

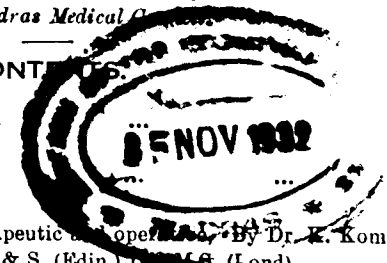
The Medical Practitioner

A Monthly Medical Journal

EDITED BY
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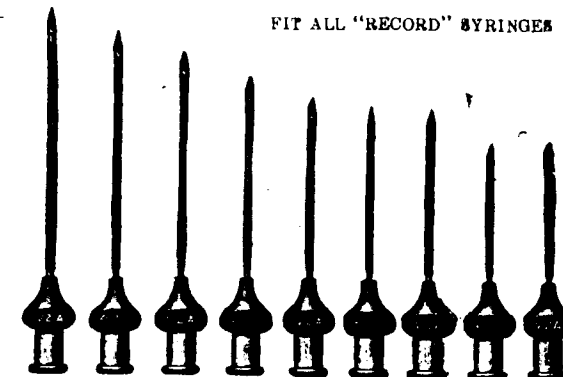
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VOL. IV.]

OCTOBER, 1932.

[NO. 1.

OURSELVES.

The journal is entering, with this issue, its fourth year of existence and we are glad to say, from the increasing number of persons subscribing for the journal, that it has been serving satisfactorily the public in general and the medical profession in particular. On looking back we are gratified to note that in spite of the economic depression, general unrest and retrenchment of expenditures, etc., which have characterised the immediate past, the efforts of the journal have been crowned with success in the matter of recognition by Government of the system of Honorary Medical Officers and the entertainment of a large number of honoraries, in ventilating the grievances of Rural Practitioners, in the abolition of Medical Schools in Districts and providing accommodation for them in the City where the facilities for imparting sound instructions are greater than in Districts, in the improvement of Medical Education in Schools and bringing it to the level of that obtaining in Colleges, in the recognition of the importance of Medical Inspection of Schools, etc. That the journal has been keeping the object of the improvement of the medical profession, whether official or private, and has been advocating in the matter of such improvements, will be evident from the fact that the number of subscribers among paid medical officers, including the members of the I.M.S. has been increasing year by year. The large number of doctors from outside the province including Burma and Ceylon, subscribing for the journal, shows

the usefulness of the journal even in professional matters. Though the beginnings have been made in all matters connected with the improvement of the medical profession, still much remains to be done to pursue and complete them, and we take this opportunity to assure our readers that we shall try our utmost to achieve our objects in view.

HONORARY MEDICAL OFFICERS.

The Government have passed final orders on the subject of Honorary Medical Officers on 29th July 1932, agreeing with the Committee's Report in the main and making a few modifications. On 16th July last, the Hon'ble the Minister in charge of Public Health presided over a meeting organised by the Madras Branch of the All-India Medical Licentiate's Association, and said, in the course of his concluding speech:

"That he was very glad to hear the frank and independent criticisms on the methods and policy of the Government expressed at the meeting. He hoped that when the time came for their representatives to associate with the Government members in a Committee their representatives would exhibit the same independence. They had recently a Committee to examine the honorary system. He was now told that their representatives did not do their duty properly. He would give them another chance. A Committee with two members of the profession in service and two members of the independent profession would be appointed to re-examine the question and he hoped the views of their association would be fully voiced in that Committee."

We have reasons to believe that the Minister would soon appoint the committee

referred to in his speech. But it looks as if the Government have said the last word about the rules regarding the scheme, reserving their order with regard to the issue of the replacement paid Government medical officers by honorary officers. The Committee did not make any recommendation on this issue and left it entirely to the discretion of the Surgeon-General who was the Chairman of the Committee. Perhaps the committee to be appointed is mainly for considering this undecided issue. Exactly a year ago, soon after the report of the Government Committee on Honorary Medical Officers was published, we commented in these columns about the Committee's findings and said, amongst other things, that, "the recommendations made, touch only the outermost fringes of the question and do not indicate the lines on which and the extent to which the honorary system could be extended. They emit the smell of departmentalism and lead one to believe that the Committee contemplates an organisation of a new Department of honorary medical officers under the Surgeon-General."

It is very unfortunate that neither the Committee nor the Government seem to have any clear and definite ideas of the purpose for which the honorary system has been introduced. The whole system should be worked in public interest and every attempt should be made so that the public might understand that the scheme is useful to them as a sound business proposition.

In Western countries and in America honorary medical relief has been part and parcel of the responsibilities of the medical profession. It was so in India before the Allopathic system was introduced by the Government, and unfortunately the public have quite queer notions of the honorary system now. They are led to think at present that the members of the independent medical profession wish to be honoraries for enjoying the loaves and fishes of private practice which their brethren in service enjoy by virtue of their being in charge of state hospitals. The cause for the justification of such a system is that the Government officers in the Medical Department, and such officers earned good money by private practice which they would not have been

able to do but for the facilities that were available to them in the hospitals under their control. The Honorary Medical Officers scheme that has been finally approved by the Government is devoid of the spirit with which such a system is worked in other civilised countries. The fact that the Surgeon-General has been made the pivot on which the whole scheme has to rest will certainly retard its progress. It is incompatible that a paid servant of the Government, in spite of his position as the Head of the paid medical department, should have under him honoraries doing the same duties as the paid department. The period of the life of the office of the Surgeon-General cannot be at the most more than five years, and even supposing a particular Surgeon-General is of progressive views with regard to the honorary system of medical relief, the policy adopted by such a head of the medical department cannot be expected to be continued by his successor. It is regrettable that the Hon'ble the Chief Minister who is at the head of a democratic party did not conceive the advisability of having the recommending authority with regard to honorary appointments transferred from an autocratic Surgeon-General to a committee consisting of the Surgeon-General and two members of the independent medical profession. This Committee should be invested with the duty of ascertaining and recommending to the Government periodically the number of paid appointments that should be replaced by honorary men. We made such a suggestion last year in these columns while commenting upon the report of the Government Committee on Honorary Medical Officers. The ideal to be followed ought to have been to do away even with the post of Surgeon-General, an office unknown and unheard of in any civilised country, instead of perpetuating it by adding one more department under the Surgeon-General.

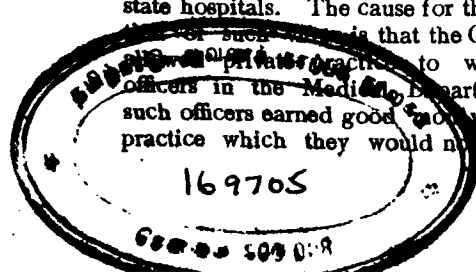
State hospitals, apart from being institutions where the human sufferings are either relieved or cured, afford also vast opportunities to the members of the medical profession to gain experience, and therefore, the State and the public are justified in demanding free service from the members of the profession to the necessitous poor for whom alone the state hospitals exist and should exist, and consequently if the honorary service in state

hospitals, does not relieve the tax-payers from the ever increasing expenditure incurred towards the salaries now paid to the state-paid doctors, it will be of little or no consequence as a good financial proposition. The Government ought to have shown their earnestness in honorary system and their concern to relieve the tax-payer by reducing expenditure in the medical department during the present economic distress. The fact, that quite recently as many as twelve new appointments have been made in the provincial cadre should make any body doubt about the true intention of the Government.

Let us discuss the other items of the G.O. on this subject, apart from the incongruity of making the Surgeon-General as the recommending authority of the scheme. Rules relating to the appointment of honoraries published as an Appendix to the G.O. on the subject has been published in the "Correspondence columns" of this issue. The first para deals with the recommending authority. Para 2 gives directions as to the method of recruiting the honoraries. It is said that vacancies should be notified in the office of the District Medical Officer in the mofussil, in addition to such notice being put on the notice-board of the hospitals. Though the Government make a pious order that "the best should be recommended", that "best" would be generally those who have much to do with either the District Medical Officers in the mofussil or with physicians and surgeons in the City hospitals, in their capacity as private practitioners. So necessarily, acquaintance, more than merit, will count much in such recommendations. A few honorary appointments recently made at the Government Royapettah Hospital had been the subject of adverse comments on the floor of the Madras Legislative Council quite recently. The profession is justified in challenging the fitness of choice by the recommending authority. Sir Henry Gidney while addressing in Calcutta the members of the medical profession recently, asked his audience a question, "When is a right thing wrong, and when is a wrong thing right?" "There is only one answer", Sir Gidney exclaimed, "When such a thing is done by the Government." The reply of the Government to the interpellation regarding honorary appointments at the Royapettah Hospital was in the nature of a conundrum.

pettah Hospital was in the nature of a conundrum.

Paras 3 and 4 need no consideration. The fifth para and the 6th and the 7th are about the designation and qualifications of honorary medical officers. In dealing with this subject, a distinction has been made between teaching and non-teaching institutions. The post of Clinical Assistant and Assistant-Physician and Assistant-Surgeon in teaching institutions is reserved for graduates only, and even such graduates are debarred to hold the position of honorary physician and surgeon in such teaching institutions. Let us forget for a moment the existence of Licentiatees and take the case of graduates only. In the legal profession a graduate of any Law College in India can rise to the position of a High Court Judge, though the University confers higher degrees in Law such as the M.L. Degree, and the British Government have not so far suggested that when M.Ls. and other higher qualified degree holders in Law were available in India, B.Ls. should not hold the position of High Court Judges. We shall repeat what we said on this subject in these columns last year regarding British qualifications: "It is not consistent with the existing notions of nationalisation, if British registrable qualifications are demanded in our country in the teaching institutions. It is not our intention to lessen the standard of medical education; the aim should be to get the best material as far as possible amongst the Indians possessing Indian qualifications. If Indians with high foreign qualifications are available so much the better, but our plea is that Indians of merit and having vast experience should not be disqualified, merely because they do not possess British registrable qualifications. As a rule it is customary to fix a minimum qualification for appointments and not the maximum as the Committee has recommended." Even with regard to British qualifications it was not fair that the Government have agreed with the Committee in demanding qualifications higher than those possessed by the majority of doctors employed by Government as full-time officers in teaching institutions. We ask the Hon'ble the Chief Minister, nationalist as he is, whether in England and elsewhere the Government, the public or the profession would have tolerated the recognition of foreign qualifications for employment either as honorary or paid officers by



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placing a high premium on foreign degrees whatever superiority such degrees might claim. The public and the profession have a right to protest against the decision arrived at by the Minister in this respect.

The invidious distinctions shown in the scheme with regard to qualifications for the appointment of Clinical-Assistants, Assistant-Physicians and Assistant-Surgeons in teaching institutions, are fundamentally wrong and practically unsuited for the healthy growth of the medical profession as a whole. The function of Clinical-Assistant, Assistant-Physician or Assistant-Surgeon, is to learn and not to teach; why should the non-graduate medico be deprived of the chances of learning more in well-equipped state hospitals where the graduate students undergo training? The Licentiates in Government service have proved their fitness to be in charge of University students in special hospitals in this City and the Government in this their very order have conceded to the claim of the Licentiates being employed as Clinical Assistants in 'hospitals for special subjects'; the more so, their fitness to serve as Clinical-Assistants in a general hospital ought not to have been questioned at all. In this respect, the scheme adopted by the Government is inconsistent even with the principles enunciated by them in the very scheme. Before closing discussion on these items, we wish to quote a few sentences from the speech of Sir Henry Gidney, an eminent retired I.M.S. officer possessing the highest British qualifications; "...we are apt to place great market-value on ex-India medical degrees, and it is we who are to blame for placing a high premium on European degrees. But remember the degree does not make the doctor; the doctor makes the degree; and whether you are a Sub-Assistant Surgeon or an Assistant-Surgeon or an I.M.S. Officer, when death faces you as medical men, it matters little to the patient whether you are English or Indian qualified; it is skilled experience alone that accounts."

Tenure of appointment forms the eighth item of the G.O. A minimum and maximum time limit has been fixed only with regard to Clinical-Assistants, the period of service ranging from 2 to 5 years. No time-limit has been fixed for the tenure of the other two grades of honorary appointments. This cannot be said to be sound

policy in the interests of the profession. As stated a little while ago, the Clinical-Assistant and Assistant-Physician and Surgeon have to learn and gain experience under their elders and the public get the benefit of such experience in the matter of treatment. If time-limit is not fixed for these two posts, there will be no room for new recruits and those who have been fortunate to get into the hospitals at the initial stage might not like to get out of their position, and so only a small percentage of medical practitioners will get the benefit of the honorary scheme. We suggested a limit of 5 years to Assistant-Surgeons and Physicians and 10 years to Honorary Physicians and Surgeons when we discussed about the report of the Committee last year.

Though special powers have been given to the Surgeon-General as the recommending authority for proposing deviations from the rules, framed by the Government, it would have been a safer course not to employ practitioners as honorary physicians and surgeons of whatever qualifications unless they have been in practice for a period exceeding 20 years and unless they have passed the age of 40. Merit and experience cannot count without age and this condition should not be relaxed, even by the recommending authority.

The other items in the G.O. excepting "reports on honorary officers," such as, duties and hours of attendance, etc., etc., are matters of detail and need not be discussed here, as they do not involve any fixed principles. Whatever might be the justification of confidential reports on subordinate by superior officers, it is certainly most humiliating that confidential reports on the work of honorary physicians and surgeons have to be sent to the Surgeon-General by the Superintendents in the city hospitals and the District Medical Officers in the mofussil. The public who resort to hospitals for medical relief are the best judges to report about the work turned out by the honoraries in state-hospitals and even about their behaviour. The Superintendents of the Hospitals in the City and the District Medical Officers in the mofussil may on their own accord complain to the authorities about the honoraries whenever necessary as do the members of the public. But these officers should not be given any special

privilege of submitting confidential reports as in the case of their subordinates. The fact that both the honoraries and the state-paid medical officers are of equal status and competitors in the field of private practice and other emoluments which they enjoy by virtue of the position they enjoy should not be forgotten either by the Government or the public.

The Government consider the training of the House-Surgeon and Physician is identical with that of the Clinical-Assistant. So, there is no need for the Government to entertain any more House-Surgeons or House-Physicians either paid or unpaid, the Clinical Assistants being deputed for such work. All the efforts of the Government in bringing about honorary system of medical relief will be of no avail if they do not at once replace at least a few paid medical officers by honoraries and the Government have at present a splendid opportunity to give effect to our suggestion without any risk of efficiency. It is said that in addition to the six Civil Surgeons, who have been given notice for retirement, there will be another batch of six more who will also be forced to retire after the completion of a service of 25 years, as a measure of retirement. All the Civil Surgeons so discharged might be requested to serve as honoraries, fresh appointments not being made to fill in the vacancies so created. To carry out the administration of the state hospitals it is enough that there is a paid Resident Medical Officer and the existing hospital committees which are now purely recommending authorities may be given the executive authority with an official President.

We believe that the Minister in charge of the Medical Department will not find hard to conceive of a scheme of honorary medical relief, devolving powers now enjoyed by the officials to the honoraries. The Minister should know that it is possible to carry out such a scheme when he himself has been found capable of displacing a bureaucrat in charge of his own Department and taking over the charge himself as the most trusted representative of the people. The Medical Department with regard to medical relief is the safest sphere involving no risk or any extra financial

responsibilities on the part of the Government, which may be safely entrusted to non-official agency to do the social work of relieving and curing human ailments.

Original Articles

*RECENT ADVANCES IN OPHTHALMOLOGY.

THERAPEUTIC AND OPERATIVE.

By

DR. K. KOMAN NAYAR L. M. & S. (Mad.)

L. R. C. P. & S., (Edin) D. O. M. S.

(Lond)

Assistant Superintendent, and 2nd Ophthalmic Surgeon, Govt. Ophthalmic Hospital, Madras.

GLAUCOMA.

Of all therapeutic measures adopted in recent years, the greatest attention has probably been paid to the reduction of intra-ocular tension in glaucoma by drugs. The two most important measures have been: (1) the use of adrenalin or one of its derivatives and (2) osmotic therapy. Adrenalin has been used as sub-conjunctival injections, retrobulbar injections, as an ointment in the conjunctival sac, and as a pack in the upper conjunctival fornix. This last method, as advocated by Gradle, has been used in this hospital very largely. A small pledget of cotton wool is soaked in adrenalin chloride solution 1 in 1000 and placed in the upper fornix for five minutes, after which it is removed. This causes a preliminary rise in tension for a few hours, followed by a distinct fall, which lasts ordinarily for the next two days. To combat this preliminary rise in tension, the patient has to be given frequent instillations of eserine drops, before and after the adrenalin pack. This procedure is useful in chronic primary glaucoma; it should be avoided in acute, haemorrhagic and absolute glaucoma. Its action is said to be a "contraction of arterioles, accompanied by a dilatation and increased permeability of the capillaries."

*A lecture delivered under the auspices of the All-India Medical Licentiates' Association (Madras branch) on 30th April 1932

Hamburger has brought into use two other preparations (1) glaucosan drops for chronic glaucoma and (2) Aminglaucosan drops for acute glaucoma. In our experience, the former has given very little help, while the latter does help to contract the pupil to some extent, although it gives rise to a severe local reaction. Thus Hamburger's claims for these drugs have not been proved in our practice. On the plea that ocular inflammations tend to produce softening of the eyeball, Hamburger advocated, in cases where operative procedures are considered risky, cauterisation of the cornea near the limbus in a few points at the upper nasal quadrant with a fine pointed AgNO₃ stick (1). Cauterisation with the galvanocautery at several points over the sclera, just outside the limbus, has been advocated by others, but has given us only temporary reduction of tension in a few cases.

Duke Elder in 1926 advocated osmotic therapy for reduction of intraocular tension, by producing a hypertonic state of the blood. He administered 1 cc. per kilo body weight of 30% NaCl solution intravenously—an average adult dose of about 50 cc.—the injection to be given very slowly during a period of 10 minutes, with the patient lying down, so as to avoid any sudden fall in the blood pressure. This is a very useful emergency measure; Duke Elder says that the "effect is largely due to abstraction of fluid from the eye, owing to the general osmotic depletion of fluid" but also suggests that "there may be some physico-chemical changes in the vitreous also." We found by experience that our type of patients cannot stand more than 20 or 25 cc. of the NaCl. solution without suffering much distress. These patients should be forbidden from taking water by the mouth for a few hours at least. A milder effect can be obtained by giving the patient large doses of saline solution by the mouth. Sometimes medicinal treatment carries a patient a long way without operative interference, but the patient has to be under the immediate supervision and control of an expert. If, in spite of medicinal treatment, there be noted either diminution of the acuity or field of vision, surgical measures should be adopted without any delay.

TRACHOMA.

Different methods of treatment have been advocated for this chronic disease, each one reporting gratifying results in his cases. Autobemotherapy has been used by Medvediev for trichomatous pannus (2). Martinez Salaberry (3) advocates massaging the cocaineised conjunctiva with sodium chloride crystals for which the author claims 80% of clinical cures. Intravenous injections of copper salts have been advocated by others.

Massaging the palpebral conjunctiva with chaulmoogra oil has been tried on a large scale. Extensive trials in Egyptian hospitals have shown that this drug is not in any way better than CuSO₄ or AgNO₃. In our practice here, we have found it useful in chronic cases, giving a very soothing feeling to the patient. The hospital doctors at Pondicherry reported well about it at the last session of the Indian Science Congress held at Madras. Another report in one of the journals stated that olive oil does equally well. One wonders whether after all the beneficial effects reported are to a large extent due to the massaging and the oily nature of the application. Massaging with a brush if, of course, a remedy that has been in vogue for many years. AgNO₃ and CuSO₄, judiciously applied, are still our stand-by in cases of trachoma.

In this connection I may mention that as recommended by Weymann, Tassmann is reported to have successfully tried subconjunctival injection of a mixture of two parts of Pot. ferrocyanide (2%) and one part of Sod. thiosulphate (12%) freshly prepared to clear up argyrosis of the conjunctiva resulting from excessive and negligent use of strong silver salts.

ULCUS SERPENS.

A new line of treatment was advocated for ulcer serpens by Sabatzky (4). He anaesthetised the cornea, curetted the septic ulcer and massaged into it, with a glass rod, synthetic oil of wintergreen; the ulcer was dried with cotton after two minutes, atropin ointment was applied and the eye kept bandaged for one or two days. He said that, in early cases, the cornea "healed without scars, facets, opacities or astigmatism"; he said that 23 out of 24

cases healed with V=5/6.1 As we get many such cases, some of which go bad in spite of all our attention, we welcomed this method and gave it a trial—and I am sorry to say the results were disappointing.

FOREIGN PROTEIN THERAPY.

Has been largely resorted to in cases, chiefly, of iridocyclitis, septic infections and septic ulcers of the cornea. The most commonly used proteins are milk and old sera (old diphtheritic antitoxin) or old T. A. B. vaccine. Raulston (5) attributes their beneficial effect to "a mobilisation of enzymes, a suppression of antiferments, a leucocytosis, and an increased permeability of tissue." Milk protein is put up ready for use in ampoules under the trade name of "Aolan."

ULTRAVIOLET LIGHT THERAPY.

Has been to the forefront in ophthalmology of late, just as in the other branches of medicine; in fact, in some hospitals it has been indiscriminately used, so much so that Prof. Vogt of Zurich called attention to the late bad effects produced by the local application of ultraviolet light in eye diseases (6).

As regards general (as contrasted with local) application of ultraviolet light you are all familiar. It is usually advised in eye cases to "start general light therapy immediately after the acute stage of the disease has passed and before the lesion is complicated by accumulation of massive deposits and restoration rendered impossible by extensive tissue destruction." The cases that benefit by this are corneal ulcers, dendritic keratitis, eczema of lids, blepharitis, eczematous conjunctivitis and tubercular lesions.

The Birch-Hirschfeld radiation lamp of Zeiss is the one usually recommended for local therapy. It has to be remembered that the direct killing of the bacteria by the short waved ultraviolet light occurs only in the superficial layers of the cornea and conjunctiva. The rays should be controlled so that the lens is excluded from their path for fear of late formation of cataract. In cases where the lesion in the cornea is central, contract the pupil with eserine and throw the beam obliquely on the cornea. The dose to excite an abiotic lesion of the cornea is very slightly less than that required

to produce a minimal erythema on the skin. The average dose for the lids and conjunctiva is said to be 15 to 30 minutes.

RADIUM.

We have been using radium in orbital tumours such as lymphoblastoma and angioma with a fair amount of success. In gliomata, it has been our practice to expose the orbit and some days later to apply radium at the apex of the orbit. We have had remarkable success in a few cases of epithelioma at the limbus with radium. The average total dosage required was about 50 mgrm hours (5 mgrm. x 2 hours x 5 sittings at intervals of 5 days). We have also had some success in cases of spring catarrh (palpebral and limbal),—the dosage given being 5 mgrm. for 10 minutes, twice a week (8 or 9 sittings).

Mode of application:—A mould of the conjunctival sac is made of hard paraffin of fairly low melting point and the radium needles are used embedded on the surface of this mould, above or below, according to whether the palpebral or bulbar conjunctiva requires treatment; a metallic filter may be inserted in the mould to protect the eye in cases where the palpebral conjunctiva is being treated. Both eyes are kept bandaged to prevent movement of the eyes and the mould.

Implantation of Radon seeds into the eye in cases of early intraocular tumours is being done; successful cases have been reported in the British Journal of Ophthalmology (Dec. 1931).

As regards the actual medicaments used in eye diseases, it is but proper to say a few words regarding the variations in the effects produced by the same drugs which are put up for sale by different manufacturing chemists. Yellow oxide of mercury ointment, a very commonly used drug in eye practice, if made up by an ordinary chemist from ordinary yellow oxide of mercury powder is far more irritating to the eye than if prepared from precipitated yellow oxide of mercury powder of B. W. & Co., Parke Davis & Co.'s ointment of this drug, as put up for sale in collapsible tubes is better and still more so the ointment made by Cusi of Spain, whose 2% or even 5% ointment gives less irritation than a 1% ointment got made locally. So also the effect of dionine, or argyrol, as got from Merck's

is far better than the several similar preparations put up by other chemists. There is a very large variety of ointments made by Cusi of Spain, containing different combinations and proportions of the important drugs used in ophthalmic practice. They have done for the ophthalmologist what B. W. & Co., P. D. & Co. and others have done for the general physician.

(To be continued).

*EARLY DIAGNOSIS OF LEPROSY.

BY

DAVID BAXTER, M. B., Ch. B.,

Medical Officer, Lady Willingdon Leper Settlement, Chingleput.

The subject for these few remarks is the early diagnosis of leprosy. One of the difficulties in dealing directly with the subject is the impossibility of knowing exactly how much this gathering knows of the modern conception of the disease as a whole.

Therefore, I propose to deal in a rapid manner with the description of certain relevant facts in connection with the disease which will help towards a general understanding of the disease. Before entering on this, I desire to state the reasons why I have chosen this subject at all. At the present moment there is a great deal of research being carried out in the epidemiology of the disease. Particularly with regard to the actual incidence of the condition in this country. And it has been found in India, especially that the incidence of the disease is much higher than was at first supposed. The accuracy of the figures depends greatly upon the knowledge and thoroughness of each particular observer. The early diagnosis of the disease, in addition, is a difficult one. Therefore, I desire to remove some of the difficulties that face those who only see a few cases in a year. Most of you are engaged in the medical examination of children in the schools, and because of that, you will have the opportunity of seeing many cases, in the early stages of the disease. In addition, many cases with doubtful skin lesions will be brought to you for your diagnosis.

Also, seeing that early treatment is coming to be recognised as a first essential to the effective control of the disease in each case, it is easily seen how urgent is the necessity for study of the early signs and symptoms of leprosy.

Of the final reasons for choosing this subject, I may mention the fact that it is coming to be realised that leprosy can only be stamped out by propaganda. The infectious case is the key to the whole problem. Prevent the case of leprosy becoming infectious. If he becomes infectious, teach him how to prevent spreading the disease to others, and leprosy would become an unknown disease, practically, as it is in the West to-day.

But let me pass on to some general facts concerning the condition. Leprosy is now regarded as being an infectious disease. It is a disease spread by direct contact. Certain articles of clothing may convey the disease, but the part they play in spreading it is coming to be seen a very small one. The most dangerous source of infection is the infectious case of leprosy himself.

We believe the healthy adult to be very resistant to infection. Leprosy is not a highly infectious disease. However, children during the stages of adolescence are exceedingly open to infection. The adolescent who lives in long and close contact with an infectious case of leprosy stands a very good chance of contracting the disease.

Furthermore, careful study of the disease from the pathological side has led observers to the conclusion that the disease is a systemic disease from the very commencement. Although the main lesions are found in the nerve and in the skin, the focus of infection does not lie in those tissues, but in the lymphatic system. In the lymphatic glands, the infection lies latent for a considerable period of time. It is this latent period in this area that makes the period of time between the date of infection and the appearance of the first clinical signs such a long and variable one.

The glands that are most commonly involved in the early stages are the inguinal and axillary. The only sign that they are affected is in a slight enlargement. But they may not show the slightest signs of

being affected until the disease has become clinically obvious elsewhere. Therefore, an observation of enlargement of the lymphatic glands is no proof of infection of leprosy, even in the early stages. Therefore this observation is of little help in diagnosis.

The two tissues in the body for which the bacillus of leprosy seems to have a special affinity are nerve and skin tissue. Thus leprosy can be divided into nerve leprosy and skin leprosy. Sooner or later mixed leprosy is the rule—both nerve and skin changes being present, simultaneously. I have already remarked that when tissues are affected, it is nearly always a secondary infection. The primary focus of the disease is definitely in the lymphatic system.

For our purpose, it will be useful to describe the changes that take place clinically when the nerve and the skin respectively are involved by leprotic infiltration.

First of all, let us look at the functional changes that take place when the nerve is attacked by the bacilli. The nerves commonly affected are the ulnar and median nerves, in the upper extremity, and the peroneal nerve in the lower extremity. In the later stages of the disease all the superficial nerves to the extremities may be affected. Whereas for some reason or other, in the earlier stages, the most commonly attacked nerve is the ulnar nerve.

We shall not dwell on the pathological changes that take place when a nerve is attacked. Rather, shall we direct our attention to the functional changes that take place when the nerve is affected.

In the first place, thermal sensibility is lost. The second sense that disappears is that of pain. And the third and most important sign from the clinical point of view is the loss of sensibility to light touch. This is the sense that is most commonly tested for, in actual practice. The areas of skin involved by this anaesthesia are usually in the extremities and are most commonly in the distribution of the ulnar and median nerves. Anaesthesia is very seldom found on the body. And only rarely are skin patches found to be in addition anaesthetic. And it is only in the later stages of the disease, that the trophic changes of the bending of the fingers, and ulceration of the feet and hands take place.

At this point it may be stated that nerve leprosy is non-infectious. A pure nerve-case is what is called a "closed case". Such an observation is important from a public health point of view.

Let us now pass on at the lesions as they are found in the skin. The most important skin-change from the standpoint of early diagnosis is what is called the "hypopigmented macule". A macule can be defined as a "circumscribed area of skin, showing changes in pigmentation, which may be either depressed or elevated above the surrounding skin." The hypopigmented macule is a circumscribed area of skin in which there has been a *partial* loss of pigmentation. It is not complete, as it is in the case of leucoderma from which leprosy is quite distinct.

The margin of such a hypopigmented macule is definite and regular in outline. But the margin tends to *merge* gradually into healthy skin, in quite a characteristic manner. This type of macule is very rarely anaesthetic. Such macules are found all over the body. Such macules contain not bacilli and because of this, such are classified as belonging to the manifestations of nerve leprosy.

The other skin changes are known as "erythematous macules", as "infiltrations" and as "nodules". These belong to skin-leprosy proper, and in such, bacilli are always present. Such skin changes may be the first signs noted, in quite a number of cases. Because of the presence of bacilli on the skin surface, bacilli are freely disseminated, and cases having such lesions are called "open-cases", and therefore are infectious.

In examining a case for leprosy what are the measures that should be taken to ensure that the examination is to be an efficient and thorough one?

In the first place, see that the examination is carried out in a good light. The early hypopigmented lesion is difficult to see, save in a good light. Examine the whole body for any areas where there is some slight loss of pigmentation. Enquire into the duration of such patches. Learn whether there has been at some stage, a stage when the lesion has been itchy. In this way, one excludes the possibility of

*A paper read at the Medical Inspectors' Conference held on 5th and 6th August 1932 under the auspices of the Health Propaganda Board, Madras.

ring-worm. In dark-skinned races, one must bear in mind the fact, that any acute or chronic inflammation of the skin leads to temporary or permanent, concurrent or subsequent, partial loss of pigmentation in the affected skin area. This fact should make one very careful of avoiding the diagnosis of leprosy from the presence of one or two isolated hypopigmented macules. Such a warning has been increasingly borne in upon me, especially in the examination of children. It may be confidently stated, for instance, that in children in South India quite innocent hypopigmented macules on the cheeks are quite common. Such hypopigmentation is due most frequently to simple anaemia.

When you have satisfied yourself that there are no areas of skin that appear suspicious, examine for the enlargement of the ulnar nerves. Very rarely are both nerves equally enlarged. With enlargement, there is quite frequently an associated tenderness. It is well to remember that enlargement, if present, must always be accompanied by the typical anaesthesia, or by lepra bacilli, in order to establish the diagnosis of leprosy.

How does one examine for the most important cardinal sign in the early diagnosis of leprosy, namely, anaesthesia? It is most convenient first of all, to test for the loss of sensibility to light touch, by testing with a cotton wool swab. Ask the case to shut his eyes; making sure that the head is turned well upwards, so as to ensure that the subject is not using his eyes. If this precaution is taken, there is little need for blind folding. Inform the case, that you are going to touch the various parts of his body, and that you desire him to point to the places that you touch. Commence with areas that you know are likely not to be anaesthetic, so as to gain the confidence of the case. Afterwards pass on to the areas that are likely to have a loss of sensibility, namely the ulnar sides of the hand and fore arm. In this manner pass over the

whole surface of the body, particularly the distal extremities.

In doubtful cases it is advisable to use the axillary test called the "pin-test." Take an ordinary pin and ascertain whether there are areas where the case cannot distinguish between the blunt and the sharp ends of the pin.

For the skin manifestations of leprosy with the exception of the hypopigmented macule, the crucial test is the microscopic examination of a smear taken from the corium or true skin. The most satisfactory method of doing this is by what is called the "slit-method." Take a sharp scalpel and make a definite yet superficial cut, into the area to be examined. Then take the point of the scalpel and scrape the depth of the wound. Smear this collection of cellular material and serum and some little blood, on to a clean slide, and stain by the Ziehl-Neelsen's method of staining tubercle bacilli. I prefer to use the Carbel Fuschin stain, cold, for ten minutes, in place of the text-book hot stain, for two minutes. The counterstain is 10% Methylene Blue. Take specimens from the lobes of both ears and from any piece of skin that looks in the least abnormal. With a blunt scalpel, it is advisable to take a nasal-scraping as well. Observe whether there is any infiltrated area, or ulceration on the septum of the nose. If such is present, ensure that bleeding takes place from the scraping.

The differential diagnosis of leprosy is easy, provided one bears in mind the two cardinal signs, anaesthesia and the presence of lepra-bacilli. In doubtful cases, ask the case to return in six month's time for a re-examination. When hypopigmented macules alone are present, this is a safe line of action to take.

In conclusion let me venture to hope that these few remarks will enable you to identify the early case of leprosy, when you meet with it.

Where Typhoid cases need a laxative Mycol is suitable and safe.

Abstracts

IS THE DOCTOR'S BEST FUTURE IN THE CITY OR THE COUNTRY?

ADVOCATING THE CITY.

BY

DR. LOUIS FAUGERES BISHOP, M. D.
NEW YORK.

In answering this question I shall assume that the doctor is young, and not drawn by particular opportunity or personal reason to one place or another. If the young doctor is an idealist, pursuing his profession from the academic and scientific point of view and wishing, above all things, to advance his professional skill, he should, by all means, turn to the city. The great city offers a fair field and no favor, and the man with the suitable qualities always succeeds. In the city are found independence and privacy. These are lacking in the country.

The man in the city can form and promulgate his own theories, carry on his own research and live his own life, forming only those contacts which he himself seeks.

In the great horde of humanity he can always find a sympathetic soul and a hearing. In the country a man must conform, in general, to public opinion—even professional opinion. All his work is subject to criticism in its immature and defenceless state, and he is lacking in the sympathetic appreciation of his struggles for medical truth because he is surrounded by colleagues who, as a group, take their opinions ready-made from what Mackenzie called "the giants in the profession."

There have been many great physicians who have lived and worked in small communities, but the vast majority of leaders have developed from the opportunities and stimulation of city life. In the city there are medical gatherings of all sorts and sizes. To the great well-attended meeting one brings his cut-and-dried ideas; to the small intimate meeting he brings his immature ideas for the sake of testing the reaction of other minds.

At the Academy of Medicine the discussion is polite and restrained. On the

lower East side they go at it with hammer and tongs, hurling at each other the weight of the opinions of great professors—with many more consonants than vowels in their names.

If the young physician, however, has no ambition to become a factor in the affairs of his profession, and only desires to practice comfortably and profitably from the view-point of a living, it is a matter of little difference to him whether he practices in the city or the country, because, as a matter of fact, many city neighbourhoods are practically small villages; and such a man has no future, any how, from the point of view of the ideal.

To stick strictly to the question then, "Is a Doctor's best future in the City or the Country?" There can be no doubt whatsoever that the answer must be in favor of the city. The best type of physicians, as stated, grow, develop and expand in their medical attainments and usefulness in the city.

On the other hand, the man practicing away from medical centres is, as again stated apt to continue to practice according to the pattern he took from his preliminary education or developed shortly thereafter. This is due to diminished contact with other workers and the consequent development of fixed individualism. In the field of cardiology, for instance, these matters are conspicuous. Problems of cardiology are in the country invariably referred to the man who has attained achievements in fields other than cardiology, ordinarily a man of advanced years with a record of success in the practice of general medicine or even in surgery. Of course, this same condition prevailed in the city up to a quarter of a century ago, but the growth of cardiology and the gradual recognition of attainments in this department of knowledge on the part of particular men has gradually shifted the solution of these problems to those men who have devoted their time and attention to this department.

There are, of course, those who maintain that the intuitive sense of diagnosis of the country practitioner is as useful to the patient as the slowly and laboriously worked-out method of the specialist. A very casual examination of some specific

cases, however, will cause a complete reversal of judgment.

So that, if we consider the future of the doctor purely in relation to professional development, the argument would seem to be entirely in favor of the city.

There is an angle of the question of the doctor's future, that has not been touched upon yet—this is the welfare of his family. The relative value of country-breeding upon growing children as compared with city-breeding must not be ignored.

The country child develops well physically, but the city child is much more resistant to infection. Nearly all country-bred children pick up some infection when they come to the city, which usually passes by the city child.

In matters of education the country child appears to be much better able to take care of itself, in the face of physical emergencies. If ten city children and ten country children were stranded on a desert island, more of the country children would be able to pick up a living from nature than the city children. On the other hand, if ten country children and ten city children were suddenly thrown into strange and unfriendly human relations, the city children would be much better able to take care of themselves than the country children.

The health, strength and character of country-bred men is well shown by the fact

that so many leaders in city life have come from the country.

There are many social and educational advantages to children growing up in smaller communities, though the older members of the family are not nearly so favored as those in the city; and most village dwellers, when all is said and done, are very narrow minded and intolerant.

The financial side of the picture must also be weighed and measured. The City physician must of necessity earn more money. The man in the country has much fewer demands on him, and he is probably ahead of the city man in matters of actual values and percentage of profit.

The country doctor, whether he is compensated in money or country produce, or in the concessions and privileges that come to him as he buys in the friendly community, is not nearly so money-conscious as the city man, who must maintain a financial standing in order to uphold his position in the community.

So if we think in terms of a living (which in the view of human needs is often the rational thing to do) instead of in terms of money, we find that the country physician has an easier living than the city physician. However from the view-point of possible scientific accomplishments the city must be given preference.

Medical Mentor—April 1932.

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ANNOUNCEMENT.

As published in previous issues The Oriental Research Laboratory has introduced a Specific for Eczema and allied skin lesions called ZAMA. The specific has been tried and found very effective in Eczema occurring at all stages, specially in infants and elderly people where the disease is usually obstinate and baffles the usual medication. The cost of ZAMA is 12 annas a cup; 20 per cent. discount will be allowed to the readers of "The Medical Practitioner" if they book their orders through The Medical Practitioners' Service Bureau, Vepery, Madras.

Notes on Treatment of Diseases.

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

Gout: Salicylates increase the output of uric acid. They are contra-indicated in urinary catarrh and gravel. To prevent the presence of uric acid in the urine, Pot. Citras. 20 grs. may be given in the morning and night. But if the acid had already formed the drugs will accelerate the progress of secretion of phosphates and so should not be given. If the reaction of urine is alkaline, diminish the quantity of Pot. Citras or stop it altogether. Fresh fruits such as pears, figs, oranges and grapes check the acidity of the urine, but do not seem to agree with gouty patients. Whey is very good in preventing uric acid. A breakfast cupful may be taken twice or thrice a day.

Uraseptine, containing Hexamine, Helmitol, Piperazin and Benzoates is a very good eliminator of uric acid as well as an antiseptic, one or two teaspoonfuls to be taken three times a day. Urogenine (Gabail) which contains Hexamine derivative, Sodium Benzoate, Piperazine and Lithia in two to 6 tea spoonful doses per day has very good effect in gout.

Colchicin and its alkaloid Colchidine, the former 20 to 30 mms. of the wine, every three hours and the latter 1/100 grain every two hours may be given. Piperazine 15 grs. in a quart of a water is also good. Pot. Iodide and Thyroid may be given (Sajous).

In women during menopause ovaries and Corpus Luteum.

Pot. Iodide, Ammonium Chloride each drs. 2 Pot. Acetas, Ext. Gly. Liq. each drs. + aqua chloroform to make up 6 ozs. an ounce thrice a day after meals. (Rudolf)

The best diuretics that act without raising the blood pressure are salts of Potassium, Bachu and Thiobromine, while Digitalis, Scopolamin increase the blood pressure and therefore to be avoided in gout. If there is already much fluid in the vessels on account of the pressure, there will be less flow of urine and so no fluid should be given. Pot. Iodide grs. 10. Pot. Chloras grs. 30, Tinct. Baccu oz. 1, Pot. Tartarate of Iron 5 to 10 grs. if there is anaemia, to be taken immediately after meals, or Pot. Citras grs. 20, Spts. Ether Nitrosi oz. 1, Liq. Ammonium Acetate ozs. 4, Aqua ozs. 2 to be taken in a tumblerful of water three times a day. (N. B.) Spts. Ether Nitrosi should not be prescribed with Pot. Iodide as it forms an explosive mixture.

To overcome insomnia, Strontium Bromide and Chloral Hydras may be given. The former is better. Barbitol or Barbiol Sodium is also useful (Hare).

Haemophilia: Haemoplastin 2 cc. to be given subcutaneously; and in severe cases it may be applied locally on a pledget of cotton wool. Spleen Extract and Adrenalin may be given hypodermically and Thyroid and Calcium Chloride by the mouth. Ovarian Extract may be given to males, (J.A.M.A.) Thrombo-plastin 10 cc. in a similar quantity of horse serum may be injected subcutaneously (Recent Advances in Pediatrics.)

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Notes on Therapeutics, Diagnosis and other Medical Subjects.

BRITAIN'S PATHOGNOMONIC SIGN OF GANGRENOUS APPENDICITIS.

In the presence of gangrenous appendicitis, palpation of the lower right quadrant of the abdomen invariably produces sudden retraction of the right testicle to the upper part of the scrotum. The testicle drops to its original position as soon as the pressure is withdrawn.

This sign was first observed by Dr. Brittain, of Richmond, Va., in 1928. It has now been constantly observed in nearly 500 cases of gangrenous appendicitis, and the absence in more than 300 other abdominal conditions make it, I believe, pathognomonic for gangrenous appendicitis. Dr. G. P. La Roque, of Richmond, Va., in *Am. J. Med. Sc.*, Aug., 1931.

PSYCHOLOGIC ASPECTS IN PROGNOSIS OF TUBERCULOSIS.

While tuberculosis may be regarded as one of the most curable of chronic diseases, the prognosis in the average case of active pulmonary tuberculosis is, at any given time, uncertain, because it is dependent on so many different factors. The more important of these factors vary with the psychology of the individual patient, and this depends for the most part upon the physician. The first step should be to explain truthfully to the patient the extent of his disease as well as the nature and the purpose of the cure. Unless patients understand their condition thoroughly and what they must do to recover, they cannot cooperate fully and follow the cure as they should. In tuberculosis there is no factor more important in the prognosis than time. Dr. E. W. Hayes, Monrovia, Calif., in *Ann. Intern. Med.* Mar., 1931.

APPLICATION OF THE BACTERIOPHAGE TO URINARY INFECTIONS.

Among other successful applications of bacteriophages, Dr. W. J. MacNeal, of New York, in *New York St. J. Med.*, Nov. 15, 1931, states that much success in urinary infections has been obtained by the following method.

The patient is put to bed on a very regular light diet, with abundant fluid intake. The urine, collected by aseptic technic, without a catheter, each morning and evening, is at once tested to determine its hydrogen-ion concentration. The reaction of the urine is brought close to the neutral point by oral administration of a drug with residual alkali, such as potassium citrate 5 to 20 grains in watery solution, every four hours. Practically always the urine is naturally acid. If it is too alkaline, this can be corrected by oral administration of acid phosphate or ammonium chloride. Two or three days may be required to get the urine nearly neutral.

The patient nearly always becomes comfortable under this regimen and there is no pressing need for hasty application of the bacteriophage, which is, meanwhile, being developed to a high potency against the patient's bacterial strain by serial filtrations in the laboratory.

When the bacteriophage is finally ready and the urine is remaining nearly neutral, (pH. 6.6 to 7.2), begin with subcutaneous injection of bacteriophage, 0.5 cc., 1 cc. and 2 cc. on successive days. On the second and third of these days introduce into the bladder, by rigidly aseptic and gentle technic, through a small soft catheter, about 10 cc. of the bacteriophage preparation, diluted with 100 cc. of sterile saline solution. The patient is encouraged to retain this liquid as long as may be convenient.

Subsequently the patient remains on the regular diet with abundant fluids and regulation of reaction of the urine as before. Bacteriologic examination of the urine should be done 48 hours after the last instillation, for bacteria and for presence of bacteriophage; and again five days later. Ordinarily a few living bacteria still persist in the bladder urine. The bladder is then irrigated with a silver preparation, which is repeated after 24 hours. Two days after the second silver treatment the bacteriologic examination of the urine is made; the patient is allowed to be up and the alkali therapy is changed over to acid phosphate, coupled with administration of methenamine during a convalescent period of two to three weeks. A final bacteriologic examination should show sterile urine.

CLINICAL NOTES AND PRACTICAL SUGGESTIONS. Dysmenorrhoea.

Dysmenorrhoea can be defined as painful menstruation, the pain being located in the lower half of the abdomen. The contraction of the uterus during menstruation is the cause of the pain. This pain may come on either during menstruation or two or three days before the period and may continue two to three days during the period. It generally causes great discomfort and sometimes it is so severe that the patient has to lie in bed.

It would not be out of place here to say a few words regarding the etiology of the affection so that a clear idea may be formed of the reasons why the treatment that is suggested is rational.

There are two classes under which this affection may be divided, Primary and Secondary, the former being due to the trouble in the uterus and the latter is usually acquired following pelvic inflammation or some sort of trouble in the ovary. The pain in Primary Dysmenorrhoea is generally confined to the hypogastric region and it becomes manifest with the first menstrual period. The most common causes of Primary Dysmenorrhoea are:—

1. **DISPLACEMENTS OF THE UTERUS:** It might be anteflexion or retroflexion. Bimanual examination will disclose a relaxed uterus either bent forward and angulated or thrown backwards in the hollow of the sacrum.

2. **UTERINE HYPOPLASIA** is another cause in which stenosis of the cervix acts as a barrier to the outer passage of the blood. The blood as a result is kept back in the uterine cavity and clots. Then it acts as a foreign body which incites painful contractions. With the expulsion of these clots the pain usually subsides. The main diagnostic feature of this condition is a long conical cervix which can be readily felt or visualised.

3. **NEUROTIC DYSMENORRHOEA:** This type as a rule presents itself quite early i. e. almost at the very first menstrual period and it increases in severity as time goes on.

SECONDARY DYSMENORRHOEA: This type usually follows pelvic inflammation which ends with adhesions in the pelvis. This can be diagnosed from the primary

one by the fact that the catamenial pain exhibits itself many months or years after menstruation has been established. The pain here is dull and persistent and is felt in one or both the iliac regions or is sometimes felt in the back and down the legs. Some abnormality of the uterus or its appendages is generally revealed on examination. This may be either endometritis, fibroids, adhesive bands or in the majority of cases ovaritis.

It has recently been recognised that certain disturbances of the glands of internal secretion cause these irregularities of menstruation. This then is the basis of Endocrine therapy in certain types of Dysmenorrhoea.

The treatment of Dysmenorrhoea may be either symptomatic or specific. For the control of pain various palliative drugs such as Cryogenine, Aspirin, Pyramidon are useful, but to correct the menstrual process causing the pain the Endocrine product of choice will be Opocrin Ovaro-Thyroid. The disturbed internal secretive mechanism quickly responds to this Endocrine product which effectively elaborates the Endocrine principles in the organism. It is because of the physiological activity of the combination of the internal secretions which simulate those produced in the body in this gland preparation, Opocrin Ovaro-Thyroid, that these results are brought about. In this product the active hormones from the Thyroid and the Ovary are isolated and standardised. From the actual clinical results it has been found that the use of this preparation is very valuable in Dysmenorrhoea. It is well-known that the pain of this complaint will not disappear unless the menstrual process has been brought back to normal and the only substances which can do this are the hormones of the Ovary and the Thyroid. These bring about normal menstruation by causing the adequate hypertrophy of the uterine mucosa. This is what is achieved by the administration of Opocrin Ovaro-Thyroid. From this we can conclude that this gland product is not a symptomatic therapy, but has a direct action on the Endocrine mechanism. Needless to say that it will not be useful in cases due to structural defects.

While this Endocrine treatment is going on it is always advisable before complete

cure can be effected to give perfect rest to the system and to relieve pain. For this purpose Cryogenine either in powder or tablets should be prescribed. This relieves the pain and if continued causes a good sedative action without any after-effects. There will however be some cases where this remedy may not be effective and then it might be necessary to resort to narcotics. In all these cases this medical treatment should be supplemented by complete rest in bed, regular evacuation of the bowels and proper hygiene. If the patients are found anaemic Hypercytol or Hemoplas may be injected with advantage. Change of surroundings and occupation will also be helpful for bringing about a speedy cure.

Here we do not want to attempt to dilate on the surgical treatment of Dysmenorrhoea, but in passing we may mention that dilation of the cervix followed by Ventro-suspension is the operation of choice as it produces better results than Dilation with Curettage.

Treatment of Coli infections.

The problem of Bacte Coli infections either of the intestinal or urinary tract has always been considered a dangerous and difficult one to treat and therefore any therapeutic agent, which is able to deal with it effectively, would be accorded a most cordial welcome by the profession. Bacte-Coli-Phage is one such remedy the administration of which is the effective method of treating such infections. Treatment by means of vaccines is usually prolonged and tedious, and in the majority of cases uncertain because of the want of proper diagnosis of the dominant organism. And although success can be attained with them it is only temporary as recurrence of the trouble is likely to occur sooner or later. All these risks and uncertainties are eliminated by the administration of Bacte-Coli-Phage, which is rapid in its results and decidedly better as an antibacterial agent than the vaccines. Besides it is easier for application and is therefore very convenient for general use.

Bacte-Coli-Phage is a mixture of strains of bacteriophagi which act specifically upon Bacte-Coli and Paracoli. One cc of this Phage contains one billion bacteriophagi which are capable of destroying large varieties of pathogenic Bacte-Coli and

Paracoli. Bacte-Coli-Phage displays a powerful antibacterial action towards these types of cocci and is thus very serviceable whenever a local and continuous antiseptic effect is desired. It is therefore an ideal therapeutic agent in the treatment of bacilluria. In troubles of the urogenital tract it acts as a reliable urinary antiseptic, but it exerts this action only in an alkaline media. This Phage is quite harmless in therapeutic dosage whether given internally or as an intra-vesical instillation or as an enema. On contact it very soon destroys the cocci and penetrates deeper into the tissues. It is non-toxic and non-irritable and is capable of being administered by the mouth.

It is always advisable to place the patient on alkaline line of treatment as this Phage only acts effectively in an alkaline media. It is therefore essential to prescribe Soda bi-carb daily in drachm doses. The Phage should be given after a big interval after meals. This alkaline medication must be enforced throughout the treatment. When urinary reaction has been found alkaline then only should the treatment be commenced. A subcutaneous injection of 2 cc should be given to start with and then the patient should swallow 2 cc of the Phage diluted in half a glass of water, preferably Vichy water on an empty stomach and again repeat the same in the evening at least three hours after the last meal of the noon. The dosage should be prescribed according to the necessity of the case. Irrigations of the bladder or the intestines can be carried on with this Phage. 10 cc of this should be diluted with 50 cc. of lukewarm water for intra-vesical instillations while for intestinal affections an enema of 10 cc of the Phage mixed with 100 cc of boiled water will be sufficient. Vaginal irrigations of the Phage are also indicated in inflammatory diseases of the uterus or the fallopian tubes.

In the treatment of urinary infections of B. Coli origin, Bacte-Coli-Phage can safely be relied upon, as its employment by a number of physicians has given satisfactory results. In Cystitis due to B. Coli this preparation has been very valuable. Besides rest in bed, diet, hypnotics and sedatives, Bacte-Coli-Phage should be prescribed at least three times a day. The disagreeable tenesmus, high temperature and pain etc. soon subside. Frequency of micturition and its pain are soon brought under control.

Even in ulcerative Cystitis this Phage seems to be very beneficial. In many cases the urine has been found free from Bacte Coli after four days' treatment. This Phage renders excellent service in Pyelitis of B. Coli origin. Its administration is followed by diminution of the subjective symptoms. Pain, frequency of urine, blood and even albumen all these disappear after about five days of this Bact-Coli-Phage treatment. The temperature soon drops and the urine clears up satisfactorily. The patient soon becomes remarkably fit after a week's treatment. In cases of Pyelo-nephritis marked improvement usually follows the exhibition of this Phage for about a week. In these cases there is obstruction as well as infection and the bacilli chiefly responsible for this are B. Coli and the staphylococci. To combat this infection Bacte-Coli-Phage has been found very useful. One generally expects a gradual disappearance of fever and inflammatory symptoms from the seventh day onwards in this condition. Timely administration of this Phage will surely prevent further complications in this disease.

In certain gynaecological infections caused by B. Boli, Bacte Coli-Phage given by the mouth has not only cured the conditions, but has often times obviated the necessity for operations. The systematic ingestion of this Phage by the mouth weakens and destroys the infectious agents, specially the B. Coli group in the genital tract and hence this is very effective in diseases like Salpingitis, Metritis and Ovaritis. It is needless to say that a more or less prolonged course of treatment is necessary in such cases. Even in chronic types of such conditions a complete cure has been observed within a month and half with this treatment. No recurrence has ever been noted.

In Prostatitis due to Coli bacillus Bacte-Coli-Phage can be employed with advantage as it shortens the course of the disease and alleviates in an excellent manner the irritability, heat sensibility and frequency of micturition which are usually the symptoms in this disease.

The other indications for this Phage are Colitis, Cholecystitis and similar other conditions. In these cases besides the daily enema consisting of the 10 cc of the Phage diluted in 100 cc. of the boiled water, it should be taken internally morning and

evening. The symptoms abate very quickly and the patients feel much better in general health. In cases of Colitis the blood-stained slimy discharge is so much improved by irrigations and ingestion of this Phage that the patients feel considerably better. Bacte Coli Phage here are effectively destroyed judging from not only the abatement of symptoms but also from the disappearance of the bacilli from the faeces as seen after microscopic examination. In cases of Cholecystitis due to Bacte Coli cure can be easily and rapidly effected. With a modified alimentary regime and regular intake of this product the disease can be effectively brought under control. There is observed in these patients an astonishingly rapid amelioration, subjectively and objectively, an abatement of pain and return of normal appetite.

Bacte Coli-Phage if given in adequate doses appears to be remarkably effective in conditions for which B. Coli is mostly responsible. There are several attributes possessed by this product which goads one to say that it should be submitted to exhaustive trials. Firstly, it is a product which is absolutely harmless and which has a sufficient bactericidal effect in the urinary as well as the intestinal tract. It is highly effective in an alkaline reacting urine. Again it is neither destroyed nor does it weaken in its efficacy when it passes through the human organism. It is non-toxic and non-irritating to the urinary tract. Besides overcoming pain and discomfort of the patient it rapidly clears up the case and prevents further complications.

The following clinical report bears out fully the remarks made above about Bacte-Coli-Phage.

A young woman came to seek my advice in the beginning of the last month for frequent and painful micturition. On examination I found that there was slight pain and tenderness in the hypogastrium. There was slight constitutional disturbance. From the clinical history I elicited I excluded Gonococci and therefore I sent the urine for complete pathological report. The urine was found to contain B. Coli. I came to the conclusion that it is subacute Cystitis due to B. Coli. I therefore decided to try Bacte-Coli-Phage. At the start I kept her on an alkaline mixture. After satisfying myself that the urine is alkaline I injected 2 cc. of the Phage subcutaneously and then

I advised her to take the Phage internally diluted in Vichy water, once in the morning and once in the evening. Intravesical instillations were also given every other day (10 cc of the Phage to 50 cc of lukewarm water) under strict aseptic conditions. This regime was continued for a week at the end of which period the pain and the tenderness in the hypogastrium disappeared. The frequency of micturition became much less. The patient had to rise twice only at night for urinating after this, while formerly she had to go about six times on an average. The physical signs disappeared entirely after two more days and the patient herself thought that she was cured. The urine was free from pathogenic *B. Coli* after this.

It can thus be concluded that Bacte-Coli-Phage is a valuable therapeutic resource, which being absolutely innocuous allows easy application in all infectious processes due to *B. Coli* with the greatest surety of success.

The modern method of alleviating pains.

The combination of an analgesic and an antipyretic has repeatedly proved its efficacy in every day therapeutics. Such ideal combination is not easily achieved and therefore many products of this nature have fallen far short of expectations. Fortunately for the profession it was found that a homogenous substance Cryogenine, has been found, which is a mild well-tolerated and harmless anti-pyretic and analgesic.

Cryogenine, to begin with, is an excellent antipyretic. After 5 to 7 grs. of its administration the fall of temperature ensues rapidly followed by profuse sweating. The effect lasts for about eight hours after which the temperature may rise but rarely does it reach the original height. Cryogenine if given at regular intervals continuously brings down the pyrexia without any gastro-intestinal disturbances even in unfavourable cases.

This product has also a strong analgesic action due to the effect of the pyrazolon derivative. This favourable action is found in the treatment of pains, of whatever origin, which are brought under control in a gratifying way. In our daily practice we come across many ailments where pain is the predominant symptom. It is always advisable first to give relief to the patients and then the disease can be easily brought

under control by means of curative medication. In all such cases Cryogenine is the medicine of choice because of its sure action and its lack of disturbance of the vital functions.

Clinical experience has fully substantiated what has been said above about the pharmacological actions of Cryogenine. On account of its reliable anti-pyretic value it has been prescribed in all affections with pyrexia to reduce temperatures. It is used in Influenza, Typhoid, Sepsis, Pneumonia, Phthisis etc. It is specially useful in Influenza because it serves not only as a diaphoretic, but also as an analgesic for the violent pains met with in this condition. Cryogenine is also useful in acute Rheumatism as it brings down temperature rapidly and thus prevents further complications in that disease, specially the cardiac ones. Its application and efficacy is also evidenced in Rheumatic affections of the muscles and joints and also in Gout, because of its antipyretic and analgesic properties with the additional advantage that its prolonged administration in active doses does not produce any ill-effects. Cryogenine renders the acute pains of Sciatica bearable to some extent. If the tablets are continued for some time it will be found that the condition can be cured. Headaches due to any cause whatever, except perhaps Migraine, yield to this therapy with remarkable rapidity. Pain of Dysmenorrhoea is wonderfully alleviated by means of this treatment and thus Cryogenine has rightly usurped the place of narcotics, which were formerly thoughtlessly used to relieve the suffering of these patients. The pains in the chest in phthisical patients are successfully relieved by means of this product. Its mild antipyretic action is of great service in fevers of Pulmonary Tuberculosis. Even sensitive patients tolerate it well without causing any unpleasant by-effects. It does not interfere with the heart and the circulation nor does it impair the gastric or the intestinal functions. A combination of Cryogenine and Creosol Syrup is particularly useful in the treatment of these conditions. The syrup is devoid of the sharp taste of Guaiacol, which disturbs the appetite and again it is specially suitable for prolonged administration and for children. It is needless to say that this combination may also be useful in the treatment of Influenza accompanied by bronchial catarrh. Cryogenine is of great

value in Pruritus because it acts as a sedative to the neurotic factor which plays a great part in this affection. Combined with appropriate local treatment Cryogenine helps to break the vicious circle viz., scratching which keeps the skin in an irritating state. On account of its good analgesic properties Cryogenine is indicated in pre and post-operative pains. It has also proved invaluable in various painful affections of surgical diseases. In fact it has replaced Morphine and other alkaloids of Opium in such cases. We however do not claim its universal use but wherever Cryogenine fails, Morphine should certainly be resorted to.

Cryogenine treatment has of late become the treatment of choice in all cases where pain and fever predominate. This is not only because of its dependable action as an antipyretic and analgesic, but also because it does not hinder metabolism or heart action in any degree. It does not have any after-effects on the patient, neither are the effects cumulative or habit-producing. It may therefore be safely given to adults and in moderating dosage to old men and children.

Common Skin Trouble.

That the diagnosis and treatment of skin affections try severely the patience of the general practitioner is a very common experience. The minor skin troubles met with in general practice cause more inconvenience and worry to patience than more serious affections. If a practitioner therefore correctly diagnoses the case and treats it appropriately and quickly, his skill will be most appreciated by his clients specially if the treatment the patient had before, had been on the wrong lines or had been aggravated by greasy ointments and unsuitable lotions. The everyday conditions one meets with in general practice are Scabies, Acne, Seborrhoea, Tinea, Alopecia, Ptyriasis etc. These form the 90 per cent of the maladies one comes across. Now in the treatment of such conditions Sarcaptol is the sheet anchor of the general practitioner. In addition to its being an effective remedy in the skin conditions mentioned, it possesses the unique advantage over other Sulphur preparations in that it has no objectionable odour of Sulphur. It does not stain the skin or the linen nor does it cause any irritating action which may result in second-

ary eczemas. Being in colloidal state Sarcaptol penetrates deeply into the folds and pores of the skin and has powerful antiseptic, analgesic and antiparasitic actions. It is a specific for scabies.

The following few cases will exemplify the facts concerning Sarcaptol more fully:—

1. A young boy of 16 was brought to me suffering from severe scratching of the head and circular patches on the scalp. The examination of the scalp showed the presence of typical patches of ringworm covered with numerous brawny scales. I had the patient's hair cut close. He was then advised to scrub the whole scalp thoroughly with Sarcaptol after washing it with an antiseptic skin soap. This was done twice daily. He was asked to sterilise every day his brush, comb and towels. This regime was continued for a week. At the end of this period the result was found extremely gratifying. The scalp became almost clear and the patient had no itching and had very little discomfort. The fungus was thoroughly destroyed by the remarkable penetrative action of Sarcaptol. The patient was recommended to discard his old hat which might have harboured the fungi so that the condition might not recur.

2. A child of about 8 was brought to me with a history that a bald patch had appeared in the scalp just above the nape of the neck about six months back. Despite medication by several doctors the patch seemed to be increasing in size. The father of the child gave me the information that he too had suffered from a similar complaint in his boyhood. I started with the application of pure undiluted Sarcaptol morning and night. Besides this the whole scalp was massaged with this product once a day. At the end of a month of this treatment hairs were seen growing and after about a fortnight more the whole patch was covered with luxuriant growth of hair. It appears from this case the Sarcaptol brought the necessary flow of blood to the part and at the same time acted as a parasiticide, as the alopetic patch may have been due to ringworm.

3. How Scabies are cured without much trouble by the application of Sarcaptol is illustrated by the following case:—

H. L. Aged about 30 consulted me for small pustules in the groins and in the vicinity of the scrotum. He complained of intense itching in these parts. He told

me he had taken treatment at the hands of several doctors who cured the condition which however recurred. I found that Sulphur must have been employed most enthusiastically as I could clearly see dermatitis set up in the region of the groin. I advised application of pure Sarcopitol. After thoroughly washing and scrubbing the affected parts with a sulphur soap he painted the part with Sarcopitol. Two such applications cleared up the condition entirely and no reinfection has yet occurred. The patient was extremely satisfied with the result.

Experiences with Bacte-Rhino-Phage

When one considers the affections of the nose and throat, the tonsils seem to be the organs that come most to one's mind. The bacteriological examination of these reveals the presence of several cocci according to the existence of various diseased conditions viz. *Streptococci*, *Staphylococci*, *Micrococci*, *Catarrhalis*, *Pneumococci* and *Bacilli* *Influenza* etc. When the throat and the tonsils harbour so many cocci, we can realise the gravity of the diseases caused by them and also the necessity of treating them seriously. Again the important role played by tonsils in the causation of Rheumatism, Heart-disease, Chorea, the necessity for treatment becomes all the more pressing. There is a good deal of controversy raging whether tonsillitis is a primary infection or is secondary to a pharyngeal one. Some believe that the infection in every case starts in the tonsils. No matter where it starts we have got to deal with the condition no sooner it is detected.

As regards the nasal affections we cannot ignore the extreme sensitiveness of the mucous membrane of this part and hence any irritant antiseptic in these affections is contra-indicated on account of its destructive action. Again when antiseptics of high strengths are applied in such cases the excessive formation and evacuation of the nasal secretions simply wash them away before they have time to exert their action. Besides, plugging the nose with cotton-wool soaked in antiseptics is a most uncomfortable procedure for the patients. Nasal irrigation is not of much use unless carried out persistently and with care.

All these difficulties and worries have been done away with by the introduction into medicine of Bacte Rhino Phage. The chief indications for this Phage mainly lie in the nose and throat. Quite remarkable results have been obtained with it in this sphere of work. Spraying this Phage either through the mouth or the nose has been recommended twice or thrice a day, in Chronic Pharyngitis. Cases of chronic nasal catarrh, which is mostly due to inflammation and suppuration of accessory nasal sinuses have been treated with conspicuous success. In the treatment of Rhinitis and Hay fever the treatment with this Phage has done immense good. Treatment of Tonsillitis, either acute or chronic has been very successful when this Phage has been sprayed twice every day through the mouth. Bacte Rhino Phage has been found extremely effective in chronic hypertrophic Rhinitis with profuse discharge.

As regards chronic tonsillitis most of the surgeons perform the Whillis-Sluder operation or they enucleate it by dissection. A safe and a better alternative for this is the rational and prolonged local treatment by means of Bacte Rhino Phage. All one has got to do is to procure a fine atomiser and spray the affected parts freely with one ampoule of Bacte Rhino Phage twice daily, once on waking in the morning and once on retiring at night. If the condition is acute spraying three or four times a day is advisable.

All the objections met with in the case of other antiseptics in nasal affections do not apply in the least when Bacte Rhino Phage is employed. Under this treatment the nasal mucosa is toned up and contracted and the turgescence and the catarrhal condition soon subside. Considerable relief and even permanent cure has been found after the use of this Phage when there is oedema and infiltration of the middle and the inferior turbinate bones. Frequent sprays of this Phage successfully overcome the chronic inflammation and suppuration of the accessory nasal sinuses. Spraying the nose with this Phage has cured patients of Hay fever. If the spraying is continued for some weeks the patients will be completely free from recurrent attacks.

Here is a case of chronic Rhinitis treated by this Phage.

A young man of 35 came to me with profuse discharge from the nose. The nasal

mucous membrane was oedematous and much reddened. I diagnosed it as a case of chronic Rhinitis. He had been under the treatment of a specialist for a year, but so far, he said, he had obtained no cure, though there were temporary periods of relief. I advised spraying the nose with Bacte-Rhino-Phage. He did so once on waking in the morning and once at bedtime. Two ampoules were used per day. After two weeks of this treatment his discharge became much less and the oedema of the mucous-membrane disappeared and the redness was distinctly less. The treatment was continued for another three weeks after which period the mucous-membrane became normal in appearance and turgor and the discharge completely dried up. He continued spraying the Phage once in the morning only for a week. The patient is at present feeling quite well.

This is a sample from a large number of cases which proves the usefulness as well as the superiority of this method as compared with other types of treatment.

Malaria Prophylaxis.

It has been for a long time the endeavour of many physicians to find out a product which possesses the property of completely destroying the Sporozoitic stage of the malarial parasite. It is undoubtedly a fact that Quinine is a specific against malaria, but unfortunately it has some grave defects so far as its preventive properties are concerned. It has been proved that it does not destroy the Sporozoitic stage mainly responsible for the infection, secondly its action on the sexual stage is very mild and uncertain and lastly if administration of Quinine is discontinued, its curative effect does not last for a long time.

Experimental results have proved the definite value of Quinarsine as a prophylactic far superior to Quinine. In considering the effect of Quinarsine on the relapse rate due weight must be given to the fact that it has been largely tried in those cases which have already relapsed after treatment with other Quinine remedies. That the relapse rate after Quinarsine regime has remained low is a factor which has been put down to the credit of the preparation. Quinarsine marks a very distinct advance in the prophylaxis and prevention of malarial fevers. It ensures the destruction of the

sexual forms, the Gametocytes, in all the three forms of malaria. This combination treatment, tablets given by the mouth together with intramuscular injections, is much more effective than either given alone. Continuous treatment promises more permanent results than large doses given at a stretch and none of the toxic symptoms are experienced as with other products.

It is not as yet well recognised that Quinarsine is an asset of great value in malaria prophylaxis. Its specific action on the Gametes of Subtertian malaria is a valuable economic factor and it has a better effect on the Schizonts. Quinarsine therefore is accepted as one of the most valuable advances that have been made in the prevention of malaria. By its administration it is now possible to sterilise populations even though other economic conditions may prevent complete eradication of mosquitoes. Malaria incidence can thus be diminished to a great extent.

As soon as the malarial wave has subsided treatment should be commenced with it and the practitioners will note that after a fair amount of trial the hemoglobin percentage will show a steady rise thus having a beneficial effect on patients whose vitality has been sapped by constant attacks of malaria. Again these patients who have the 'drawn' look, will soon appear better and even get fatter. There is also a steady diminution in the size of the spleen which becomes normal within a short course of time. The seasonal incidence of malaria is at first delayed and then entirely disappears and there is general improvement in the health of the patients. It has been observed that attacks of malaria can be prevented in pregnant women without danger either to her or to the child. This fact is really of great significance, since chronic malaria leads specially during pregnancy to marked secondary blood changes and the inability to use Quinine in such cases leaves the patient helpless and with very serious prognosis. Quinarsine is therefore a boon to such patients. It has been noticed that even after prolonged administration of Quinarsine no toxic effects were ever observed so far. It is by this time realised that the selective action of Quinarsine is of prime importance particularly in sanitary measures. The blood of Gametocyte carriers can easily be sterilised thus avoiding mosquito transmission since the sexual form is the only

factor in natural transmission. Under the usual Quinine treatment it has been found that Gametocytes take at least 4 to 6 weeks to disappear from the blood, which means that relapses are quite frequent, while with Quinarsine the average period of disappearance is 4 to 7 days i.e., the relapse rate is much reduced.

The administration of Quinine during the malarial attacks and supplemented afterwards by Quinarsine is a very beneficial treatment as prophylaxis against malaria. It has an admirable effect on the general health of the community. It rapidly reduces the malaria rate during an epidemic. It has more marked effect than Quinine alone. It reduces the parasite rate, increases the hemoglobin percentage and improves the general health. It can safely be given as mass treatment either in the form of tablets or better still intramuscularly. It can therefore be used during malarial epidemics in labour forces. The cost, though a little high particularly of the ampoules, does not bar it from use in bad malarial districts. The expense here is most justified.

The clinical results after the treatment with Quinarsine indicate clearly that there is a progressive diminution of parasites from the very beginning. The parasites disappear mostly or completely after five days of treatment. After the treatment with Quinarsine, when the acute attacks of all the three types of malaria have passed away, we have seen that relapses are less frequent. Another feature in favour of Quinarsine is that it is well-tolerated in cases of Quinine idiosyncrasy and hemoglobinuria.

The preceding observations verify that opinion is rapidly gaining ground in favour of Quinarsine in the prophylaxis of malaria. Its rapid gametocidal action confers on it a unique place amongst the numerous remedies for protecting people against malaria infection.

Quinarsine, the compound of Quinine and arsenic, has become of late the standard scheme of treatment in all forms of malaria, particularly its prophylaxis. Formerly for the prevention of the disease the chief method employed was of mosquito control, but the difficulties in eradicating malaria with this method were really great. Eradicating the human being of malaria offers a real and permanent hope of wiping out

this weakening disease and this hope is based on the action of Quinarsine which destroys the sexual forms of the plasmodium which alone is infective for the mosquito. Destruction of the malaria plasmodium is much more easy than destruction of mosquitoes wholesale and looking in this direction, Quinarsine requires to be used more widely than hitherto.

Quinarsine as a prophylactic was tried in a number of cases out of which only the typical are given below.

A young girl of 16 was getting attacks of malaria off and on for the last one year. She had become anaemic. The spleen was felt three finger-breadth below the costal margin. After the acute attack had subsided, she was kept on Quinarsine. To supplement the treatment she was also given orally the tablets. After one course of these injections was finished, she was given a complete rest for a fortnight and then another course was started. After this regime she had only one attack of malaria. Her spleen was reduced in size and could not be palpated after the two courses of injections. Add to this her general condition improved and there was no trace of anaemia. Her health became quite normal after about two months of this treatment.

A man aged 40 complained of malarial attacks for two years. The resultant secondary anemia was very marked. Examination of the blood showed the presence of Subtertian Gametes. He was injected Quinarsine. After the first course the blood count showed less Gametes, the Subtertian rings were much less. There was appreciable improvement in his anaemia. When the second course of injections was finished the blood showed here and there a degenerated Subtertian ring and no Gametes. No further malarial attack was observed. The patient has been under observation for the last three months and he is completely free from fever and anaemia and his blood-examination has been carried on monthly which shows that it is quite free from the parasites.

These cases demonstrate the efficacy of Quinarsine as an excellent prophylactic. The temperature does not rise after two or three injections and the parasites disappear after usually one or two courses of treatment.

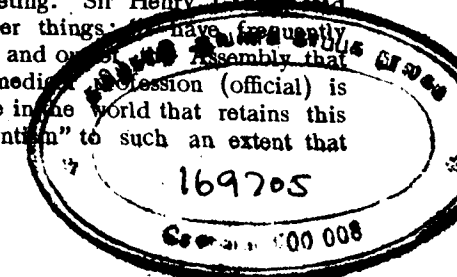
News and Comments.

Honorary Medical Officers: We wish and hope that the members of the profession not only in the Madras Presidency but also in other provinces would go through the rules relating to Honorary Medical Officers as published in our "correspondence columns" and express their views either individually or through existing medical associations and press the same on the Government so that eventually the control and running of the scheme is entrusted to the members of the profession as a whole. Members of the profession in other provinces will do well to compare and contrast what is obtaining in their provinces regarding the honorary medical relief scheme and bring about a uniformity in the working of the scheme of Honorary Medical Officers throughout the country.

Sentiment versus reasoning: News about the Indian Medical Council Bill cannot be stale till the Bill is passed into Law. A verbatim report of a meeting held in Calcutta in July last is published in the August issue of The Journal of the Indian Medical Association, which came out of the press at the end of the first week of September. This was a meeting of the members of the Calcutta Medical Profession and was presided over by Sir Hasan Suhrawardy, the Vice-Chancellor of the Calcutta University. Sir Suhrawardy in his speech pointed out the necessity of an All-India organisation to control medical education of an uniform standard throughout the country. He was against recognition of the British qualifications in case the General Medical Council did not recognise the Indian medical qualifications. He made out a very strong case for the inclusion of the Licentiate within the purview of the Bill. It was the considered opinion of Sir Suhrawardy that the Bill should not be rushed through hurriedly and the best time for the consideration of the Bill was after the Indian Constitution is finally settled. Almost all the other speakers agreed with Sir Suhrawardy excepting one Dr. M. N. Bose, a teacher in one of the medical schools in Calcutta, who strongly objected to the inclusion of the Licentiate in the All-India Medical Register, as the duration of the course of training of the Licentiate was less than that of Graduates. Any amount

of reasoning put forth by Sir Suhrawardy and others would not convince Dr. Bose. It looks as if Dr. Bose has not understood the object of the Medical Register either in India or other civilised countries. The Medical Register is only a guide to the public to find out the qualified practitioners. It is a record of the names, qualifications and addresses of the practitioners and nothing more. The qualifications entered in the Medical Register denote clearly who has more training and who has less. The argument of Dr. Bose that those whose names appear in one Register should have the same standard of qualification cannot be followed to its logical sequence as practitioners other than Licentiate will have to be entered in different Registers according to the qualifications they possess, as no two qualifications are of the same standard. Dr. Bose seems to be a sentimentalist, a quality incompatible with the teaching profession. We wish Dr. Bose goes through the British Medical Registration Act passed in 1858, when there were in England and Wales almost all qualifications as they are there to-day and yet the British Parliament thought it was desirable to have in the Register all those who practised Allopathy even if they did not undergo training in any school or hospital, the purpose being to bring all those who practise medicine under disciplinary control of the General Medical Council. It cannot be for a moment said that the products of the medical schools who very often treated eminent doctors like Sir Suhrawardy, and whom the latter was proud to own as his colleagues, are inferior in their training to the unqualified practitioners in Great Britain in 1858. Dr. Bose being carried by sentiments and not reasoning did condemn himself unconsciously by condemning the class of medical practitioners whom he had the privilege to train.

We are glad to note that Sir Henry Gidney, the medical Knight possessing the highest British qualifications and a M. L. A. to boot, created quite cordial feelings at the Calcutta meeting. Sir Henry Gidney said amongst other things: "I have frequently said both in and out of the Assembly that the Indian medical profession (official) is the only one in the world that retains this 'compartmentation' to such an extent that



one is once a subordinate in that service he is always a subordinate. Why should we allow that to be tolerated and perpetuated in this country? Why should we allow this "compartmentism" to be introduced in the official Medical Cadres? Speaking for myself I would hail with delight the day when the word "Subordinate" is deleted from the official vocabulary. (cheers)..... I go further and say that you have in the present D. M. S. in India, General Corrie-Hudson, I. M. S., an equally sympathetic official. He said to me 'I should welcome the day when a Military Sub-Assistant Surgeon will be able, if he proves his fitness, to become the Director of Medical Service in India'. Why should any able man be barred?' (cheers.)" The Committee appointed by the Calcutta University to go through the Bill seem to have recommended that the Licentiates should be included within the purview of the Bill, but their names should be registered in a separate Appendix. Sir Henry Gidney spoke vehemently against such an arrangement and said: "There might be difference according to your degrees, but any attempt to have two categories on the Register of the Council would perpetuate the evil which we desire to stamp out. And I can assure you that when I speak on this Bill in the Assembly, I shall stress this aspect of the question as strongly as I can—that we should not perpetuate this compartmentism."

An Appeal to the profession: The Legislative Assembly had adjourned its session to November. Sir Henry Gidney who has no bias against any class of practitioners though he possesses the highest British qualifications and the only medical man in the Assembly, will be absent from India having to attend the Round Table Conference in London during the winter season. The lay members of the Assembly will certainly be guided by their medical colleague, Sir Henry Gidney. His arguments will also be listened to with much interest by the Government members. So it is highly desirable that the further discussion on the Bill should be taken up in the winter session of 1933. We suggest to all the Medical Associations in India to meet and pass resolutions requ-

sting Government to postpone further discussion on the Bill till the winter session of 1933.

Major Amir Chand speaks out: Major Amir Chand, I.M.S., Principal, Medical School, Amritsar, had contributed an article "Some Problems of Medical Licentiate in India" to the September issue of The Journal of the Indian Medical Association. His views are worth the consideration of the profession, coming as they do from an Indian member of the I. M. S., holding the responsible position of the Principal of a Government Medical School, in addition to his having been the Professor in the Lahore Medical College for some time. Major Amir Chand summarises his views under six items:

1. In India a lower medical qualification than the University degree is a necessity, at least for a long time to come.
2. Matriculation Certificate should be the minimum preliminary qualification for admission to medical schools.
3. It would be very advantageous if a "Matriculation Medical Group Certificate" qualification could be started like the F. Sc. Medical Group.
4. The minimum period of training in medical school should be four calendar years.
5. If the preliminary qualification has to be the I. Sc., and the length of curriculum, 5 years, there is no sense in maintaining the medical schools and the diploma of Licentiate; the former should be converted into colleges and the latter into a medical degree.
6. Indian Universities should be asked to provide facilities to Licentiates to enable them to appear at their examinations for medical degrees granted by them under conditions suggested above in the text of this paper.

Major Amir Chand's plea to have a lower standard of medical education is to help poor parents to have their children trained as medical men who being accustomed to village life would eventually settle in rural areas instead of towns and cities as do their more fortunate brethren the graduates who being sons of rich parents would like to enjoy the town or the city life. But unfortunately facts are otherwise in Bombay and Madras, and it must be so even in the Punjab and in the other provinces, as is evidenced by the fact that almost all provincial governments have inaugurated the system of subsidised rural medical relief in villages as they found that even the lower qualified Licentiates would not settle in rural areas. Major Amir Chand has evidently relied upon the

speeches on this subject made by the members of the profession who met in Conference last summer in Calcutta. We wish he read or he reads now the Presidential Address delivered by Dr. Jivraj N. Mehta, M.D., the Dean of the Seth Gordhandas Sunderdas Medical College, Bombay, at the Seventh All-India Medical Conference, held in Poona in 1931. Dr. Mehta took some pains and on an analysis of the Bombay Medical Register found that the largest number of Licentiates settled in cities or important towns of Bombay or in other cities or towns outside the Bombay Province. So the plea that a lower standard of medical men is essential to expand medical relief in rural areas cannot hold water. We agree with Major Amir Chand in his view that an increase in the course of studies does not necessarily mean additional efficiency in training. The methods employed in teaching and more than this the ability of the teacher that count much and not so much the lengthening of the course of studies. Even in other civilised countries, as quoted by Major Amir Chand, increase in the course of studies, is being condemned these days. The clamour for increase in the course of studies from four to five years, is more in the spirit of aping. If the university course was not increased, nobody, much less the Licentiates, could have agitated for the increase in the course of studies.

Major Amir Chand is quite right, in saying "there is no sense in maintaining medical schools and the diploma of Licentiate" if the preliminary qualification for admission into schools is raised to the standard demanded by medical colleges and the length of course in the schools increased to five years. We wish the Licentiates more than any body else realise that they are doing more harm to themselves and do not help their own cause if they use such terms as "half-baked", ill-equipped ill-trained" doctors for themselves while competent authorities like the Principal of the Amritsar Medical School, express their opinions about the Licentiates to the contrary. Major Amir Chand says, "It is my experience and of others also—that in ordinary general practice, whether in a city or in a village, an average Licentiate fares as well as an average Graduate." The Licentiates cannot have any cause to grumble

if a uniform standard of medical education is introduced in this country on the lines suggested by us in the July, 32 issue, and if the existing Licentiates are given facilities for higher qualifications as suggested by Major Amir Chand without demanding any additional preliminary qualification at least from such of those who have been in actual medical practice for a period exceeding five years.

All-India Hygiene Institute: Ever since the School of Tropical Medicine, Institute of Hygiene and the Carmichael Hospital for Tropical Diseases came into existence in Calcutta, no distinction was made between practitioners with regard to the dissemination of knowledge of special subjects taught in those institutions. It is said that Lt. Col. Megaw (now Major-General) the then Director of the School of Tropical Medicine was mainly responsible for the admission of Licentiates into those institutions in spite of opposition from some quarters; and it must be a matter of pride to this class of practitioners that they proved the justification of throwing open the doors of the Tropical School to them by not only coming out successful in the examinations conducted in the school, sitting side by side with the graduates and other diploma holders, but also in holding a few responsible positions as research workers in the very School; and their work has been appreciated year after year in the Administration Report of the School of Tropical Medicine. The Institute of Hygiene, in the School of Tropical Medicine has been now converted into a separate unit, under the name of the "All-India Hygiene Institute", and Lt. Col. A. D. Stewart, I. M. S., has been made the Director of this institution. It is said in the last Administration Report of the School of Tropical Medicine that the "All India Hygiene Institute" will be affiliated to the University of Calcutta for the purpose of conferring the D. P. H. Degree to those who undergo training in the Hygiene Institute. If this is done, there will be a practical difficulty for the Licentiates availing themselves of the benefit of the study of Hygiene, which facility they have been so far enjoying at the School of Tropical Medicine and successfully passing the D. T. M., and the L. T. M. examinations along with the other practitioners. There

Boldine A. D. helps in Jaundice and dissolves Gallstones.

might have been some justification at least if the Hygiene Section of the School of Tropical Medicine was affiliated to the Calcutta University before the institution was called "All-India Hygiene Institute," but certainly not now, when the Institute is an All-India concern and not particularly of Bengal. The importance and much more the utility of the All-India Hygiene Institute will be curtailed if those who are responsible to run this All-India Institute get it affiliated to some other body even if it be an University. On the other hand, the Institute will denote what its name indicates—that it is in no way under the control of a second agency, but is an independent body of which advantage may be taken by the whole profession in India as was the case with it while it existed as a section of the School of Tropical Medicine. Under no circumstance, we trust, Lt. Col. Stewart will be a party for debarring the Licentiates from entering the All-India Hygiene Institute. He has the noble example of Major-General Megaw in this respect.

Lay Press and the Profession: A registered practitioner has sent us a cutting from one of the dailies in Madras, which contains a group photo of a social gathering held in appreciation of the services rendered by another registered practitioner in the City to a patient. A brief account of the gathering appears in that cutting, and it is also said: "Eulogistic speeches dwelling at length upon the new lines of up-to-date and modern treatment employed by the doctor were delivered on the occasion. A silver trophy and a handsome purse were presented to him in recognition of the valuable aid rendered to.....". The propriety of publishing such news about registered practitioners is questioned. How far this news differs from the news published in newspapers about the case notes (which form part of the reports of the proceedings of meetings of medical associations) where accounts are given how a particular doctor performed a particular operation quite successfully or from the news where the Surgeon-General or the Minister of Public Health or such eminent personages eulogise the special skill and merit of doctors in service in connection with the opening

ceremonies of hospitals or wards and from various other news concerning practitioners appearing in lay papers, is a matter for opinion; before we comment on the subject we thought it desirable to give our readers the benefit of the opinion of the highest authority in these matters and have therefore sent this cutting to the President, Madras Medical Council, with a request that it should not be treated either as "information" or "complaint" from us. We shall publish in these columns the reply from the President as soon as it is available.

Arbitrary decision: It is said that the President, Madras Medical Council, has decided not to summon the October meeting of the Council though the rule regarding the convening of meetings of the Council framed under Section 24 (2) of the Madras Medical Registration Act (IV of 1914) runs thus: "The Council shall ordinarily meet for the transaction of business on the first Monday of March provided that day does not fall on a holiday when the meeting should be held on the following Monday and on the last Monday in October, but if a holiday on the previous Monday." It is seen from the rule that it is mandatory on the part of the President to summon two ordinary meetings of the Council in a year, one in the first week of March and the other in the last week of October. We learn that Dr. V. Rama Kamath, Member, Madras Medical Council, has given notice of some resolutions for the October session and has also addressed the Government questioning the decision of the President in not summoning the meeting in October.

Registrar, Madras Medical Council: It is reported that Dr. H. Chatterjee, Registrar, Medical Council, Madras, has been relieved of his duties and Major Cosban, one of the members of the Madras Medical Council, has been requested by the Council to take over charge of the office of the Registrar as a temporary measure, till a permanent Registrar is appointed. From the advertisement which appeared in the newspapers it looks as if the Madras Medical Council have decided to have a lay Registrar or a non-practising medical man. We are glad that the principle advocated by us in these columns that it was against the

principle of the Medical Act to have a practising medical man as a Registrar, is now adopted by the Medical Council. The Medical Council is a body who have statutory disciplinary control over the registered medical practitioners, and if the Registrar, Medical Council, is also a practising medical man, there is likely to be a deadlock if any complaint is made against the Registrar himself regarding unprofessional conduct as the proceedings in these cases have to be initiated by the Registrar. So far so good. But the pay of Rs. 150 offered for a part-time Registrar having to work only for 3 hours a day is certainly too large an amount when it is known that the Council had no funds to pay the travelling allowances of its mofussil members and the staff could not draw their pay for the past several months. The first two Registrars who had been in office during ordinary times when there was no economic depression in the country were drawing Rs. 100 as their salary. How and how far the Council will be able to pay Rs. 150 as a part-time salary to their Registrar is too much for us to calculate at present, till perhaps the amount of nearly Rs. 5,000, which is alleged to have been misappropriated, is made good by those who were responsible for the misappropriation.

Medical Licentiates' Conference: As reported in one of our previous issues, the 26th All-India Medical Licentiates' Conference will take place during the Christmas week in Madras. We refer our Licentiate readers to the bulletin published in the "correspondence columns" of this issue. The affairs of the Licentiates are at present in a melting pot and it depends upon them more than anybody else to give a proper shape to the melted metal. So it is needless for us to say that the Licentiates should take a lively interest in the coming Conference and make it a success. The adage that 'Unity is Strength' may very well be realised by the Licentiates who number nearly 4000 in this province, perhaps the highest figure in India.

Doctor's mistakes: Major-General C. A. Sprawson, the Surgeon-General with the Government of Madras, addressed a gathering of medical men at a meeting held under the auspices of the Madras Branch of the British Medical Association on the 11th instant at the

Madras Medical College. The gathering was fairly large, consisting mainly of the service group. Naturally, the person of the Surgeon-General, more than the subject, attracted the doctors in service. It is only persons of official eminence who can count upon seniority also that could talk on subjects like the one chosen by Major-General Sprawson that night. The lecturer dealt upon the mistakes usually committed by the members of the profession, in taking the history of the cases, in making physical examination of the patient, in diagnosis of the diseases and their treatment, even in the matter of writing prescriptions, the prognosis and last in making bills to the patients. All such errors, the lecturer said, are due to one or more causes, such as want of knowledge, error of judgment, haste, carelessness, injudiciousness, callousness, etc., some of which are pardonable and others not. The errors enumerated by the lecturer are likely to be more in places where they are least detected. In private practice they are likely to be few and far between than in institutions where people are treated free. If there is a profession where faults could be committed and go undetected, it is the medical and if there is any profession where a person can afford to be most independent, yet conscientious and saintly, it is the medical profession, and any amount of care and attention in training up the students cannot at any time be said to be too much. Habit and character are moulded more in school days than in adult life and all the errors enumerated by the lecturer could certainly be prevented and many lives saved if no errors are committed in choosing teachers to teach boys the science of medicine. The Major-General occupies a most enviable position in pointing out the doctor's mistakes and also preventing them, and we are sure he believes, as does the humblest member of the medical profession, that prevention is better than cure.

Amendment to Madras Medical Act: At the last session of the Madras Legislative Council, amendments were passed without a single dissenting voice, making it no offence for a registered practitioner to associate himself with a non-registered practitioner and giving registered practitioners the liberty to withdraw their names from the register. If those who are

responsible for the passing of the Medical Act conducted the affairs of the existing Councils, making the public and the profession realise the necessity of such acts for public good, the public and the profession would have certainly taken more interest in the existence of the Medical Council than they do now. Even independent medical profession which is the larger group than the state-paid profession has no interest as the Medical Act has not enabled them so far to enjoy the rights and privileges of registration. The Government group enjoy privileges in spite of the Act and they have no concern in the privileges mentioned in the Medical Act. The public are not made to realise the necessity of medical registers as they are published to the convenience of the Registrar so far.

An Invidious Distinction: The Government of Madras have recently passed an order that the fees collected from the paying patients in the X-ray Department should be divided between the staff and the Government in the proportion of 40 and 60 per cent. Till now a distinction was made in the private patients: those coming direct to the staff and those sent over by the hospital or by private practitioners to the X-ray Department without specially directing such patients to them; and in such cases the Government allowed 75 per cent of the fee collected in the case of the former and 25 per cent in the case of the latter.

Officers employed in the X-ray Department are paid their grade pay and a special allowance. Why the fees collected from patients should not go to the Government Treasury in full as in the case of the other paying patients from whom the fees charged for advice and for major and minor operations, are credited to the Government in full and why the officers for this special Department alone should be treated with invidious distinction, is a question that is perturbing the minds of the officers under the Government, working in the other sections of the Medical Department. The public are entitled to ask the Government why the officers employed under the Government who are paid handsomely and allowed private practice in addition, should get a share of the fee earned by the X-ray Department during the

usual routine office hours when every full-timed officer is expected to work for the pay he receives. There is yet another query as to the time when the paying patient will be examined and when the non-paying. It will be quite consistent with human nature that paying patients will naturally be given a preference to the detriment of the poor for whom the Government institutions primarily exist.

Mahatma Gandhi's Fast- A lesson: Though there were grave apprehensions and arguments in favour and against the justification of a fast by Mahatma Gandhi to remove untouchability in this country judging from the result, the psycho-analysis of the fast proves without a shadow of doubt that at times what others consider a sentiment works out as a sound reasoning though ordinarily one is paradoxical to the other. Such and similar events for the good of the country have taken place in Bombay Presidency, especially after the entry of Mahatma Gandhi in the political and social fields. Is it too much for us to expect that a day will soon dawn in that Presidency when the untouchability now existing in the medical profession will be wiped out? This is certainly a far more easy problem than the one solved by the Mahatma. The fact that Mahatmaji has disciples in the medical profession amongst the leaders in Bombay has also to be reckoned. Some of them to our knowledge are the members of a medical fraternity in Bombay. Though the latest news that this fraternity would not admit the Licentiatees as members of that fraternity in spite of its President and other prominent members crying hoarse on public platforms to include the Licentiatees within the purview of the Indian Medical Council Bill, may startle some, we have not lost faith in the patriotism of the President of that fraternity and his followers in solving the problem of untouchability in the medical profession.

Homogeneity at last: Early this year a notice for retirement was served by the Surgeon-General with the Government of Madras on medical officers in the provincial cadre who had finished 25 years service. The Civil Surgeons amongst them brought to the notice of the Government that as Civil Surgeons their cadre was quite different from the provincial service men and as such the retrenchment axe could not be

made applicable to them. Whatever might be the legal and technical bearing differentiating the Assistant Surgeons from the Civil Surgeons in the provincial cadre, we said at the time that the rule should be made absolute to all who have entered service as Assistant Surgeons in spite of the varied designations they might have earned during the period of their service. It is now reported that though the Government for some time were in favour of treating the Civil Surgeons as a separate cadre, after further consideration they have decided that the provincial cadre consisting of Civil Assistant Surgeons and Civil Surgeons should be treated as one homogeneous service and accordingly in addition to the retirement of such of the Civil Surgeons who have already received notices, six more have been recently included in the list of such retirement.

How far the retirement of medical officers of 25 years service would help the Government substantially in retrenching expenditure is rather doubtful so long the vacancies so created are filled in by entertaining fresh recruits in the provincial cadre. Unless the vacancies are filled in by honoraries, as has been suggested by us in these columns and elsewhere, retrenchment in the Medical Department cannot have practical and tangible results. The officers who are forced to retire might have been requested to serve as honoraries. Such an arrangement would have served a double purpose to the satisfaction of all concerned.

U. P. Medical Council Election: We are informed that early in November there will be an election in the U. P. Medical Council to choose a representative for the Licentiatees and that the sitting members Dr. Rai Sahib Ram Narain Lal and Dr. Prem Shanker Varma are the

contending candidates. As is usual with contested elections, there seems to be a keen fight. Manifestos and counter-manifestos are being freely distributed by the candidates and their supporters. We trust that the electors will not be perturbed by the heat of the election or any undue influence brought to bear upon them either by the candidates or by their agents and consider that their vote is a sacred trust to be made use not in individual interest, but for the good of the class whom the candidate has to represent. They have greater opportunities to judge about the record of work and services rendered by a sitting member and if such a record is bad as is evidenced by the facts before the electors such a candidate should not be elected and a chance is to be given to a new one. The person to be chosen should have the qualities of a fearless fighter, a tried and trusted individual who without fear or favour should fight out battles in the interest of the Licentiatees not only in the Medical Council but outside.

Congratulations: We learn that Dr. S. L. Sharma, sitting member of the U. P. State Medical Faculty has been selected to represent the Licentiatees in that Body. Dr. Sharma has been a member of the Faculty for several years and has a good record of work. We congratulate Dr. Sharma and wish him a long life of usefulness.

A Mistake: A mistake appeared in the September issue of The Medical Practitioner in the Editorial on Rural Medical Relief Scheme where it was mentioned that the Government took two years and a quarter to arrange for a Conference of Rural Medical Practitioners. It ought to be one year and a quarter. We regret the mistake.

PHONE No: 3034.

Dr. S. R. BHAT

M. B. B. S., L. D. Sc. (Calcutta)
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GOVERNMENT OF MADRAS

LOCAL-SELF GOVERNMENT DEPARTMENT
(PUBLIC HEALTH)G.O.—NO. 1610, P.H., 29TH JULY
1932.Honorary medical officers—Rules issued in
G.O. No. 899, P.H., dated 11th April 1930,
revised.ORDER—NO. 1610, P.H., DATED 29TH JULY
1932.

In G.O. No. 1705, P.H., dated 11th September 1931, the report of the Committee appointed to consider the question of revision of the rules relating to the appointment of honorary medical officers was published for general information. The Government have since considered the recommendations of the Committee and also the resolutions passed by the South Indian Medical Union and certain other associations thereon.

2. The rules relating to the appointment of honorary medical officers as revised and approved by the Government are appended to this order.

3. Separate orders will issue on the recommendation of the Committee in regard to the replacement of paid Government medical officers by honorary officers.

4. The Surgeon-General is requested to publish a general notification in the *Fort St. George Gazette* and in the more important daily newspapers of the Madras City announcing that honorary appointments will be made to all the Government hospitals in the Presidency and inviting applications before a certain date. He will then consider the applications and make recommendations in those cases in which honorary appointments are considered necessary and also suitable candidates are forthcoming.

(By order of the Government,
Ministry of Local Self-Government).
S. G. SENGODAIYAN

Deputy Secretary to Government.

To the Surgeon-General.

Secretary, The South Indian Medical
Union.
Press.

APPENDIX.

Rules relating to the appointment
of honorary medical officers in
Government hospitals in the
Madras Presidency.

1. Honorary medical officers will be appointed to all Government hospitals in Madras City and to all Government headquarter hospitals. In the case of medical institutions at divisional

centres, the appointment of honorary officers will ordinarily be restricted to those institutions where only one medical officer is employed. Appointments will be made by the Government on the recommendation of the Surgeon-General.

2. Whenever it is proposed to make an honorary appointment in any hospital, due publicity should be given to such proposal by publication in the notice board of the hospital concerned (and in the office of the District Medical Officer in the case of mofussil hospitals) and otherwise. Applications should at the same time be invited and out of those received the best should be recommended.

3. Medical officers desirous of honorary appointments in special subjects but who have not had the special training necessary to give them proficiency in that subject will be permitted to undergo training without payment of fees at one of the Government Medical Colleges or hospitals attached to a teaching institution for the period considered necessary by the Surgeon-General provided they execute a bond to serve the Government as honorary medical officers in that speciality for a minimum period of two years on completion of the training at a place to be agreed to beforehand by the applicant and the Surgeon-General. The officers will not be entitled to any travelling allowance for journeys which they may undertake in this connection.

4. Honorary officers with special qualifications will, as far as possible, be placed in independent charge of special departments, e.g., (i) eye, (ii) ear, nose, and throat, (iii) radiology, (iv) venereal diseases, etc., and given full scope to work up successful clinics.

5. *Designation.*—Honorary medical officers appointed to hospitals which are attached to teaching institutions and to those which are not so attached will be designated as follows:—

(1) Clinical assistants.

(2) Honorary assistant surgeons or honorary assistant physicians.

(3) Honorary physicians or honorary surgeons. Honorary medical officers appointed for a speciality such as ophthalmology, ear, nose and throat work, pathology, radiology, venerology, dermatology including leprosy work will be appointed to one of the above three grades with further indication as to their speciality.

6. Ordinarily an honorary medical officer will start from the lowest grade and gradually work up; but in exceptional cases and for special reasons the recommending authority may propose deviations from this course. Medical graduates who have served as house surgeons and house physicians and have been successful or may be successful in the competitive examination for Assistant Surgeons held in the year 1929 or subsequently will be permitted to commence service as an honorary assistant surgeon or assistant physician.

7. *Qualifications.*—*A. Hospitals not attached to Teaching Institutions.*—A candidate for appointment as honorary surgeon and honorary physician in a hospital which is not attached to

a teaching institution should satisfy one or more of the following requirements:—

(a) That he has held hospital or other appointments affording special opportunities for acquiring special skill and experience of the kind required for the performance of the service rendered and has had actual recent practice in performing the service rendered or services of a similar character, or

(b) that he has had special academic or post-graduate study which comprises the service rendered; and has actual recent practice as aforesaid, or

(c) that he is generally recognized by other practitioners in the area as having special proficiency and experience in a service which comprises the service rendered.

B. Hospitals attached to Teaching Institutions.—A candidate for appointment as clinical assistant in a hospital attached to a teaching institution should hold the degree of M.B.B.S., or its equivalent. A candidate possessing the L. M. P. diploma or an equivalent qualification may however be appointed in exceptional cases as clinical assistant in a hospital attached to a teaching institution for licentiate or in a hospital for special subjects. A candidate for appointment as honorary assistant surgeon or honorary assistant physician should have previous service as a clinical assistant for a minimum period of two years from which one year may be deducted for service as a house surgeon or house physician. A candidate for appointment as honorary physician or surgeon should possess one of the following academic qualifications: M.D., M.S., M.R.C.P., F.R.C.S., F.C.O.G., or one of the special diplomas signifying skill in the speciality of his appointment. The age-limit for appointment is fixed at 60 years.

8. *Tenure of appointment.*—The minimum period that an honorary medical officer should spend as clinical assistant is two years and the maximum five years. If he has served as house surgeon or house physician in a hospital approved for the purpose by the Surgeon-General he will be allowed to shorten his period as clinical assistant by a maximum of one year. No period less than six months as a house surgeon or house physician will be counted towards the deduction of the period to be spent as clinical assistant. There will be no time-limit for the tenure of the other two grades of honorary appointments.

9. *Duties.*—Honorary officers should conform to the rules in force in the hospital in which they are working in so far as they relate to the care of patients.

10. Honorary surgeons and physicians will be placed in charge of a specified number of beds for surgical and medical cases respectively and they will be entirely responsible for the treatment and care of the patients in their charge. They should visit the patients in their charge daily or more than once should that be necessary except on Sundays and answer all emergent calls relating to these patients on Sundays. In

the hospitals which are attached to teaching institutions, the honorary officers will be responsible for imparting clinical instruction to students in connection with the beds in their charge in accordance with such plans as may be laid down by the professor in charge of the medical or surgical unit or by the Superintendent of the hospital.

11. In the case of large hospitals, the honorary surgeon or physician will be given an assistant to help him, who may also be an honorary worker.

12. Honorary clinical assistants, honorary assistant surgeons and honorary assistant physicians will perform such duties as may be assigned to them. The allocation of their duties either in the in-patient or out-patient department or in both will be made by the Superintendent of the hospital in the case of hospitals in the Madras City and at the district headquarters by the District Medical Officer in the case of other medical institutions at divisional centres. An appeal shall, however, lie to the Surgeon-General against the allocation so made.

13. *Hours of attendance.*—Honorary medical officers who have charge of hospital beds should attend the hospital daily except on Sundays. Those who have only out-patients in their charge may attend daily but need not attend after previous arrangement with the Superintendent of the hospital and the District Medical Officer more than three days a week. In the case of hospitals attached to teaching institutions the honorary officers should be present at the respective hospitals on such days and at such hours as may be necessary for the proper instruction of the students. In the case of other hospitals honorary medical officers should make their hospital visits during the recognized hospital hours.

14. Honorary clinical assistants, honorary assistant surgeons and honorary assistant physicians should attend the hospital at such hours as may be fixed by the Superintendent of the hospital in consultation with the honorary officer after obtaining the approval of the Surgeon-General.

15. If for any reason the honorary officers are unable to attend during the prescribed hours they should inform the Superintendent or medical officer in charge in time to enable him to arrange for their work.

16. Honorary medical officers will issue the necessary certificates for patients under their treatment but should not except at the special request of the Superintendent or in his absence of the senior medical officer in charge deal with any cases in the in-patient or out-patient department other than those assigned to them or with the other miscellaneous work of the hospitals.

17. *Reports on officers.*—On the 31st January of each year, District Medical Officers and Superintendents of Presidency Hospitals should submit to the Surgeon-General in the form prescribed by him confidential reports on all honorary officers serving under them.

18. *Leave*.—Honorary medical officers may be granted casual leave up to fifteen days in a year by the Superintendents or medical officers in charge of the hospitals. They may be granted leave of absence other than casual leave by the Surgeon-General if he is satisfied that arrangements can be made for carrying on their duties without extra expenditure to Government. In such cases, the honorary officers will be considered to have a lien on their appointments during the period of leave and they will be allowed to rejoin their appointments on the expiry of the leave. If no such arrangements can be made, the honorary officers should be instructed to resign their appointments and fresh appointments should be made in their place.

19. *Transfer*.—Honorary medical officers in Madras City will be liable to transfer from one institution to another at the discretion of the Government.

20. *Termination of appointment*.—The appointments will be terminable by three months' notice in writing on either side.

21. *Re-employment*.—Honorary officers re-employed after discharge will be re-accepted into their former rank.

22. *General rules*.—Honorary officers will be allowed the use of the respective hospital libraries and in the case of teaching institutions, of the libraries of the college or school attached to them.

23. They must abide by the Government rules in force in regard to the acceptance of fees from patients by the staff of the hospital.

24. The entire management and control of the hospital and the discipline of the staff are vested in the respective Superintendents or medical officers in charge. Honorary officers will be expected to observe all rules in force or issue from time to time and to report all instances of neglect or inattention or other breaches of discipline relating to their wards to the Superintendents or medical officers in charge who will deal with them. They may freely consult the Superintendents or medical officers in charge on any points in respect of which they consider the rules to admit of improvement but must abide by any decision the latter may arrive at.

The Superintendents and medical officers in charge of the hospitals should give full scope to the honorary workers and endeavour to make the scheme a success.

SOUTH KANARA DISTRICT MEDICAL ASSOCIATION.

The Annual General Meeting of the Association was held on 17-9-'32 at the Government Wenlock Hospital Mangalore. There were 21 members present and Dr. M. Shiva Rau the President occupied the Chair.

The annual report submitted by the Secretary Dr. K. R. Kini was adopted and passed and also the Budget for the ensuing year, increasing the provision towards Medical Journals to Rs. 150.

The office bearers for the year were selected, Dr. M. Shiva Rau and Dr. K. R. Kini being unanimously re-elected as President and Secretary, respectively. By the unanimous vote of the members Dr. C. P. Kamath, W. E. Mascarenhas, H. V. Adappa, K. G. Rau and A. G. Bhat were chosen as members of the Committee. The services of office bearers for the previous year were appreciated by yet another resolution and an amendment to the existing bye-law was made making it possible to have branches of the Association in the mofussil.

The function ended with a social, the President winding up the proceedings with good and sound advice to the junior members of the profession and suggesting a programme for the future work of the Association.

ANNUAL REPORT.

MEMBERSHIP. There were 44 members on the rolls against 41 the previous year out of which 23 were resident and 21 non-resident.

FINANCE. Fees for resident members was Rupee one per month and non-resident members Rs. 4 per year. The total collection for the year amounted to Rs. 564-8-8 including previous year's opening balance of Rs. 122-15-8 and expenditure Rs. 392-13-1 leaving a balance of Rs. 191-10-9.

MEETINGS. There were 11 meetings for the whole year of which six were for the discussion of scientific subjects. Of the remaining five, one was the Annual General Meeting, another a condolence meeting in connection with the untimely death of the two ex-Presidents of the Association, Lt. Col. Rai and Dr. B. Iswarayya. Two meetings were held to bid farewell to two other ex-Presidents, Major Mehta and Dr. Ganapathi Aiyar. Another meeting was specially convened to congratulate six members of the Association, who were returned to Mangalore Municipal Council. The fact that of the six, one was chosen as the Chairman of the Municipality by a overwhelming majority is a factor of which the Association may well be proud of.

On the whole the Association has a good report of its progress and activities and deserves praise.

INTERNATIONAL MICROBIOLOGICAL SOCIETY (INDIAN COMMITTEE.)

The International Microbiological Congress is held every 3 years. The first Congress was held at Paris in 1930. The next Congress will be held at Berlin in 1933. Only those members who are recommended by the National Committees are eligible for membership of the International Society. The membership fee for the Indian National Committee is Rs. 6 only a year. The fee for membership of the triennial International Congress has been fixed at 4 dollars or its equivalent. Members of the medical profession or of the Biological and Veterinary Sciences who want to contribute papers or to become members of the International Society are requested to communicate, with Dr. A. C. Ukil, Secretary to the Indian Committee 82/3, Cornwallis Street, Calcutta, for further information.

An interesting note on the constitution and present status of The International Society of Microbiology will be supplied to the members of the medical profession on application to Dr. A. C. Ukil whose address is given above.

THE 26TH ALL-INDIA MEDICAL LICENTIATES' CONFERENCE, MADRAS. BULLETIN NO. 1.

The fact that in spite of statutory obligations, the Madras Medical Registers are not published in time and do not contain the complete addresses of practitioners, has been a great handicap in the way of the Reception Committee in not reaching the Licentiates individually in time and consequently the Executive Committee has made use of the hospitality of the columns of the Medical Journals and the lay press to keep the Licentiates in touch with the activities of the Conference.

The function being an All-India one, it is expected that the Reception Committee will have to meet a large expenditure for the lodging and boarding of guests who will attend the Conference in large numbers

from all parts of India including Burma. All those who attend the Conference from outside the City of Madras will also be the guests of the Reception Committee.

The Executive Committee makes an earnest appeal to the Licentiates in the Madras Presidency to help and co-operate with them in making the Conference a success.

In addition to the consideration of subjects concerning the life and prosperity of the Licentiates, such as The Indian Medical Council Bill, Medical Education, Rural Medical Relief Scheme, Honorary System of Medical Relief, grievances of the Licentiates in service, etc., etc., there will be discourses and discussions on scientific subjects and there will also be an exhibition of goods and appliances both foreign and indigenous required by the profession. Practitioners who wish to read papers are requested to send their papers (preferably typewritten on one side of paper or written legibly) to the Secretary, Scientific Section, 323, Thambu Chetty Street, G. T. Madras, so as to reach before the end of November noting their full names and addresses.

FEES.

For membership of the Reception Committee Rs. 5 or more.

For guests with arrangement for lodging and boarding, Rs. 3.

For guests without arrangement for lodging and boarding, Re. 1.

N. B. The city and the mofussil practitioners are earnestly requested to send their contribution towards the funds of the Conference. To facilitate the collection of funds, the Executive Committee have passed the following Resolution:

"Resolved that the Provincial Secretary, Dr. D. V. Venkappa, be requested to do propaganda in the mofussil with regard to the collection of funds for the ensuing Conference and the Publicity and General Secretary of the Conference Dr. V. Rama Kamath, be authorised to make a similar request to the mofussil Licentiates through the press and medical journals to do similar propaganda work, and the actual travelling allowance of all such workers be defrayed from the Conference funds."

(By Order of the Executive Committee)

V. RAMA KAMATH,

Secretary, Publicity and General Section.

MADRAS MEDICAL COUNCIL.

Resolutions of which notice has been given by Dr. V. Rama Kamath to be moved at the October Session.

(1) Resolved that such of the medical practitioners, who show proof of their having paid the required fees for the registration of their names in the Madras Medical Register and whose names do not appear in the published registers, be registered immediately.

(2) Resolved that a notification be published three times in two English dailies immediately after the publication of the Register for 1932 to draw the attention of those medical practitioners who might have paid the fees and whose names do not appear in the published register to show proof of their having paid the money required for the registration and immediately after the production of such proof the names of such practitioners be registered in the Madras Medical Register.

(3) Resolved that before the expiry of the probationary period of the clerk now employed at the Registrar's office the post of the clerk be advertised demanding higher grade qualifications in Shorthand and Typewriting.

(4) Resolved that the moffusil members of the Madras Medical Council be paid double second class fare for their journey to Madras for attending the meetings of the Madras Medical Council as a measure of economy till the financial condition is sounder than what it is now.

Reviews.

NOTICE.

The Agfa Photo Company who have their branches in Madras, Bombay, Calcutta and Delhi will be pleased to supply free of cost to the members of the medical profession interested in X-ray work a book called "An Introduction to X-ray Photography" by John Eggert Dr. Phil, A. O. Professor at Berlin University who describes the book as follows:

"The purpose of this booklet is 'to introduce the reader to the domain of X-Ray Photography by giving a short exposition to the theory of the process and then dealing with the points of which knowledge is needed in practice.' The new theoretical knowledge and practical experience of the last few years have rendered necessary a complete revision, and this has been done with the aid of Dr. Hællsig, Dr. Limpach and Dr. Urban to whom I here express my thanks. Furthermore I must thank several radiologists for a number of X-ray photographs which are reproduced in the appendix. The ground covered has been materially extended even as compared with the

previous edition published in 1923, so that the booklet is also of larger bulk. The practical section contains some matter from Dr. F. W. Petersen's 'Anleitung für die photographische Behandlung des Röntgenfilms.' The two supplements—an exposure table and 'Rules for the X-ray dark room' are intended for hanging up in the respective work rooms."

THE MEDICAL VALUE OF PSYCHOANALYSIS

BY

FRANZ ALEXANDER, M. D.,

Publishers: Messrs George Allen and Unwin Ltd. Museum Street, London. Price 10s. 6d. net.

The fact that the author rose to the responsible position of a professor of Psychoanalysis in an American University, an appointment created for the first time to deal with a subject which has assumed great importance in the treatment of mental illness should induce the members of the medical profession to go through the book. Five chapters have been contributed by the author in addition to the preface, the first deals with Psychoanalysis and Medicine describing the development of Psychoanalysis, Resistance to Psychoanalysis, Sources of error in Psychological Observation, Elimination of the Sources of Error and Psychoanalysis as a Therapeutic method; the second chapter deals with the present Status of Psychoanalysis as a Theoretical and Therapeutic System and in this chapter the theories of Cathartic Hypnosis, Repression, Instincts, Symptom Formation, Discoveries of the method of Free Association, of Infantile Sexuality, the Oedipus Complex, Development of Ego-Psychology and the Theoretical Foundation of the Psychoanalytic Technique form the new features. The third chapter is an interesting one discussing the Critical Considerations on the Psychoanalytic Treatment of Psychoses and the fourth is about Psychogenic Factors in Organic Diseases; under this heading Early Views of the Psychogenesis of Organic Diseases, the Resistance against Psychogenic Factors in Modern Medicine, Psychological Influences on the Body, the Relation of the Automatic Nervous System to the Central Nervous System, Recognition of Psychic Factors in Modern Medicine and Analysis of Psychogenic Factors are the subjects dealt with. The last chapter dealing in Psychoanalysis in Medical Education is still more interesting and will benefit not only the members of the profession but also the lay public.

During these days of advanced civilisation when it is the lot of the members of the profession to come across mental defectives in larger numbers and when many of the ordinary general diseases could be traced to causes disturbing the nervous system as a whole, it is necessary that even the general practitioner should have some ideas of psychoanalysis to enable him to understand and treat even ordinary diseases apart from mental illness. The book under review discusses the subject of Psychoanalysis in simple clear terms and we recommend the book as a valuable addition to a reference library of every practitioner.

List of Postings of Sub-Assistant Surgeons for the month of September, 1932.

No.	Name of Sub-Asst. Surgeons.	From	To
1	F. Padamadan	Police Hl, Coimbatore	L. F. Dy, Bungalowpudur.
2	M. Rama Rao	Govt. Hd. Qrs. Hl, Cocanada	L. F. Dy, Darsi.
3	S. H. Ghulam Muhammad Sahib	Leave	c/o D. M. O, Trichinopoly.
4	M. A. Subrahmaniam Pillai	L. F. Dy, Watrap	Govt. Dy, Devakkottai.
5	A. R. Shanmuganathan	Govt. Dy, Devakkottai	L. F. Dy, Aruppukkottai
6	D. Madurainayagam	L. F. Dy, Aruppukkottai	c/o P. D. B. Ramnad.
7	T. R. Subramaniam	Govt. Hd. Qrs. Hl, Trichinopoly	Govt. Hd. Qrs, Hl, Ooty.
8	T. Sitharamayya	c/o Asst. Dt. Supdt. of Police, Koraput	L. F. Dy, Kovur.
9	K. Krishnamurthy	L. F. Dy, Kovur	c/o Civil Surgeon, Vizag. Agency.
10	P. K. Raman Nambiar	L. F. Dy, Mannarghat	Govt. Hd. Qrs. Hl, Coimbatore
11	T. R. Venkataraman	Govt. Hd. Qrs. Hl, Coimbatore	c/o P. D. B. Malabar.
12	N. S. Raman	L. F. Dy, Denkanikota	Govt. Hd. Qrs. Hl, Salem.
13	M. Gopalan	Govt. Hl, Cochin	Govt. Hl, Palghat,
14	K. Narayanan Nair	Govt Hl, Palghat	Govt. Hl, Cochin.
15	S. T. Thiagaraja Pillai	Leave	c/o Municipal Health Officer, Negapatam.
16	S. Arunachalam	Govt. Hl, Coonoor	c/o Principal, Madras Forest College, Coimbatore.
17	T. K. Gopal Rao	Leave	c/o P. D. B., South Arcot.
18	T. N. Doraiswami Ayyar	L. F. Dy, Merkanam	Central, Jail, Salem.
19	A. R. Venkatarao	Govt. Hd. qrs. Hl, Guntur	L. F. Dy, Achempeta.
20	C. H. Lakshmana Rao	L. F. Dy, Achempeta	L. F. Dy, Sattanapalle
21	R. Venkatakrishnayya	L. F. Dy, Sattanapalle	Govt. Hl, Rajahmundry
22	K. Narasimham	Govt. Hl, Rajahmundry	L. F. Dy, Addatigala.
23	A. Satyanarayana	L. F. Dy, Addatigala	Govt. Hd. Qrs, Hl, Cocanada.
24	D. Satyanarayana	Govt.-Hd. Qrs. Hl, Ellore	Office of the Exec. Engineer, Koraput.
25	I. V. Narasimham	Leave	L. F. Dy, Tanakal,
26	Muhammad Chirag Ali Sahib	L. F. Dy, Tanakal	c/o Civil Surgeon, Vizag. Agency.
27	J. Satyanarayanamurthi	L. F. Dy, Kunnavaram	Govt. Hl, Kanigiri.
28	K. Krishnamurthy	Govt. Hl, Kanigiri	L. F. Dy, Kunavaram.
29	G. Govinda Menon	Govt. Hd. Qrs. Hl, Calicut	Govt. Hl, Cannanore.
30	M. Kelu	Govt. Hl, Cannanore	Govt. Hd. Qrs. Hl, Mangalore
31	P. K. Gopala Panikkar	Leave	Govt. Hd. Qrs. Hl, Cuddalore
32	M. Goparaju	Leave	Govt. Hd. Qrs. Hl, Masulipatam

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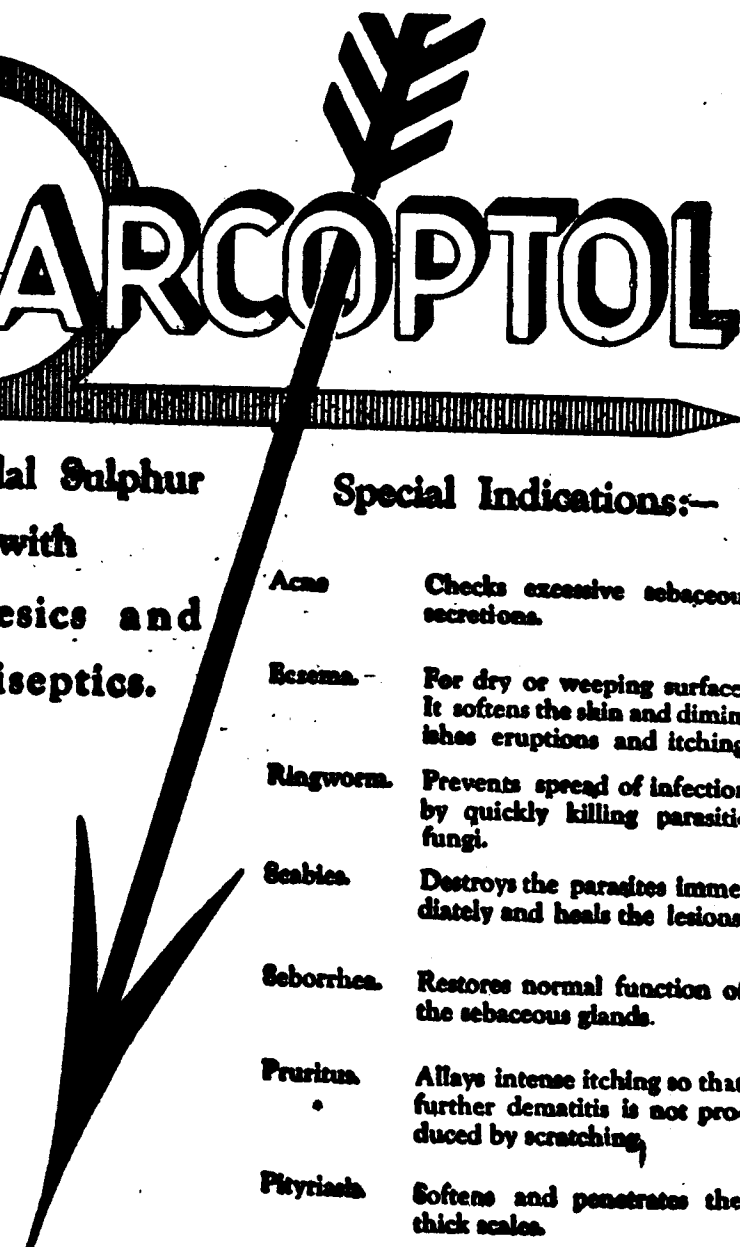
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