medical School Students Union' and I humbly request that the Surgeon-General will, during his tenure of office, improve the L. M. P., course to 5 years and earn the everlasting gratitude of the numerous L. M. Ps. both past and present.

Besides the various facilities available to the students, in their respective hospitals and medical schools, the museums of the Royal College of Surgeons of England and Royal College of Physicians of London, are always open for energetic students and it is no exaggeration to say that every subject of the medical curriculam can be easily and thoroughly revised by a patient study of the museum specimens. So exhaustive is the collection. Similarly are the facilities available in Edinburgh and Dublin as well. Besides, there are any number of post-graduate lectures, clinical meetings, demonstrations, etc. which are held almost every day and could be attended by any interested student. Only there should be the will to learn! I may also as well appeal to the readers and prospective students who are thinking of going abroad, to avail themselves of the full facilities available to them and to 'study medicine' not merely for getting through the examination but to learn it thoroughly at its very fountain head

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Deputation of The All India Medical Licentiates' Association.

MAJOR-GENERAL J. W. D. MEGAW'S REPLY.

First let me welcome this deputation of the All India Medical Licentiates' Association. I am particularly glad to have an opportunity of having a frank discussion with you with regard to the various matters which you have brought before me. I am speaking to you in my personal capacity, and I hope you will not regard me as giving you an authoritative statement of the policy of the Government of India. Like you I consider that it is desirable to work for unification of the medical profession in India, and you may rest assured that any advice that I may give to Government will be directed towards the final achievement of this object. Sometimes, however, it is desirable to hasten slowly, and I think that the formation of a unified All India Medical Register will be more likely to be effected by taking one step at a time rather than by attempting to reach the goal by a single leap. If we were to attempt at this stage to form a register, which would include all classes of the medical profession both graduates and licentiates, the only result would probably be that we should fail to secure international recognition of our Indian degrees, whereas if we begin by

securing the recognition of the university degrees and then raise the standards of school medical education to the same level we may hope eventually to secure the desired unification of the medical profession. Even if we ignore for the moment the international aspect of the question, there is likely to be a very strong opposition in India to the immediate formation of a single All India Medical Register. The action which Government proposes to take in forming a register of the university graduates is not likely to have any harmful effect on the licentiates as their position in India will remain exactly the same as before. The object of the All India Register is not in any way to upset existing arrangements but merely to secure recognition of Indian degrees by the G. M. C. and other foreign bodies. I am sure that you would not desire to interfere with the achievement of that object especially as by doing so you would damage yourselves in the long run.

You are probably aware that the committee, which was appointed to consider the question of medical education in Madras, over which I presided, about 18 months ago, made certain recommendations which if carried out, will constitute an important step towards raising the status of the licentiates in that province. The committee recommended that the minimum course of instruction should be of five years and that the standard of qualification should be raised as soon as possible with a view to attaining the ideal of a uniform high standard of training with a single high minimum standard of qualification. It also recommended raising the standard or preliminary education and limitation of the number of students so as to prevent the evils of overcrowding in the profession and lowering of the professional and ethical status of medical men. Another important recommendation was that those holders of the diplomas who possess the minimum educational qualifications which are prescribed for admission to the medical colleges, should be eligible for recruitment to Government service on the same terms as the university graduates. It is by raising the standards of education and examination in the medical schools that a real improvement will be brought about in the status of the diploma holders rather than by the purely artificial means of placing them on the same Register as university graduates.

I freely recognise the hardship which is caused to diploma holders in India by placing serious obstacles in the way of their admission to the university medical examinations in India, whereas it is possible for them by taking much shorter courses of further study in England to secure registrable qualifications. You must realise, however, that it is not practicable for Government to interfere in the internal affairs of the Indian universities and your proper line of action is to bring pressure to bear on the universities to relieve you of this disability.

I fully realise the ability and the value of the scientific work which has been turned out by many of the medical licentiates in India, and my recognition of the worth of the licentiates has been no more "lip service." I have always insisted on their being judged by the quality of the work which they have done rather than by any artificial standards of academic qualifications. As an example of this, I may mention that I fought and won the battle of the licentiates in connection with their admission to the course for the diploma of the Calcutta School of Tropical Medicine, and you may be aware that some of the Assistant Professors in that School, as well as some research workers have been chosen from the ranks of the licentiates. In the various departments of medical research especially in the I. R. F. A. there are large numbers of licentiates. I think you have no cause for complaint on the grounds that their valuable work has failed to secure recognition.

So far as I can see it is likely that the All India Medical Council Bill will be so framed that there will be nothing to prevent the inclusion of medical licentiates on the Register when once their standards of education and examination have been raised to such an extent as to justify their claim to recognition on equal terms with the university graduates and the diploma holders of other countries. Of course you must recognize at the same time that the increase in the duration of the medical course, and the raising of standards of preliminary education, as well as of training and examination, must involve a considerable addition to the cost of the medical course. There will therefore be some hardship on the part of some of the poorer students, who will find it increasingly difficult to secure admission

to medical schools. I think my record during my thirty years in India has proved me to be a real friend of the medical licentiates of India: for this reason I claim that I have earned the right to speak to you as I would to my own brothers. My advice then is, concentrate all your efforts on raising the status of the licentiates in every respect. Do not rest satisfied with a mere imitation for the university standards but aim at something which will be recognized as being sounder and more practical. When you have succeeded in this the recognition of the licenses will follow as a matter of course.

Mysore Medical Registration Bill.

To

N. SAMIENGAR, ESQ.,

Secretary to the Select Committee,

GENERAL AND REVENUE SECRETARIAT,

BANGALORE.

Sir,

While I am agreeable to sign the draft report of the Select Committee on the Bill to provide for the Registration of medical practitioners in Mysore, I wish to record my opinion that the Bill does not go far enough to protect the less informed section of the public from being exploited by quacks and unqualified persons who practise allopathy. There is no special clause in the Bill compelling every qualified practitioner of allopathy in Mysore, to come on the Register. It is left to his or her option. The only disadvantages to them if unregistered, would be to disqualify them for any post as physicians, surgeons &c., and to make their certificates required by law, invalid. The appointments of physicians, surgeons &c., in Mysore are made by the Government and it is not likely that they would err on the wrong selection of men. An ordinance is not necessary to serve this purpose. It wouldn't trouble very many if their medical certificates are not valid. These two so-called advantages are more or less mystical to an ordinary medical practitioner and he is not likely to seek registration on that score.

Neither is there any provision to prevent unqualified persons and quacks from practising allopathy in Mysore, to the detriment of life and health of the ignorant masses. The educated classes know to whom to go to in times of medical need. But the ignorant masses need protection from these unlicensed practitioners of allopathy. If any and every unqualified person is allowed to practise allopathy without any restriction, there is no meaning in our maintaining a medical college and a school at great expense to the tax-payer. Further, allopathy as practised by this class of practitioners, is likely to fall into disrepute, a contingency we should avoid at all costs.

A Medical Register of this nature should serve two definite purposes, *viz.*, (i) to protect the general public from being exploited by unscrupulous quacks and charlatans for gain, and (ii) to protect a body of medical practitioners who have undergone a severe course of medical studies extending over a period of five years and more, especially in the case of such men who have been to Europe to qualify for higher degrees and to obtain wider practical experience.

In Ceylon, allopathy cannot be practised by any one other than registered medical practitioners. It is compulsory that everyone should be registered. This provision in the Ceylon ordinance completely shuts the door against unqualified medical practitioners. Any one who contravenes the regulation is placed before a Police Magistrate and on a summary conviction fined Rs. 200 for each offence. Unless some such strict provision is made in the Bill, the value of such an important and a far reaching ordinance would be lost. I am not a believer in "negative benefits", as advocated by some of our countrymen. I think we should take some courage in hand and legislate for a substantial benefit to our country instead of mistaking the shadow for the object. No useful purpose is likely to be served by a halting legislation of this kind which neither protects the ignorant public nor the qualified medical practitioner. We need not slavishly follow Madras and other Presidencies in India in this respect but set out an example of our own worthy of others to follow us.

If there be any deserving unqualified practitioners of allopathy in our midst, of whom there may not be more than one or two, special concession could be made to bring their names on the General Register.

Ayurvedic and Unani practitioners are not brought under the purview of this Bill. Those who practise these acts will not be interefered with by this Bill. A separate register for them will be necessary. But what is contended for is to prevent allopathy falling into the hands of quacks and charlatans, when there are in our midst many qualified medical practitioners, whose numbers are increasing annually, and whose interest, a Bill of this kind is expected to protect.

This minute of mine may be kindly circulated among the members of the Legislative Council along with the Select Committee's report.

I intend proposing an amendment to this Bill when it is taken up for discussion at the next session of the Legislative Council.

H. B. MYLVAGANAM, F. R. C. S. (ENG.).

Burma Private Medical Practitioners' Association, Rangoon.

(FROM A CORRESPONDENT.)

A meeting of the above Association was held with Dr. Murray in the chair in the house of Dr. N. N. Parakh, one of the leading practitioners in Rangoon. It was attended by about 40 doctors though the members of the Association totalled about 60. Although the total number of private practitioners in the City was 210 according to the 1931 census figures, the members who joined the Association were small as the Association was only recently started.

A number of resolutions came for consideration. The first was about the counter-signature of certificates which was moved by Dr. P. Guruswamy, L.M. & S. He dwelt upon the injustice done to private practitioners by the unreasonable and unethical practice of counter-signature. There was then a discussion, and eventually it was resolved that the existing system of counter-signature was against the spirit of the Medical Act and the Government be requested to abolish it without any reservation.

The next resolution was for a family benefit fund which was moved by Dr. G. Ramaswamy, L. M. & S. This resolution was referred to the executive committee of the Association.

The third resolution was about a public health scheme for the city. It was decided that private practitioners should help the public health authorities in the discharge of their duties.

The next subject discussed was about the abuse of the privilege of private practice by medical officers in Government service. It was eventually resolved that Government be requested that service men be not allowed to engage in active private practice or run nursing homes etc.

The last resoultion was about the starting of a magazine for the uplift of the independent medical profession. After some discussion, it was resolved to refer the matter to the executive committee of the Association.

Do Round Worms cause death ?

Sir,

I request you to kindly publish this and let me know the real cause of death from the following case:—

A Hindu boy aged 3, Venkatasubbiah, weaver by caste, came for treatment on 14th February, 1931 at about 12 P.M.

COMPLAINT: Fever 101° F, Abdomen ballooned.

PREVIOUS HISTORY: The patient had temperature since 4 days, sometimes with rigor and sometimes without. He was attended by a Vaidyan. It seems some purgative pill was administered on the 14th February morning and the boy had no motions.

When I exmined, the patient looked thin, anaemic, tongue coated and rough slightly blue at the tip. Both sides of the chest moved symmetrically. The abdomen was abnormally full and bulged out and due to the pressure over the diaphragm the patient had short breaths. Palpitation: The appex beats were palpable on the left side of the chest in the fourth interspace slightly external to the mammary line. Abdomen hard on pressure. Percussion: dull note throughout the abdomen. Auscultration: The appex beats were 79 per minute; there was a short murmur; gurgling sound throughout the abdomen. As the patient's condition was precarious, I had to stop further examination.

TREATMENT AND PROGRESS: Turpentine stupes to reduce the flatulence; 2 gr. dose of Calomel. After a few minutes foul-smelling flatus came out of anus. At about 1 P.M., the patient had motion and a bundle of six long worms measuring more than 4 to 5 inches was evacuated. Immediately after, there was a sudden fall of temperature to 95·2° F: extremities cold and clammy; pulse 45 per minute. Another worm measuring 6 inches came out. When I was just opening the camphor in

oil 1 c.c. for injection and before brandy and Tr. Musk reached me from the dispensary, the patient expired.

As the patient's relatives refused a post mortem examination, may I request you to let me know the probable cause of death.

Tq. Dispensary, Madhavaram, Cuddapah. } K. S. RANGASWAMY.

[The signs and symptoms enumerated above are those of perforation of the intestines It is quite possible that the perforation might have been brought about by worms. It is not improbable that the perforation might also be due to Typhoid ulcer which might have been perforated by the worms.—Ed.]

List of postings of Sub-Assistant Surgeons for the month of February, 1931.

Name of Sub-Asst. Surgeons	From	To
1. Dr. J. Apparao Naidu	L. F. Dy., Kunavaram	Hd Qrs. Hl., Cocanada.
2. ,, K. Varadarajan	(Newly entertained)	Hd. Qrs. Hl., Cocanada.
3. ,, A. J. C. Joseph	Alipuram Jail, Bellary	Hd. Qrs. Hl., Calicut.
4. ,, Ramalinga Nainan	L. F. Dy., Vedaranyam	c/o. P. D. B., Ramnad.
5. ,, K. Ramaswami	Govt. Royapetta Hl, Madras	c/o. P U. B., Sembiam, Perambur.
6. ,, M. Sridharamurthy	Govt. Hl., Gudur	c/o. P. T. B., Gudur.
7. ,, P. V. Subba Rao	L. F. Dy., Kota	c/o. P. D. B, Nellore.
8. ,, N. Ekambara Acharya	Govt. Mental Hl, Madras	c/o. D M. O., East Godavari
9. ,, B. Appalanarayana	Leave	King George Hl, Vizag.
10. ,, T. R. Venkataraman	Forest College, Coimbatore	Hd. Qrs. Hl., Coimbatore.
11. ,, T. R. Manikam Pillai	Hd. Qrs. Hl, Coimbatore	c/o. P. D. B., Coimbatore.
12. ,, M. Krishnan Nair	L. F. Dy., Kangayam	c/o. D. M. O., Ganjam.
13. ,, B. Rukmanga Rao	Hd. Qrs. Hl., Cocanada	L. F. Dy. Kalyanadrug
14. ,, R. Krishna Ayyar	F. F. Dy., Kalyanadrug	c/o. P. D B., Anantapur.
15. ,, K. N. Subramaniam	Govt. Hl., Palghat	Municipal Dy, Palghat.
16. ,, T. R. Subramaniam	Municipal Dy., Palghat	Govt. Hl., Palghat.
17. ,, Kunhi Raman Nair	Leave	Hd. Qrs. Hl., Trichy. and then c/o. P. D. B., Trichy.
18. ,, S. Arunachalam	Balliguda Dn., Russelkonda	Hd. Qrs. Hl., Salem
19. ,, T. C. Sitaram	Hd. Qrs. Hl., Trichy	c/o. Civil Surgeon, Vizag. Agency.
20. ,, K. Narayanan Nair	Leave	c/o. Civil Surgeon, Vizag. Agency.
21. ,, P. K. Narayanan Nair	Leave	c/o. P. D. B., Coimbatore.
22. ,, T. K. Nagarajan	L. F. Dy., Umarkot	c/o. P. D. B., Trichinopoly,
23. ,, K. Kuppusami Pillai	L. F. Dy., Sendurai	c/o. P. D. B., Trichinopoly.
24. ,, R. Krishnaswami	L. F. Dy., Marungapuri	Hd. Qrs. Hl., Trichinopoly.

Reviews

(1)

MYSORE MEDICAL ASSOCIATION.
2ND ANNUAL CONFERENCE HELD IN THE MONTH OF MARCH, 1930.

It is indeed very satisfactory to note that there is much co-operation between the private medical practitioners and medical officers in service in Mysore. At the Annual Conference, several interesting papers were read and the Conference seems to have been held on the model of the American Medical Association, and it is hoped that as in the case of the latter it will be held each year in different places and not in one and the same place.

Mysore State shows much advance in all matters pertaining to public health and medicine. Dr. Subba Rao, the Senior Surgeon is to be congratulated for his endeavour to bring about hearty co-operation among all medical men, private and official, and to advance medical relief and public health as much as possible.

M. S. K.

(2)

POPULATION AND BIRTH CONTROL
IN INDIA BY
DR. M. S. KRISHNAMURTHI, M. B. C. M.,
RETIRED SANITARY COMMISSIONER OF TRAVANCORE.

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Dr. Krishnamurthi with his varied and multifarious activities after he had retired and settled in Madras, as an Editor of "The Medical Practitioner" and of "The Madras Birth Control Bulletin" and as the Honorary Medical Superintendent of the Sree Ramakrishna Mission Free Dispensary at Mylapore and other work, has found time and energy to write a book of the nature of the one under review, is indeed highly creditable to him. Anybody reading the book will realise that he has brought to bear on it his extensive knowledge and varied experience on all matters concerning the welfare of the people. He has treated the subject not as an isolated one but as a part of the world problem affecting particularly the prosperity of the people of India and after giving facts and figures collected from almost all parts of the world for which statistics are available, he convincingly proves that the condition of India is serious and that birth control alone would save it as it has done in other countries of the world. His presentation of statistics and the marshalling of figures, in both of which he is a past master, are in best evidence in this book. According to the Chinese proverb, the doctors are divided into three grades; the first grade doctor serves the nation, the middle grade treats the individual and the lower grade treats the symptoms apart from the patients and Dr. Krishnamurthi evidently belongs to the first grade. As birth control is intimately connected with doctors they should take much interest in it. The present day administration requires scientific knowledge and not to be guided by precedents and antiquities in the administration. Of all classes of persons turned out from different colleges, it is the medical men who are given training in and are acquainted with a large number of sciences than any others. Perhaps time has come when for higher offices scientifically trained men are appointed. In this connection, the following quotation from the President of the Far Eastern Association of Tropical Medicine will be useful:

"A few advanced and intelligent countries such as Czecho-Slovakia are beginning to discover that the medical men make the best statesmen because their knowledge of life is very real and their mental outlook a genuinely wide one. The world, long centuries ago escaped from the peril when the public health was under the domination of priesthood with vested interests. To-day it seems to be passing through the transitory phase when administrative and executive power is concentrated in the hands of the legal profession and is under the control of men with quite intelligent minds but with no outlook upon life wider than that of precedent and antiquity. Tomorrow it may discover that the real role of the doctor is to prevent disease rather than to cure it and may reluctantly surrender administrative and legal control of preventable diseases to the medical fraternity. Ultimately it may discover that a true philosophy is the secret of life."

It is, therefore, recommended that medical men should not merely be satisfied with the treatment and prevention of sickness but interest themselves with the daily administration of the State and to assist them for this purpose, the book "Population and Birth Control in India" will surely be of great help. V.R.K.

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