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# The Medical Practitioner

## A Monthly Medical Journal

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# THE Medical Practitioner

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## NEW YEAR GREETINGS.

We wish our readers a happy new year. The destinies of India are now being melted in a pot and doubts are expressed from all quarters if India will ever be a free country. If she is made free, it will be to the mutual advantage of Britain and India; if not, both countries will materially suffer. The future of the medical profession, both paid and independent, depends upon the constitution that is now in the process of moulding, and the pace of progress of the medical profession will certainly be retarded, in case India is not to enjoy equal rights and privileges with the other nations of the world. The prevailing atmosphere in India is one of distrust. It cannot be otherwise in the medical profession. The existence of caste system in service and more, outside the service has been seriously hampering the growth and prosperity of the medical profession in India. We wish the profession takes a lesson from Mahatma Gandhi, who has shown to the world that untouchability is a most heinous disease and has to be put down. The Mahatma has enunciated by his own example that life is not worth living, if the disease of untouchability is not rooted out. The fact that at least some of the leading members of the profession have joined hands with the Mahatma in the campaign against untouchability gives us hope that time will not be far, when serious attempts will be made by the profession as a whole to put down caste system in the medical profession also, as the principle involved in the bigger problem is identical with that in the medical profession, and the solution is certainly less risky and hence by far more practicable. The equatorial position of India has made its people more lethargic than their more fortunate brethren living at a

higher altitude, and whatever progress or reform that came to this country depended upon the injudicious administration of the rulers. If India is united today more than she was ten years ago, it is due to the common adversity in all aspects and forms, and if the medical profession is steadily growing as one union, in spite of the existing castes, it is also due to their having common grievances, the latest of this nature being the Indian Medical Council Bill. If the profession puts forth all its energy in bringing about necessary changes and modifications in the proposed Bill and gets ready a strong phalanx in the Legislative Assembly to uphold their cause, and if the Government do not yield to the mandate of the medical profession as a whole, to use the strength of this phalanx in vetoing the measure, we should say that the profession could be proud of one of the biggest achievements in the new year. The Medical Licentiates, the most aggrieved party in the profession, have just met in an all-India Conference in Madras and so also the representatives of the whole profession, including the licentiates, have just closed a momentous session at Lucknow and we wish both these Conferences good luck and pray their deliberations will bring about in the new year healthier growth and brighter prosperity than they were in the past.

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## THE TRIENNIAL REPORT OF CIVIL HOSPITALS AND DISPENSARIES IN MADRAS FOR THE YEARS 1929-31.

### PATIENTS TREATED.

The number of both out-door and in-patients treated shows an increase. The number of beds available for in-patients is 9541, which works at the rate of 1 bed for every 5,000 persons, is quite inadequate for the province, the majority of whose population is too poor to afford medical relief and dieting in their own homes and the number of medical practitioners is too few to meet such demands. In the United States of America, the richest country in the world, and where the number of medical practitioners is very many, there is one bed for every 270 persons. As the funds of the Government are limited, every effort should be made to cut down the expenditure of the department by the replacement of paid officers by honoraries, and every opportunity for making such reduction should be utilised as it presents itself. From the Report under review, it does not appear that either the Government which controls and guides the administration, or the Surgeon-General who administers it, keeps the goal in view and takes steps to reach it.



### RURAL MEDICAL RELIEF-PROVINCIALISATION OF LOCAL FUND, MUNICIPAL AND VISITING DISPENSARIES.

It is gratifying to note that the number of rural dispensaries has increased from 327 in 1929 to 506 in 1931. The rural medical scheme is a step in the direction of making the scientific system of medicine popular and cheap among the villagers, so that in course of time private medical practitioners without any aid from the Government and the Local Funds, may settle down in villages for practice and earn their livelihood, as is the case in all civilised countries of the world. The conversion of seven rural dispensaries into Local Fund dispensaries goes against this very principle of rural medical scheme,



and defeats its object. In the Conference of the rural medical practitioners, held in Madras in 1930 it was pointed out that Presidents of Taluk Boards, under whom the rural medical scheme is working, convert rural dispensaries into Local Fund dispensaries and appoint their kith and kin or favourites permanently in charge of them. In the operation of the rural medical scheme the next forward step, after the establishment of a rural dispensary in a village, is its abolition, when the Western system of medicine becomes popular and is appreciated by the villagers, and an unaided private practitioner settles down for practice there, on his own account. The conversion of a rural dispensary into a Local Fund dispensary is not only demoralising, but is incompatible with the object of the organisation of the scheme.

Even in the matter of provincialisation of Local Fund and Municipal medical institutions the goal of medical relief to the public to be given by private medical practitioners should be kept in view. It may be necessary for the present that at the headquarters of each taluk there should be a Government hospital, well equipped with accommodation for treating in-patients. But the taking up of Local Fund and Municipal Dispensaries in places which are not headquarters of taluks is a step in the backward direction. The provincialisation of the hospital at Srirangam which is not the headquarters of a taluk and which is very near Trichinopoly, in which there is a well-equipped hospital, and of converting the Local Fund dispensary at Usilampatti which is not the headquarters of a taluk is certainly a retrograde step.

It was found that the visiting dispensary system was not popular. We have already pointed out in these columns that this roaming commission will be of no use and failed in other parts of India where it was tried.

### THE HONORARY MEDICAL OFFICERS.

The object of the introduction of the honorary system of medical officers is, as stated by His Excellency the Governor of Madras in opening the hospital at Coimbatore, to replace the paid staff in conformity with the practice obtaining in all civilised countries of the world. If this object is to be achieved, there should be a decrease in the number of paid officers in proportion to the increase of honorary officers. It is stated that the savings effected by the appointment of honorary officers comes to about Rs. 185,000, and their work is appreciated. While such is the case, the meaning of making six paid appointments (excluding women in the period and 12 officers in 1932, when the number of honorary officers has increased from 9 in 1929 to 90 in 1931) is not apparent. The Royapettah Hospital is said to be almost entirely staffed by honoraries, except 3 Government officers, of whom one is the Superintendent. There is no necessity at all for a highly paid Superintendent, and if he is disposed to interfere in the professional work with honoraries, the condition of the hospital will become bad. For the purely administrative work, it is quite sufficient if a resident medical officer and an assistant to help him, if necessary, are appointed. In this connection we mean no disrespect against the present Superintendent of the Government Royapettah Hospital who, we are told, has the best cordial relationship with his honorary collegues in the hospital.

Though it is stated that the number of I.M.S. officers has fallen from 33 to 25, the expenditure on salaries has increased by about 4 lakhs of rupees. If only some of the 90 honorary officers are replaced by paid officers, there would not have been any increase in the expenditure.

### MEDICAL EDUCATION, HOUSE-SURGEONS AND CLINICAL LECTURERS.

As the result of the recommendations of the Committee appointed to enquire into the system of medical education, the medical education was concentrated in Madras and Vizagapatam by the abolition of medical schools in Madura, Calicut, Tanjore and Guntur. As long as it is proposed to extend the course of study to five years for L.M.Ps. and raise the general educational standard for admission to the Intermediate Examination, no difference need be made in the course of instruction between the L. M. Ps. and the graduates. After a common training for them for five years, those who are willing to appear for the University degree may appear for it and others may be examined by a Board and given diplomas if found qualified. No

difference should be shown in the matter of appointments, status, etc. between the degree and diploma holders. Want of accommodation for the common training need not be an obstacle. At present, there are the Royapuram Medical School and the Medical College in Madras. The course of instruction may be given, say, for the first few years in one place and for the remaining in the other place. In Trivandrum, when the number of admissions in the College became large, the course was divided into two, the Arts course and the Science course, and instruction was given for the one in one building, Arts College, and for the other in another building, Science College. Similar arrangements may be made here also for some years till new buildings are constructed.

It is also a matter for the serious consideration of the profession and of the Government if after the introduction of the 5 years' course in the medical schools with the Intermediate Examination as the preliminary standard for the entrance, whether it is necessary to run two types of institutions for imparting medical education.

The concession now granted to L.M.Ps. to appear for M. B. B. S. after their passing the Intermediate Examination or an equivalent to it, is absurd. Will the medical members of the Senate recommend that the M. B. B. S. degree holder should qualify himself for the B. A. before he wishes to appear for the M. D. or M. S. degree? It is not known how the training of the Intermediate Examination will help the L. M. Ps. in qualifying for the M.B.B.S. The L. M. Ps. as they are at present should be allowed to appear for the final M. B. B. S. examination, and if they are successful, they may be given the degree.

There are now 28 house surgeons, of whom 13 are paid and 15 unpaid. The meaning of the division into paid and unpaid is not known, nor the principle by which selection made is clear. Every successful candidate passing out of the medical schools or colleges should, as a rule of course, be given training as house surgeons for one year before he is registered and permitted to practice. The house surgeons' course should be a part and parcel of the medical training and no pay or allowance should be paid to the candidates. Provision should be made in all hospitals in which there is accommodation for in-patients for the training of house surgeons.

There are now 7 assistant surgeons in the General Hospital, 4 as assistants to the first 4 physicians and 3 as assistants to the first 3 surgeons. The giving of clinics to medical students in the clinical hospitals forms part of the duty of the officer employed there. Officers employed for this duty should be borne on the establishment of the hospitals concerned. The practice, however, obtaining in Madras is to bear the officers on the establishments of the medical colleges and schools, though they work in the hospitals. We would like to know why this procedure is not adopted here and the officers are maintained in the establishment of colleges and schools. Is it to give special allowance which they will not get if borne on the hospital staff?

## MEDICAL INSPECTION OF SCHOOLS.

For the medical inspection of schools, Surgeon-General Megaw is said to have submitted a scheme prepared by the Director of Public Health for trial in two districts, Chingleput and Coimbatore, at a cost of Rs. 56,000 a year. As the Government thought that the expenditure would become enormous if the scheme had been extended throughout the province they rejected the scheme and required the Director of Public Instruction to prepare another in consultation with the Surgeon-General and the Director of Public Health. Accordingly, one was sent, but on account of the present economic depression it was simply recorded. In the recent Conference of the medical inspectors of schools, the Director of Public Health suggested the formation of a Committee to frame a scheme as cheap as possible. It is not proper to expect Government to spend large amounts of money on this item, but the question whether it cannot be solved otherwise remains. The senior Editor of this journal, who has taken a good deal of interest on this question, and has contributed a large number of articles to the press, has read a paper at the same Conference, suggesting a scheme which costs little or nothing to Government. The following is an extract from our editorial on it:

"In the paper on Medical Inspection of Schools, contributed to the Conference by Dr. M. S. Krishnamurthi Ayyar, Retired Sanitary Commissioner of Travancore, and published in the previous issue of our journal, he has formulated a scheme involving little or no extra expenditure for the organisation of School Medical Service by the employment of part-time medical officers recruited from private practitioners. The payment for these medical men may be met from the saving effected by the retirement of lay teachers in schools who are now teaching Hygiene and Natural Science, by the fees collected from pupils for medical inspection, from the money made available by the withdrawal of the Rural Medical Scheme in places where there are sufficient numbers of the school medical service men to take up the duties of affording medical relief to the rural population, and if necessary from a small grant by the Government. With such a school medical service of part-time medical officers, (1) Hygiene and Physiology and Natural Science may be taught in schools, (2) medical inspection of pupils conducted systematically and thoroughly, (3) school medical clinics opened and treatment given to such of the pupils as require it, (4) medical relief afforded to the rural population by supplementing at first and replacing in course of time the rural medical organisation and (5) lastly the unemployment question among medical men solved to a large extent. The importance of the Public Health service, one of the chief duties of which is medical inspection of schools, is well put by the late Dr. Rivers, in the following words: "There is little doubt that when the history of the medicine of to-day comes to be written, the greatest achievements will not be found in the operative procedures, the anti-toxins and the glandular extracts, which bulk so largely in the estimation of the profession and of the laity, but in the systematic developments of the public health service."

## CONCLUSION.

From the foregoing review it will be seen that the working of the Medical Department does not follow any principle and does not indicate any goal in view to be reached. It is simply drifting, and its activities are directed by the individual inclinations of the Surgeon-General in charge of the Department and the Minister in control of the Department that may be connected with it from time to time.

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# Original Articles

## ENDOCRINOLOGY.

BY

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M. B., & C. M.,

XXVI

APPLICATIONS AND POSSIBILITIES (*continued*)

*(Taken from Berman's Gland regulating personality).*

The knowledge that the shape and action of a man's body as well as his mind depend on the internal secretions inspires the hope that human life in the future admits of control. For in the wake of chemical discovery there has always come chemical control. The nature of chemical research, the necessity for clear thinking, accurate measurement, and experience in actual handling of materials, the fundamental tradition and technique of the science, have made and will make the practical application possible. The mystery of personality, the most marvellous, complex and variable process in the universe, would be attacked and at length penetrated systematically and persistently with the ideal of absolute control of its composition as the goal in view. It may be glanced, however, now at some of the immediately useful aspects that might exercise those concerned with the everyday life of men, women and children.

## THE ENDOCRINE EPOCHS OF LIFE.

This is no more famous classification of the epochs of life that mark off the milestones of the individual's evolution than Shakespeare's Seven Ages:

The infant, mewing and pucking in nurse's arms, the whining schoolboy with his satchel and shining morning face, creeping like snail unwillingly to school, the lover sighing like furnace, with woeful ballad made to his mistress's eyebrows, the soldier seeking the bubble reputation even in the canon's mouth, the justice in fair round belly full of wise saws and modern instances, the lean slippered pantaloon with spectacles on nose and pouch on side and the last is second childishness and more oblivion, sans teeth, sans eyes, sans taste, sans everything. So different is he at those different stages of his development, so

changed his body and mind, that it has become a part of popular physiology that we are entirely made over every seven years and that no cell in the organism lasts longer than that. The tradition certainly does not apply to the brain and nervous system, for the number of brain cells is fixed at birth and cannot be increased, because they are too highly specialised to reproduce themselves. What happens as the individual grows is simple wear and tear of tissues and not the replacement of the old by the new cells. It is the rearrangement of relationships among the ductless glands, the shifting of influences from the predominant to the subordinate and *vice versa*, in the constellation of the internal secretions that determines the unfolding of the personality. Growth, as a general name for the mutations, from year to year, passes through five epochs that are standard for the normal. The normal is the being who harmonises with his environment and yet reacts with it because of recurring needs within him. His endocrine equations settle what is unique and different in him. But the gland which flourishes during the epoch at its time of triumph, when it has its day determines what makes him like his fellows. From this point of view, it is possible to speak of the five endocrine epochs: (1) Infancy—as the epoch of the pineal gland, (2) childhood—as the epoch of the thymus, (3) adolescence—as the epoch of the gonads, (4) maturity—as the epoch of whatever gland is left to control, as the result of the life struggle, and (5) senility —as the epoch of the general endocrine deficiency.

(1). Infancy—As the epoch of the pineal explains why, in any given geographical locality, the babies look alike and act alike. It is recognised that not until after the second year, is any tendency to differentiation discernible to any extent among them. The pineal gland is the greatest inhibitor of all the glands of internal secretion. By its checking activity upon the other endocrine glands, the thyroid and the pituitary in particular, it gives the baby time to grow in bulk which is its chief business during the first two years of its existence. It quadruples its birth weight. The brain and the nervous system complete their growth in mass by the end of the fourth year. After the seventh year, the pineal begins to shrink, i.e., its involution begins.

(2) Childhood—If the pineal retrogresses after the seventh year, what takes place as a break upon the forward driving impulses of the other endocrines? There is every reason for assigning that role to the thymus. It performs its service mainly, in all probability, by inhibiting the stimulating effect of sex and playing upon the growth. Since it is especially a sex-gland inhibitor, the thyroid and pituitary begin to act freely, and it is found that after the second year that thyroid and pituitary tendencies manifest their effects.

(3) Adolescence—is the period of stress and strain throughout the somatic and psychic factors of the organism, because of the volcanic upheavals of the sex-glands. The history of the individual is dominated by them to twentyfive or so when maturity commences in the sense of a relative sex stability.

(4) Maturity—The sex-glands continue to exert a powerful pressure throughout maturity. But life episodes and crises, diseases, accidents, struggles, experiences of pleasure and pain, as well as climatic factors settle finally, what endocrine or endocrines are left in control as a consequence of the series of reactions the period of maturity may be analysed into.

(5) Senility—inevitably follows maturity not as night follows day by a mathematical necessity, but because of the process of degeneration which ultimately overtakes all the glands of internal secretion, dominant as well as subordinate. Just why the degeneration must occur none can say. Injury to the endocrine glands of one sort or another, ranging all the way from emotional exhaustion, to bacterial infection, is the result usually considered sufficient. Just why recuperation and regeneration do not preserve them in the elderly as they do in youth is a problem to be solved when the laws of regeneration which is at present almost totally beyond control, is understood. Some say that it is a matter of wear and tear of blood vessels, and in the classic phrase a man is as old as his arteries, *ergo* his ductless glands will be as old as their arteries. And the age of arteries is simply a matter of wear and tear, the resultant of the function which is universal among



molecules. The works of Steinach, Sand, and others have contributed most to the elucidation of the non-arterial factor in senility. No one has asserted more loudly the importance of the interstitial cells that fill in the spaces between the tubules of testes in the male and the follicles of the ovary in the female.

## THE POSSIBILITIES OF REJUVENATION.

From the experiments so far made among rats and other animals, it is proved beyond doubt about the existence of an endocrine factor in the process of aging, as well as an arterial. They also demonstrate that the internal secretion of the sex-glands well advertised as it has been as the Elixir of Youth that Ponce-de-Leon and Brown Sequard with so many others pursued in vain, is not the whole story. For if it was, the duration of the new youth should be another span of life, whereas in actuality it is only a fraction of that time. Since old age is an exhaustion, permanent and irreparable, of all the members of the endocrine system, the reason becomes clear for the temporary quality of the rejuvenation effected by the procedures of Steinach.

The first gland involved is the thyroid. Its endocrine contents decreases with the age and becomes specially low after forty. In women, after menopause, myxedema, the disease caused by the degeneration of the thyroid, is frequent. Thyroid feeding, properly controlled, will clear up certain of the deterioration of mind and body observable in the aged. Of course, the improvement at present achievable is only relative. But on the prematurely aging, marvels have been achieved with feeding of the gland.

The pituitary, too, begins to retrogress after the period of maturity. In women the onset of an obesity and coincidentally of a lazy and dull morale, coincides with this declination of the pituitary powers. All the gland of internal secretion, in fact, shrink and shrivel as old age advances. Only as in other relationships, the predominating endocrine stamps its signature more visibly upon the documents of decadence than the others. Pituitary types get fat and slow, thyroidal become bulky and stupid or thin and sour, the adrenal dark, shrunken and for ever tired of life. The problem of rejuvenation is the problem of re-charging, or replacing all of the endocrine glands, at least the most important of them—the thyroid, the pituitary, the adrenals, the gonads. Longevity is perhaps largely a matter of preventing or postponing their wane. Persistence of youth or juvenility may be manufactured by nature in two ways. There may be a presistence of early glandular predominance as in the thymocentric and pineal-centric. Nature's only other mode of securing perpetual youth seems to be by prolonging the time allotted to the sex gland crescendo. The continuance of any stage of development means the maintaining of the glandular administration peculiar to it. So the chubby, debonair, irresponsible whom nothing can touch is happy in the possession of a pineal uncorrupted by the years, while the genius who can turn out his best work at sixty-five must thank his pituitary for standing by him to the end.

## THE SCIENCE OF PUERICULTURE.

There is a speciality now growing in the womb of science which in its own good time will come to fruition as the study of the child's needs or puriculture. Even to-day there exists a scientific basis for the formulation of the principles upon which every child should be brought up. Though there have been marvellous results from the campaign to lower infantile mortality, most of what has been done, has been medical in its interest, and so largely negative in its accomplishments. The removal of the cause of evil no doubt gives the good its opportunity. But how to raise a child, endowed with satisfactory ancestral stuffs, as a grade A normal or supernormal still remains to be erected into an exact science.

Child culture, as the foundation of all systems of education has continued more or less of a hope rather than an achievement because of lack of appreciation of the different constitutional varieties of children. A certain amount of attention has been lavished upon children needing special attention, those mainly suffering from insufficient development of one sort or another. In the last decade or so an endeavour to focus upon the exceptional child, exceptional in intelligence or some special creative endowment, has started an interes-

ting movement. All of them have suffered from the fallacies and troubles of the pure psychologist who would handle mind as an entity in a vacuum.

A realisation of the different physical and psychic educational needs of various children will arrive only when they are seen as built differently. Just as shoddy and silk, cotton and wool, alone or in continuation all possess different qualities as wearing material, so different children have varying capacities for the wear and tear of education. The endocrine classification of the human race, applied to children will here yield a harvest to the educator and to the country. Nothing is more evident than the diversified nature of the needs of the various internal secretion types, once they are realised as such.

The history of a thymo-centric type, for instance, is predictable from the very first few months of his life. Difficulties in feeding, in habit formation and adaptation, the reaction to infections, in social play and so on, one may expect from him. The course of events for the other endocrine types also follows laws of their own. It will be above all in the understanding of children, their make-up, reactions and powers, that the physician will achieve some of his finest triumphs.

The educator will have to take into account of the state of the pituitary in estimating the normal intelligence or influencing the abnormal and sub-normal intelligence. As well will he have to consider the thyroid in the child whose conduct is a refractory even though his proficiency in his studies is excellent. And the condition of the adrenal will be ascertained in the types that tire easily and that seem unable to make the effort necessary and desirable periodic seasonal and critical fluctuations in the equilibrium among the harmones will have to be taken into account in the explanation of what have hitherto been put down to laziness, naughtiness, stupidity and obstinacy.

A child's capacity for education, especially its capacity for the highest and most productive kind of life is limited by inherent factors. These factors are two: the quality of the nerve tissue, its ability to make a number of associations, and the quantity of the internal secretions, measured by the maximum obtainable in a given secretion. These inherent factors explain, too, why children born and bred in virtually the same environment show the most extreme differences in educability. That the differences are inherited was made evident by Galton's finding that the chance of the son of an eminent man exhibiting eminent ability was 500 times as that of the son of a man taken at random.

Everybody then is born with a combination of nerve cells and ductless glands which determines its capacity for mental development that may never be exceeded. If, in any family, minor differences in educability are observed, they can be put down to disturbance of these two factors occurring after the fertilised germ cell had started to divide and reproduce itself. But any marked falling off in either the nervous or endocrine factors has to be considered pathologic, due to an impairment of them by adverse environment.

Recent studies have amply established that the proportion of certifiable mental defectives, and of a much larger class, the sub-normal but not certifiable class, is progressing by leaps and bounds. It is perhaps the most absurd frailty of the present system of education that it takes almost no account of innate differences in educability. To spend money upon the teaching of children along lines where they are unteachable is not only waste, but crime, for it deprives the educables of their just due.

These, of course, are the crude and simple lines upon which the finer and more complex evolution of the endocrine problems of the schoolchild will build. The fine art of education itself is crude and gross and simple compared with what it might be even as a beginning. The science of education has yet to begin as the offspring of that science of the future, to which knowledge of the internal secretions will contribute no little, the science of puriculture.

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# THE NUTRITION OF THE SCHOOL CHILD.

BY

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*(Continued from previous issue).*

## APPLICATION OF RECENT ADVANCES TO PRACTICAL DIETITICS.

The first question naturally arises "What is the amount of food needed by the child?" It has been aptly said that two chief factors should govern all dietary regulations, firstly, the person's needs, and secondly, the combined experience of the past. Common sense, no less than custom and instinct, recognises that the amount of food varies according to the needs of the body, the nature of the bodily activity, climatic environment, etc. In children particularly, besides the normal work, one has to consider and make allowance for the greater need during the period of growth and puberty.

The starting point from which all computations of man's nutritive needs proceed is furnished by the Basal metabolic rate. Worldwide investigations have established some standards of normal requirements of adults. Other statistical compilations help to give one an idea of the calorific needs of children as compared with those of adult men.

| | | | |
|---|---|---|---|
| Man ... | 100. | Boy 6 - 10 yrs. | 50 - 70% |
| | | 10 - 14 „ | 63 - 83% |
| | | 14 - 16 „ | 81 - 100% |
| | | Over 16 „ | 92 - 100% |

It is recommended that an extra amount to the extent of 10% should be added to the calculated energy output to compensate for the wastage during digestion and absorption.

Accurate and long-continued investigations have also been undertaken to arrive at standards for children. Most authorities recommend for children over 44 lbs. in weight, the Du Bois "Hight-Weight formula" as the most acceptable. Du Bois gives the following basal metabolic rates.

| | | |
|---|---|---|
| Boys aged | 14-16 yrs. | 46 C. per sq. metre per hour. |
| | 16-18 „ | 43 C. „ „ „ |
| | 18-20 „ | 41 C. „ „ „ |

For children weighing less than 44 lbs. Harris and Benedict's Prediction Formula is recommended.

Having arrived at the B. M. R., one must proceed to add a sufficiency of calories for ordinary activities. Various workers have published tables showing the needs of different types of work. But it has also been pointed out that the statement about the accuracy of metabolic prediction does not apply to the active child. No one has yet been able to measure accurately the enormous amount of energy put forth by the child—an active boy who burns up a great deal through incessant activity. Benedict and Talbot have mentioned that the activities are enormous and that the food consumption is proportionately great. The total metabolism of the child of 12-14 yrs. exceeds that of his father. Benedict found that the total calorific output of ordinary school boys to be 75% above the basal rate.

There are two factors, entirely local, which tend to reduce the B. M. R. of our school-boys. One is that in South India, with the high atmospheric temperatures, the calorific needs are lower than in temperate climes. Secondly, the comparatively smaller quantities of protein taken in minimises the rise due to the "Specific Dynamic Action" of protein. Actual determinations of B.M.R of Indian Adults, also demonstrate that the normal figures for Indians fall short of the Standards given in textbooks by about 10-15%. This is perhaps a natural adjustment of individual metabolism to external environment. It may therefore be safely concluded that the following figures roughly indicate the average requirements of our schoolboys:

| Age | B.M.R. | Allowance for ordinary activities. | Special additions for hyperactive types. |
|---|---|---|---|
| 6-10 | 1,600 | 800 | 400 |
| 10-14 | 2,000 | 1,000 | 500 |
| 14-16 | 2,400 | 1,200 | 600 |
| over 16 | 3,000 | 1,500 | „ |

The protective value of a well-balanced diet is as important as the total number of calories. McCullum, McCarrison and other workers have discussed in great detail the

ideal normal diets and emphasise the inclusion of whole wheat, milk, and milk products, uncooked vegetables, sprouted legumes, fresh meat, eggs and fruits. Dr. Neale has represented in a diagrammatic manner the circle of diet, the omission of any sector (factor) causing a break in the circle of normal physiological play of forces.

## PROTEIN REQUIREMENTS.

With regard to the relative proportions of fats, carbohydrates and proteins in an ideal diet, there is seen a great divergence of views. The protein requirement of an individual has been a much discussed question. Statistical studies of the last century seemed to suggest that a minimum of 100 grms. per diem was necessary. Chittenden's experiments demonstrated that people could be supported on 1/2 to 1/3 of the stated minimum. "Not only so, but was averred that distinct improvement was experienced in the general sense of well-being and of mental efficiency." As against this view, there is the authoritative opinion of the Committee of the Royal Society, prescribing that proper diet should contain 100 grms. of protein per day.

Recent work suggests that much depends, not so much on the amount of protein taken as on the nature of the protein, the kind and number of aminoacids linked together, their relation, to the non-protein calories, and the extent of the tissue activity. The source of the protein is a good guide to the biological values, given below:

| | | |
|---|---|---|
| Meat | ... | 104 |
| Milk | ... | 100 |
| Fish meat | ... | 93 |
| Rice | ... | 88 |
| Potato | ... | 79 |
| Legumes | ... | 56 |

Animal proteins have a high tissue building capacity. It is said that 50-60 grms of animal protein will satisfy the daily needs of an adult, whereas larger quantities of proteins from plants or vegetables are required to make up for the deficiency in aminoacids. Peas, beans and lentils contain proteins of low value and are inadequate for growing children. At the same time, it must be remembered that the supplementary value of proteins is great. Two cereals do not supplement each other but a good supplementary relation exists between cereals and legumes. (eg. Wheat and Peas) or between milk and cereals or meat and cereals.

What is the optimum quantity of protein? Here, again there are conflicting experimental observations and opinions. McCoy has compared the poor physical condition of the Bengali with the fine physique of the Sikh. He says "To enjoy sustained vigour and to experience his normal expectancy, man must eat a liberal quantity of good protein." McCarrison discusses the relative values of national diets of different Indian races and opines that the Madrassee diet (consisting of washed polished rice, dhall sparingly, vegetables as columbu, iddli, dosai, vadai, coffee with sugar, a little milk, buttermilk occasionally, ghee very sparingly) was definitely inferior to the Punjabi diet, on account of the low content of unsuitable proteins, minerals and vitamins.

Two sets of students of the same age, living under the same conditions of life were given two different kinds of diet, one consisting of Anglo-Indian diet with a daily allowance of 3 oz. of protein and the second a Bengali diet with a daily ration of 2 oz. of protein. At the end of three years, it was found that the Bengali diet had prejudiciously affected the physique, health and efficiency of the second group of students.

The relationship of proteins, "the building stones" to growth if yielding interesting results. Certain diets are adequate for the maintenance of life although they are inadequate for growth. That a mixture of protein foodstuffs is desirable has been apparent to the physiologists. We must combine, as suggested by McCleod types of protein, utilising low-priced proteins, such as the by-products of cereals, meat and milk industries, for this purpose.

McLester recommends that for maintenance and growth, children should have 15% of their calorific intake in the shape of proteins of high biological value 2/3 being animal protein. He recommends 2·5 grms. per day per kilo weight for children between the ages of 6 and 12, and a daily allowance of 3 grms. per kilo weight for boys aged 13 to 16 yrs. Next, one has to consider the economic aspect. Vegetables form the cheapest source. Taken with milk or its preparations or by products, or with meat, vegetables form valuable supplementary proteins.



Carbohydrate, the most economical and readily available source of energy, is concerned in the physico-chemical changes of contracting muscle and is also a protein sparer. Carbohydrate lack is seldom found among Indian diets, except when the question is one of absolute want. On the other hand, carbohydrate forms the predominant and oftentimes the entire bulk of the food. Mellanby has pointed out that an unusual excess of cereal food in the diet interferes with calcium and phosphorus absorption. It is generally recommended that 50 of the energy requirements should be given as Carbohydrate (bread, cereals, potatoes, green vegetables). Some authors suggest 10 grms. of Carb. should be given for every kilo weight in children. While on the question of carbohydrates, a note of warning seems to be warranted regarding the immoderate use of sugars, syrups and sweets, which act detrimentally. Our chief source of carbohydrate is rice, in all its forms. Wheat enters but little into our diets but there is a welcome tendency of increasing the quota of wheat in the family budgets.

Fat has a high fuel value, is the chief source of Vitamin A, and is also necessary for digestion. A fair allowance of fat to the extent of 35% of the total calorific needs is recommended by McLestor. For a child, 2-4 grms. of fat per kilo of body weight is regarded as the optimum. According to the latest animal experiments, high fat diets proved definitely injurious at the higher (28-30) temperature of the environment. One is tempted to speculate whether similar effects are also probable in human beings and whether the traditional diet of Indian with its limited quantity of fat, is not after all, one dictated by instinct in the light of past experience. Milk, butter, ghee, yolk of eggs, fish, most of our vegetable oils, nuts and seeds are some of the cheapest and readily available sources of fat.

## MINERAL REQUIREMENTS.

"Every element which finds place in the structure of the cell is essential to life." Analysis of animal tissue shows that it has iron, sodium, potassium, manganese, calcium, phosphorus, sulphur, chlorine, iodine, flourine, lithium, barium, Magnesium, Aluminium, Copper and Silica. Each mineral element has its place in metabolism and substitution is not possible. Some are antagonistic; some are synergistic. Their functions are manifold.

IRON is required to the extent of 15 m. grm. per day per adult. A growing child requires even more. Experiments indicate that for the utilisation of iron minute amounts of copper and perhaps of other metals as well, are absolutely essential. Iron is abundant (along with copper) in the hull of cereal grains, green leafy vegetables, fruits, (dried or fresh), dried legumes, like peas and beans, nuts, leanmeat and yolk of eggs. Non-leafy vegetables and milk have a low content of iron. Manganese acts as a catalytic agent, regulating the capacity of the tissue cells to utilise oxygen. It augments the production of antitoxins and accelerates the growth of the organism. It is contained in concentrations sufficient to influence the growth favourably in all parts of plants which are very active (e. g. leaves, shoots, seeds) and also in milk, eggs and animal tissues.

CALCIUM has numerous functions in the body, such as bone building, keeping up normal activity of the heat; bringing about the coagulation of blood, acting as iron, taking part in the physiology of nerve conduction and in the energy exchange of muscle. The need for calcium is particularly great in growing children. Under ideal conditions, boys are said to consume from 3 to 4 times as much calcium per kg. body weight as is required for man (who needs about 1 to 1·5 grm. daily.) Fruits, vegetables, milk are rich in calcium and are essential to children.

PHOSPHORUS forms an integral part of nuclear structure, an essential constituent of plasma and is concerned in cell-multiplication. 1·5 grms. of phosphate is the lowest intake compatible with safety for adult. For the growing child, 2-3 times more is needed. Here again eggs, wheat, dried legumes, nuts and milk contain the required amounts.

Other elements are not usually lacking in diets and are not considered here.

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Iodobesin contains the anti-obesity hormones.

## VITAMIN REQUIREMENTS.

In this field, great advances have been achieved in recent years by Hopkins, Chick, Osborne, Mendel, Hess, MeCullum and McCarrison. Instances of the significance of the "infinitely little" in Nutrition are provided by the vitamins. It has been calculated that an ounce of calciferol (Vit. D) dissolved in suitable liquid could provide the necessary vitamin for more than a million children. "It seems almost incredible that a particular addition to the food so infinitesimal in amount, taken into the body for distribution to every part of it, should be so potent in its deepseated activity as to make all the difference between crippling and diseases on the one hand and healthy life and development on the other."

The list of vitamins is gradually increasing. It is becoming evident that there are many gaps in our knowledge of vitamins. A list of the vitamins, signs and symptoms due to their lack and the commoner and easily available sources of these vitamins is given in the appendix.

A few observations seemed to be called for, at this stage. The Vitamin B content of our diets has gone down considerably after the introduction of highly milled rice, as an article of food. The old type of hand-pounding left behind as much hull as one wanted. Preparations like 'Atukulu' (made from germinating rice). 'Shundalu' (made from germinating Bengalgram or some common type of legumes) afforded in the part easy and cheap sources of Vitamin B as well as of proteins. Soyabean also yields a good amount of Vitamin B. These articles are rapidly disappearing from household lists—on account of the ignorance and the dangerous trend of discarding old things for new, indiscriminately.

Rice forms the chief article of diet for half the human race. What is the degree of milling that may be permitted? Vedder states that at least 75% of the external layers of the grain should be left behind as determined by a simple inspection after staining with gram's Iodine. A more accurate chemical index of Beri-Beri prevention rice is described by some. Rice should contain 1·77% of phosphorus pentoxide and not less than 0·4% of phosphorus pentoxide is considered very effective in preventing Beri-Beri. Under-milled rice loses Vitamin content after some time. Heat and storing up are said to destroy Vitamin content. Insects also damage the rice to some extent. It has been noted that rice will retain its full vitamin content if it is kept unhusked in a place not very hot. The generally accepted composition of rice is as follows:

| 100 gramms. | Unhulled. | Cured. | Polished. |
|---|---|---|---|
| Protein % | 7·95 | 8·02 | 7·18 |
| Fat % | 1·65 | 1·96 | 0·26 |
| Carbohydrate % | 65·6 | 76 | 79·4 |
| Fibre % | 10·42 | 0·93 | 0·4 |
| Ash % | 4·09 | 1·15 | .0·46 |

It is evident that polishing removes not only Vitamin B, but also phosphates, minerals, etc. Hence the importance of whole cereals but more particularly of grain embryos, as possible sources of nutritious elements.

Milk has come to be regarded as an ideal food. McCullum refers to the fact that Aryans developed into a verile race in the high pasture lands of Central Asia, where care of herds formed the chief means of subsistence. In former days, most Indian households had one or more cows, buffaloes or goats or all, as their perennial fountains of milk and milk products. Children feasted on milk, cream, butter and curds. Even at present most of the agricultural communities and almost all the middle class families in the rural parts possess one cow or buffalo. Physical beauty, mental qualities, and longevity are said to be very much in favour of the people who own flock and consume milk. There is also a dying custom in South India, based on an old belief that cow's milk, taken fresh, hot and foaming as drawn from the udder, is a good, prophylactic tonic against all the ills human flesh is heir to. Some dietary deficiencies of milk have also been pointed recently, particularly its low content of iron. The composition of pure milk is given below.

| | Water | Solids | Fats | Casein | Sugar. |
|---|---|---|---|---|---|
| Cow's | 87·8 | 12·2 | 3·4 | 2·7 | 4·7 |
| Buffalo's | 82·2 | 17·7 | 7·7 | — | 4·4 |

Goat's milk is said to contain more iron than cow's. The proteins of milk, lactalbumin and casinogen, are rich in essential aminioacids. In addition, milk contains calcium, phosphorus, and fat soluble vitamins. Experiments by Orr and his collaborators on school children have confirmed



and expanded those of others on the diets of the growing children, that an addition of ¾ to 1 pint of milk per boy per day brought about in 6 to 8 months such changes that milk-fed boys were picked out by a casual glance. This great improvement was proved to be due, not to the extra calories nor to the fat content but to some unrecognised influence. On the other hand, Miss. Lane and Miss. Bosshardt have recently claimed equally good results with mixed and vegetable diet. They quote Appleton's statement that one is struck by the fine physique, excellent teeth, strength and the endurance of the Chinese coolies "who never have tasted milk". After an elaborate review of literature, supporting their views, they present some experimental observations and opinions. "A diet of vegetable foods carefully selected with special reference to the quality and quantity of protein, low in fat, comparatively high in carbohydrate, with adequate amount of minerals and high in vitamins produced in ten weeks as satisfactory increase in all physical measurements in children 7 to 15 years old, in most cases greater increase than a similarly carefully planned milk and meat containing diets". They consider milk as one of the useful articles of diet, but question its claim to be regarded as the most essential or vital one indispensable for human welfare. Perhaps the truth lies between the two extremes. Indian medical writers and tradition had long ago recognised milk and its products as very useful and sometimes essential to human body.

Buttermilk as an article of diet is relatively unknown in the West, and our textbooks do not give it a place of honour. Everyone in India must feel highly grateful to Col. McCarrison for his valuable advocacy before the Agricultural Commission, for a more intelligent and liberal use of buttermilk. Buttermilk contains all the residue which remains in the churn after the removal of butter. It has all the constituents of milk except fat. It has a very pleasing flavour. For centuries in India during the hot days of summer no drink more refreshing cooling and nutritious has been known than a cup of buttermilk. Every household uses buttermilk morning and evening, either for mixing with rice or for making the numerous popular preparations (Thayirvadai, etc.) Buttermilk is also cheaper and is easily available to all. Enlightened opinion must attempt to improve the quality and purity of this valuable food-tonic.

## NUTRITIONAL FACTORS OF LESSER IMPORTANCE.

Food has been defined as a palatable mixture of foodstuffs. A point that ranks high in practical dietitics is the preparation of food so as to make it appetising to the child. As pointed out by Dr. Neale, simple errors in domestic preparation may do greater harm than adulteration. Good cooking is neither softening nor hardening but the act of making food appetising and more digestible than before. "Cooking is the first stage of digestion, the stage that we can control."

Man eats in order to feel staisfied. This "Satiety Value" is greater and lasts longest when the food remains longest in the stomach, demanding greatest functional activity and passes on slowly. Meat has the highest value; milk comes next. The satiety value of eggs depends upon cooking. Fats tend to increase the satiety value. Bread or Rice has low satiety value. Butter, ghee or oils have high values. Buttered bread has a good value. "That is why we want our bread to be buttered." Potato has a low value, but mixed with meat, has a good value. Sweets following a food, increase the satiety value of the meal.

Roughage favours functional activity of the large intestines, and promotes regular evacuation. Hull of grain, peel of fruits, vegetable fibre, eaten abundantly in former days and less civilised lands, are of great value, here. The artificial life of a city, the concentrated and highly refined foodstuffs that form the bulk of the diet of the present generation must undoubtedly share some responsibility for the degeneration of the race.

Digestibility should also be considered. Rice is completely digested. Combination of milk and bread improve the digestion of both. Concentrated sugar solutions inhibit the secretory and motor activity of the stomach.

## PSYCHIC INFLUENCES.

Physiologists state that the first stage of the digestive processes are started by pleasant smell, sight and taste of food. Sham feeding experiments of Pavlov demonstrated that chewing and swallowing of unpalatable food produced no gastric juice. Gannon has emphasised the necessity of daintiness, aesthetic details, etc. in serving the food, as well as of the desirability of good conditions, pleasant conversation and good humour at the dining table. Prof. Pavlov refers to the old and empirical requirement that the food should be eaten with attention and enjoyment and to the special customs of every land designed to distract from the business of daily life. Some degree of appetising taste is desired by everybody, even by animals like dog. Eating without observing or complete disregard of the act of eating is considered to prepare the body for future disturbances. Prof. Pavlov's sage advice deserves to be remembered by some of our book-worms. "It is of course degrading to indulge excessively and exclusively in culinary enjoyments but on the other hand a lofty contempt for eating is also reprehensible."

* * *

These physiological principles have to be disseminated widely among the teachers, the pupils, the parents and the school nurses or nutrition workers and hostel authorities. It may be added that while the cost of the meal per head may not be materially increased on account of incorporating these principles, the benefits, present and future, to the individual and to society, appear to be immense and far-reaching.





# CLINICAL NOTES AND PRACTICAL SUGGESTIONS

## Treatment of Pediculosis.

Despite the fact that civilization and with it personal hygiene is at present so much advanced, the ubiquitious louse still lives and thrives not only in the head but in the public region of his body in all classes from the rich down to the poor on a scale that is not adequately estimated. This condition known as phthiriasis (infection with lice) to give its appropriate scientific title is more often overlooked by the physician and ignored by the patient. Troublesome scratching and some discoloration of the skin due probably to alteration in haemoglobin draws the attention of the patient and drives him to take some measures to get rid of the condition.

The symptoms are not very obvious. Although the patient complains of severe itching in the head or the pubis according to the location of lice, he has no serious feeling of irritation. This should not however prevent the physician to take active steps to destroy the parasites, which though do not cause much mischief to the host are a serious source of infection to others. For the destruction of these nits and lice many ointments and lotions mostly of Mercury are prescribed or the patient may use them having read of them in the advertisement columns of the daily papers. Though it cannot be denied that some of them may prove successful still more often than not they cause severe dermatitis which leads one to believe that cure is worse than the disease.

The experience of various physicians has justified the use of Sarcoptol, a colloidal Sulphur preparation, which has been found very effective in this affection. It is recommended that the patient should wash himself with soft soap and the body should be thoroughly rubbed with a towel by friction until the skin is completely dry. Sarcoptol pure is then rubbed into the affected regions as well as into the roots of hairs until it is completely absorbed. Two or three such applications eradicate this condition.

The use of Sarcoptol in phthiriasis is to be preferred to any other Mercurial or other ointment as it is safer and stronger in action than these. Two or three applications at the most are necessary to get rid of the parasites. In addition to its being a good antiparasitic it is absolutely non-irritating. It soon relieves the patient from troublesome itching and all these actions are brought about without any harmful by-effects viz. dermatitis etc. Sarcoptol treatment in short can be considered as a simple but certain method of destroying these parasites.

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## Treatment of Endogenous Psychosis

Although we talk of Endogenous Psychosis as some affection of the brain, we are still in the dark as regards its etiology. Some explain it away as a manifestation of faulty metabolism while others believe that it is the result of accumulation of toxic products. So far the exact causal factor has not been discovered. Treatment is of course symptomatic and consists of rest in bed, application of ice to the head and administration of sedatives and hypnotics. Some time back Glandular therapy was tried but without much success. Even injections of milk, vaccines and serum were of no avail although some temporary relief is obtained by those means.

Of late Elixir-Bromo-Valerianate is given a trial and it has been noticed that good results follow its use in these cases. Many patients, specially those in excitable moods and those suffering from involution psychosis are calmed down by the regular administration of Elixir-Bromo Valerianate for at least a week. Hallucinations and fits disappear after a certain period. Excitable patients are soon quieted after this Elixir treatment, which if continued for a sufficiently long time, prevents recurrence of the condition.

Elixir-Bromo-Valerianate is given orally. Unlike other bromide preparations there are absolutely no signs of cumulative action after its prolonged administration. With a daily dosage from 6 to 8 teaspoonfuls after meals there are no ill-effects resulting from it even if the treatment continues for a long time. The chief advantage of the employment of this Elixir is that the patient enjoys normal sleep at night and wakes up quite refreshed in the morning. Thus it ensures

proper rest to the brain, which is so much needed in these cases. All this is possible because this Elixir unlike other preparations does not only relieve the symptoms but acts centrally on the nervous system.

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## Sclerosing Treatment of Varicose Veins.

This treatment of Varicose Veins, which consists of injection of certain substances into the vein in order to occlude its lumen, has been gaining ground recently and has probably come to stay as a standard method of treatment in medicine and has superseded the removal method. Experience in a vast number of cases has proved its safety and efficacy. Of all the solutions employed Quinine-Urethane is unquestionably the best and the safest as it is prepared with neutral Quinine Hydrochloride and as it does not cause sloughing even if a little of it happens to escape into the connective tissue outside the vein.

The technique of injection is not very difficult. It is always preferable to keep the patient in a standing position as it helps the veins to dilate but any position, sitting, lying flat or with the extremity raised will serve the purpose. After sterilising the part to be injected with Rectified Spirit or Ether and applying the tourniquet introduce the needle of the Syringe which is partly filled with the solution, in the vein. After aspirating some blood which mixes with the solution inject the whole into the vein slowly keeping the needle in position for at least half a minute. The needle is then quickly taken out and the puncture is sealed with either Tr. Benzoin Co. or Collodion and bandaged with cotton-wool. If it is advisable to give any further injections at the same time, the distance of the sites of injections should be at least two inches apart. The chief item that needs emphasis is that the injection should be given slowly so that it has sufficient time to act on the walls of the veins and also because too rapid a distension of the vein is always painful.

The tolerance of the patient and the number of veins involved should regulate the dosage to be given at one sitting. Injection should be given in every dilated vein. After the treatment has started we will find dilated veins cropping up which should be injected. The failure of surgical treatment is due to this tendency of the veins to dilate. While with injection treatment we can deal with these dilated veins it is next to impossible in surgical treatment to operate on these every now and then. Another point which the injection treatment scores over the operative one on account of which it should be preferred, is that it enables the varicose patients either to avoid or cure the usual complications resulting from Varicose Veins viz: rupture, eczema, varicose ulcers and periphlebitis.

As stated above the treatment consists in producing sclerosis of the varicose veins and not thrombosis as is generally supposed. The solution injected sets up endophlebitis in the portion of the vein reached by it. The walls of the sclerosed veins are thus brought together without causing thrombosis and hence there is very little danger of embolism. Further there is hardly any risk of this sort as we know that in the standing position the circulation in the varicose veins is not towards the heart. Following the injection of Quinine-Urethane it has been observed that the blood flows back, that is, it runs from above to the distal end of the extremity and does not flow towards the heart. Consequently no accident need be feared from the use of these injections. At the most there might be a painful reaction along the course of the sclerosed veins. This is due to the inflammatory process started in the veins. It should in no way deter the physician from continuing the treatment as it soon passes off. Another trouble, which is very insignificant, is a cramp which follows the injection. It hardly lasts for more than two minutes.

If one bears in mind the few contra-indications for this treatment one sees no reason why it should not be given an extensive trial. If the patient is too old and weak and if he cannot stand any treatment he should be given only palliatives. If he be subject to infectious phlebitis, this treatment is not indicated. Albuminuria and Diabetes are also bars to this line of treatment. Oedema of the extremites should prevent us from carrying out this treatment as we are aware that in this condition the deep veins are involved and no amount of treatment of the superficial veins will improve the condition. This injection treatment is contra-indicated in pregnancy and in cases of skin diseases chiefly of Staphylococcal origin.

This method will henceforth remain as the standard routine treatment of Varicose Veins in any part of the body. Most of the cases are cured in a few weeks. The splendid results it achieves, its safety and less expense and above all its ambulatory form undoubtedly recommend it over the operation treatment in the vast majority of cases.

The Quinine Urethane Ampoules used by us were obtained from The Anglo French Drug Co. (Eastn.) Ltd.

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## The modern therapy of Pernicious Anaemia, Sprue and Secondary Anaemias.

From the excellent results obtained by a number of clinicians all over the world during the last six years from the administration of liver in cases of Pernicious Anaemia, we can deduce that we are at last on the right path of an effective treatment of a disease which was formerly considered as irremediable.

Pernicious Anaemia as is well-known, is the result of the failure of megaloblasts to mature. The primitive cells in the bone-marrow fail to differentiate to mature Erthrocytes. Whether this phenomena is due to the action of toxins or to the absence of some requisite stimulant either in the liver or the blood-stream we are not in a position to say at present. Some consider that toxins are responsible for this failure while others believe that there may be some deficiency either of the Vitamins or of iron. The daily intake of iron of a normal individual is from 15 to 20 m. grms. The anaemic patient is not able to assimilate this quantity due to defective iron metabolism and therefore it is true that the anaemic requires not only the daily normal amount, but some additional quantity to make up for the loss. The liver besides its bile-secreting and detoxifying functions sends some special hormone which when it is in the blood-stream is able to stimulate and mature megaloblasts and to effect iron-metabolism. Pernicious Anaemia is then the result of some functional defect in the liver which fails to send this special hormone.

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From the above it is quite clear why Liver is indicated in Pernicious Anaemia and the best product which effectively meets all the requirements is Opocrin Hepar. Although the original clinical results, obtained by Minot and Murphy who were the Pioneers in this field, were from the whole liver either raw or cooked, it has been found that for therapeutic effects this is absolutely unnecessary. A few grammes of the non-protein fraction of the liver about 2% of the whole organ are quite sufficient to yield good results which can be compared to those of ingestion of 200 gms or more of the whole liver. Opocrin Hepar provides this substance and eliminates the difficulty of patients taking large quantities of liver daily which is really a nauseating process. Besides it is difficult to obtain fresh liver and still more difficult to prepare it in a palatable form. Opocrin Hepar removes all these uncertainties and is as efficient as the whole liver.

Afrer ingestion of this product improvement is visible after four or five days. Achlorhydria, langour, mild fever, profuse bowel evacuations soon disappear after the administration of this Opocrin. Marked pallor and subicteric tinge of the skin soon give place to the normal colour over the fingers, palms and cheeks. Neuralgic symptoms are distinctly alleviated. The stimulating effect of this product upon the haematopoietic system is evident after a week. It consists of a progressive increase in the percentage of reticulocytes. The number of Erthrocytes also increase daily and the haemoglobin percentage is raised by 1 to 2. The colour index is also brought to 1. Other remarkable changes are the disappearance of macrocytosis and the appearance of normocytes. After two weeks of this treatment no megaloblasts are found. In fact a favourable response is obtained by the Opocrin Hepar therapy as regards the circulating blood which is given below in a nutshell:—

(1) Appearance of normoblasts.

(2) Increase of reticulocytes.

(3) Production of mature Erthrocytes and Eosinophils.

How definite is the response [illegible] Hepar in all true cases of Pernicious Anaemia can be seen from the foregoing remarks. Besides the Opocrins which

are meant for oral administration, the ampoules of this product are also available which are injected intramuscularly or intravenously in those cases where oral therapy is undesirable or where extreme speed in action is essential. It can be injected at any stage of the disease or in any critical condition. The ampoules are usually successful in completely altering an unsatisfactory blood-picture in 24 hours. Further it obviates the necessity for blood transfusion in the majority of serious cases.

Coming now to the disease known as Sprue in which soreness of the mouth and the tongue and the disturbed condition of the gastro intestinal tract are accompanied by anaemia and general wasting, Opocrin Hepar comes in good stead. It can be considered almost a specific in resistant anaemia of this disease. Besides the increase in the red blood corpuscles and the percentage of Haemoglobin which the Opocrin brings about, the general health of the patient is also improved. It has been noticed after clinical trials in severe cases of Sprue that simultaneous administration of Opocrin Hepar by mouth as well as intramuscularly has benefitted patients immensely. This product has several advantages over other preparations of the same kind in that it effectively stimulates reticulocytosis, it is more stable and more palatable. Opocrin Hepar treatment associated with butter-milk diet has rapidly improved patients in this disease.

As regards Secondary Anaemias we will now see the possibilities of the application of this Opocrin Hepar. The treatment of these anaemias is based on several principles which must be strictly observed without which it would not be successful. At first the cause must be removed and then the patient must be able to take proper and sufficient nourishment. After this is done we can administer specific measures for rebuilding the blood. No case of Secondary Anaemia can be brought under control unless the original cause is removed. Nor can we expect to build up the patient's blood unless proper nutrition is taken by him. Rest and adequate nutrition are therefore absolutely essential for the management of a case of this anaemia.

The only important medication formerly was some form of Iron in these affections. Recently it has been found that some form of Liver Extract combined with Iron is undoubtedly of considerable value. For this purpose Opocrin Hepar administered with Fer-Ma-Pho orally or Pharmasol Iron injections will be most suitable. Various types of secondary Anaemias resulting from whatever cause respond well to this line of treatment. The type of anaemia associated with infective arthritis improves well with this treatment. Satisfactory results have been obtained with Opocrin Hepar in Secondary Anaemia following serious haemorrhages, pregnancy and puerperium. Many clinicians have claimed that Opocrin Hepar with injections of Pharmasol Ferrum or Fer-Ma-Pho by mouth, are of great service in Secondary Anaemias resulting from Syphilis, Pulmonary Tuberculosis, Hypothyroidism, Bothriocephalic infestation and malignant disease.

Opocrin Hepar though meant primarily for Pernicious Anaemia has been tried by many physicians in Secondary Anaemias mentioned above. It is interesting to record here that it has been found quite useful in the treatment of those much more common types specially if it is combined with Fer-Ma-Pho or injections of Pharmasol Ferrum. Clinical investigations indicate that this product (6 Opocrins or 1 ampoule daily) causes a rapid and satisfactory red-blood-cell and haemoglobin regeneration in many common forms of Secondary Anaemias. Many severe red-cell deficiencies of severe and long-standing nature have been effectively overcome by this Opocrin treatment within a period ranging from three weeks to two or three months. In fact marked improvement has been observed in those cases which have been found refractory to other forms of treatment. The use of Opocrin Hepar therefore is fully justified in Secondary Anaemias in view of the facts mentioned. It must however be borne in mind that the effects can never be obtained unless the cause is removed. This is the most obligatory proviso before the treatment is instituted. From the observations made in a number of cases of Secondary Anaemia we can conclude that:

(i) Opocrin Hepar can be given orally or by injections without any untoward symptoms appearing even if administered over long periods.



(ii) It is always advisable to begin with injections in severe and chronic cases, as they require immediate and protracted treatment.

This liver treatment in Secondary Anaemias must be supplemented by a suitable preparation of Iron. It is interesting to note that both the above mentioned Ferrum products answer the therapeutic purposes in these conditions most admirably. The clinical evidence about the definitely superior results obtained with it is so conclusive that its use has been more than amply justified. Iron is contained in these preparations in Colloidal form as Colloidal Iron Hydroxide. The Fer-Ma-Pho is given orally and Pharmasol Ferrum as injections intramuscularly. They are both most serviceable in those cases of Secondary Anaemias where the haemoglobin percentage is low. Red-blood-cell regeneration is rapidly accomplished best by the administration of either of these preparations when given simultaneously with Opocrin Hepar. With suitable diet these remedial agents ensure splendid results. Again none of the objectionable qualities of Iron are present in either of these preparations nor are they acid or astringent. In fact the advantages they both possess can be summarised thus:-

(1) Rapid assimilation irrespective of the hydrochloric acid content.

(2) Rapid rise in haemoglobin content.

(3) Improvement in appetite.

(4) Rise in body-weight.

(5) Harmlessness to the teeth.

(6) No undesirable effects on the gastro-intestinal canal.

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## On treatment of Rheumatic affections and Gout.

The efficacy of Urogenine is very high because of the excellent combination of Hexamine with Sodium Benzoate, Piperazine and Lithia. Urogenine possesses the uric acid eliminating property combined with antiphlogistic, antiseptic and diuretic action with the advantage that no matter how long it is administered it produces absolutely no ill-effects.

The activity of Urogenine can be greatly helped if intravenous or intramuscular injections of Iodaseptine are given with it. It has been found that by injecting this remedy combined with the oral administration of Urogenine in Rheumatic affections as also in Gout the therapeutic effect is observed to be much increased with no ill-effects resulting from it. The most remarkable effect of Iodaseptine when given intravenously is that the pain in Rheumatic and Gouty affections is soon relieved after injection and this effect lasts for a considerably long period. It is to be noted that this analgesic action goes side by side with antiseptic and antipyretic ones. The result is that the pain subsides, swellings diminish and the temperature comes down.

Clinical experience has demonstrated that the use of this Urogenine-Iodaseptine combination has produced beneficial results. In acute muscular and joint rheumatism and in gout the action is certain, prompt and lasting. In muscular rheumatism complete cure was effected after five injections of Iodaseptine together with the administration of Urogenine for two to three weeks. The pain disappears soon after the second injection and if Urogenine is continued for three weeks there is no possibility of a relapse. In articular affections also similar results have been obtained without much trouble. In these affections patients, in whom several joints were involved, were free from fever, pain and swellings of joints with this treatment for roughly two weeks. Except for the treatment of tonsils and cleaning of teeth no other remedy was employed. The most beneficial result following this treatment was that there was no cardiac involvement as an after-effect of the disease. Similarly at the most six injections of Iodaseptine are required in a case of subacute rheumatism. Pain disappears after two injections and joints are entirely cured after four injections given at the interval of two days. In acute Gout five to ten injections are required according to the severity of the case. Simultaneous administration of Urogenine is absolutely needed. Considerable swellings have been seen to disappear within a week and pain has been removed and temperature brought down in some cases with even one or two injections. Besides this, the general experience is that if the treatment is continued for some time, no relapses have occurred.

It is no use denying the fact that chronic forms of these affections are more refractory

to this treatment. Of all the chronic affections however, muscular rheumatism responds to this combined treatment most effectively. Chronic lumbago for instance is cured with 5 to 6 injections of Iodaseptine. In chronic rheumatism of the joints, in which there is some mobility remaining which means that the ligaments are not involved, it has been found that two to four injections of Iodaseptine with Urogenine by the mouth have produced increased movements of the joints. We have seen that in acute gout the results of this combined treatment are quite satisfactory, but its application in chronic forms requires a good deal of perseverance and steadiness. The injection do increase the movements of joints in these cases, but the results must be maintained by the continued use of Urogenine supplemented by dietetic measures. The latter not only helps elimination of uric acid, but prevents relapses. Massage and physical exercises are found to be valuable adjuncts to this treatment.

This combination therapy appears very encouraging from the pharmacological standpoint. So far no ill-effects have been observed resulting from this therapy. The treatment can be followed specially in those patients who have cardiac troubles or neurosis and who have intolerance towards Salicylates. In acute rheumatism if this treatment is instituted right in the beginning there is every possibility of avoiding any cardiac complication which usually is the sequel of this disease. The treatment of muscular and articular rheumatism by this method is a great step forward in present-day therapeutics because of the fact that durability of the effect is attained in almost all cases without any discomfort to the patients.

The conclusions that we arrive at therefore are that Iodaseptine injections rapidly remove pain in Rheumatic muscular affections and arthritis, either gouty or rheumatic. It helps to reduce all signs of inflammation. The combination of Urogenine with this besides eliminating Uric Acid and other toxins intensifies the effect and thus even obstinate cases are cured.

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# Abstracts.

## HOW A DOCTOR CAN INCREASE HIS INCOME

### BUILDING A CONSULTATION PRACTICE.

BY

HAROLD HAYS, M.D., F.A.C.S.

NEW YORK CITY.

In times like these, when the depression of the last three years has been particularly distressing to physicians, one hesitates to preach on any economic subject, whether it be an attempt to increase an income or to build up a consultation practice.

However, I am committed to express my thoughts, and primarily the thought comes to me that there is no such thing as attempting intentionally to increase one's consultation work. A man's worth, the regard in which he is held by his fellow workers, will depend entirely upon the seriousness with which he is regarded, either in his devotion to a special branch of medicine or to medicine in general.

Rather than dwell upon my own experiences as a consultant and expressing the reason why I may or may not have been preferred to another man for consultation work, it may be more interesting for me to mention why certain men are so outstanding as consultants that when they pass away, one wonders who the next man is to whom he can turn.

In the past year, two outstanding laryngologists have died—Dr. John Makenty and Dr. Sidney Yankauer. Each one had attained great fame. Each one was held in great esteem by the men in their own field. Each one was needed as a consultant. To whom shall we turn now?

Surely no young man, unless he is a confirmed egotist or a jackass would attempt to build up a consultation practice until he had had himself recognized along some particular line. There is no way for him to impress his confreres with the fact that he is a great man until he becomes a great man—at least not until he is told by others that he is equally as good or greater than they are. One may be fortunate enough to be recognized while he is still quite young. He is indeed fortunate as long as he keeps a mental eqilibrium and doesn't parade his greatness. Some years ago, in a novel, "Doctor and Patience," which I had the timerty to write, I stated that the best way for the young man to be recognized was by doing something that the other fellow said he couldn't do. In that way, a young man is brought suddenly and prominently to the attention of everybody, and often it will mean consultation work which will increase as time goes on, if the young man lives up to his reputation.

The consultant is placed in the position where, often, he must render an opinion after a very short and superficial study of the case. The history of the patient is briefly reviewed by the physician in charge, the immediate data on the case are gone over hurriedly, including temperature chart, nurses' notes, X-ray and laboratory findings, etc. and finally an examination of the patient is made. An opinion must be rendered and the opinion thus expressed, candidly and openly will stamp the consultant as a success or failure and his increase in consultation practice will depend to a great extent on the courtesy and consideration he shows the attending physician. It isn't necessary to pander to the man in attendance; it isn't necessay to defend him when he is wrong but it is necessary to show him that you appreciate his intelligence. Moreover, the man who makes the attempt to show his importance by exaggerated opinions or overextended examination of the patient is soon found out.

Two or three experiences of my own may show how to or how not to build up a consultation practice. Some years ago when I was still young in practice, I called a prominent otologist in consultation on a patient who possibly needed an operation on his mastoid bone. The consultant agreed that an operation should be performed. He almost persuaded the patient and his family that he was a greater man than I was and almost managed te take the case out of my hands. Needless to say, I never called him in consultation again. In building up a consultation practice myself, I have always impressed the patient and his family with the fact the physician in charge was competent and have always made a rule, without exception, never to operate or take

charge of a case on which I had been called, no matter how strongly I have been urged to do so. I have not maintained this attitude as a bid for further work but because people who are ill are unfair and I must never consider myself more competent than the other man.

I have had the opportunity to call in men in other lines than my own. Why have I considered them the best consultants? Why have I chosen them? Why and how have they build up large consultation practices? I have two men in mind—both of them great, both of them the simplest men I have ever met. Neither of them attempts to impress you with his knowledge. They take it for granted that you know or you would not have asked them to see the patient.

I had one of these men see a post-operative mastoid case with me—a woman running an intermittent temperature after the wound had healed. He hastily but expertly examined the patient, talking to her quietly while doing so. Finding that she was interested in music the examination continued to the tune of a Bethoven Symphony. The patient hardly knew she had been examined but the consultant found out all he wanted to know, with no fuss or bother, satisfying both the patient and me.

The consultant who flunks on his job and is avoided as often as possible, is one who feels it necessary to render an impressive opinion, a positive diagnosis at direct variance to the history and symptoms of the case. A case in point is the following: I was troubled about a patient with an acute ear condition who had a possible mastoid infection. At the first consultation, I called in a man in whom I have the greatest confidence and who agreed with me that the case was baffling but that it would be wise to indulge in watchful waiting. Two days later, I needed a consultant again and was prevailed upon to request the services of a man who is well known but has an ego to the "nth" degree. I had no valid reason for not asking him to see the case.

Dr. N.—— examined the patient with the utmost care, even going into neurological data because he was mainly interested in oto-neurology. In spite of the fact that I never like secret consultations, to the exclusion of the family, we went into the bathroom, (the usual meeting place for secret and private consultations) where he began to lecture me as he would a third year medical student.

I interrupted his didactic lecture.

"Dr. N.——"I said, "I wish you would take it for granted that I know something about otology. I asked you on this case to give an opinion. Will you please tell me what you think the patient has?"

Looking at me knowingly, he said,

"I believe your patient has erysipelas."

I was astonished. I was flabbergasted. The last thing that the patient could have would be erysipelas. My experience with this disease, I regret to say, was greater than his.

"Much obliged for your opinion, Doctor" I said as soon as I could recover myself. "The one thing this patient hasn't got is erysipelas."

I am giving this story because it emphasizes the point that the consultant ruins himself in the eyes of those who could use him in future cases by rendering an opinion which is so impossible that it brands him as a numbskull no matter how brilliant he is supposed to be.

Building up a consultation practice is dependent entirely upon how much one impresses his confreres that his opinion is really worth while. No one can force such a practice. No one can brand himself as a consultant merely because he wishes to be one. He must be worthy of his hire.

I have been in the practice of medicine long enough to know that there are two kinds of doctors—the one class that are simple, intelligent and really worth while and a second class who through personality or otherwise, force themselves to the front with a modicum of common sense and a microscopic intellect. The former can always be relied upon to build up a successful consultation practice: the latter never will.

*(Medical Mentor, July—October, 1932.)*

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# 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.**

**Haemorrhoids**: A suppository containing Acid Gallic grs. 20, Ext. Opii gr. 1, Ext. Belladonna grs. 2, Ol. Theobromatis q. s., to be inserted every night. If the prolapsed haemorrhoids are inflammed and difficult of reduction, the following ointment may be used: Cocaine grs. 12, Iodoform dr. 1, Ext. Opii grs. 30, Petroleum oz. 1. (Cocaine Hydrochlorine should not be used).

FOR THE EXTERNAL VARIETY: hot compress with adrenal chloride 1 in 3000 to be used externally after defaecation or washing clean the parts with a solution containing Ext. Hamamelidis. In cases complicated with habitual constipation, Ext. Cascara Sagrada liq drs. 5, Tinct. Belladonna, Tinct. Nux Vomica, Tinct. Physostigmin each 1 dr. 20 drops of this in water thrice a day before meals. (Hare). Large Haemorrhoids often disappear by the daily application of a powder containing equal parts of calomel and starch after first cleaning the parts. (Kellog). Injection of 0·5 cc. of Adrenalin 1: 1000; the piles disappear after 15 injections. Adrepatine (A. F. D.) is highly recommended.

Injection into the piles of 0·5 to 0·7 cc. of 5–10% solution of carboilc acid in equal parts of water and Glycerine. 2 to 4 injections have been used with satisfactory results.

Rectone ointment (Luyties) containing Adrenaline, Orthoform and Lanoline, and Bulkeye Salve (Luyties) containing Hamamelis, Strammonium and Calamine have been used with varying success.

**Hairs (Falling of)**: To prevent the falling of hairs, Hyd. Perchlor. grs. 12 Glycerine drs. 3, Spts. Rectificatus drs. 3, Ol. Rosi mms. 2, Aqua ozs. 6, to be well rubbed into the roots of the hair both morning and night.

**Hairs (Superfluous)**: for removing the superfluous hairs, Barium Sulphide drm. 1 to be made into a paste with Zinc Oxide and amyli each drs. 3 with a little water. Apply over the part for 5-15 minutes. In place of Barium Sulphide, Strontium Sulphide drs. 2 may be used. After removal apply cold cream. (Practical Medicine).

The parts may be painted over by the following: Tinct. Iodine parts 3, Turpentine parts 6, Castor Oil 8 parts, Collodium add 80 parts, to be painted twice, after drying the skins. (Modern Medicine).

**Hair Gray**: Suprarenal glands grs. 2 Hypophysis Sicca 1-10 gr., Strychnine 1-10 gr., Ferric Chloride ½ gr., Thyroid gland ½ gr. to be made into a capsule and taken after each meal. (Sajous).

**Hand-Fissured**: Acid Tannic grs. 7½, Glycerine oz. 1, Aqua Rose ozs. 1½. To be rubbed well over the parts morning and night. (Practical Medicine).

**Headache**: Due to relaxing climate. A mixture of Quinine Sulph. grs. 2, Liq. Strychnine mms. 5 and Acid Hydrochloric dil. mms. 10, in an ounce of water; and for that due to bracing climate, Pot. Bromide and Pot. Iodide, each grs. 10, three times a day, but this should be preceded by a dose of Calomel.

(Leonard Williams).

If due to renal disease: Pot. Iodide and Citrate of Theobromine, grs. 10 in a cachet three times a day, or the last may be given in the form of "Diuretin" which contains salicylate.

(Leonard Williams).

Pyramiden and Salicylates are of value. In trait-de-gin 2 per cent solution of dry extract of Mistletoe in alcohol and water in 2 cc doses after meals. (Modern Medicine).

If due to vaso constriction Liq. Trinitrinis m. 4 and Acid Hydrobromic dil mms. 20, Aqua oz. 1 to be taken 3 times a day but not continued long. If the pain is dull and heavy and worse in the morning with a tendency to wear off as the day advances and accompanied by mental and physical lassitude and which is often due to the deficiency of the coagulation of blood, Calcium Chloride is good.

(Leonard Williams).

In young persons caused by eye strain with pain in the eye balls and forehead having a sensation as if the orbits are too small for the eye balls, Belladonna is good and also Acid Hydrochloric dil mms. 15-60 in sweetened water to be followed by Tinct. Nux Vomica drs. 2, Tinct Cannabis Indica drs. 2, mms. 15 mms. of this to be taken in water twice a day.

In some cases of neuralgia small and daily doses of castor oil is good. In sick headache due to error in diet without much

nausea, Tinct. Nux. Vomica mm. 1 in a teaspoonful of water every 10 minutes till mms. 10 are taken.

In the headache which is severe on walking and disappears in 1 to 6 hours, and which is heavy, dull, frontal, occipital, or temporal, throbbing and chronic due to serous exudation or haemorrhage into the meninoge, Calcium Lactate is the best drug. (L.B.)

In pituitary headache, pituitary should be given either by injection or by mouth with Thyroid or Sodium Iodide. (E.S.)

Excess of fat in the food may cause headache. This is usually worse in the morning. Lemon Juice 1 to 3 in water or solution of Citric Acid 2 % will stimulate the gall bladder and make the digestion of fat easier. (Kellog).

If due to deficient coagulability of blood, which is followed by urticaria and chracterised by increase on waking and disappearing after a few hours. This is chronic and usually attacks women. The face and eye lids may be puffy and there may be edema. For this Calcium Chloride is the best remedy. (L. B.)

For menopause headache Thyroid.

For headache coming on after Lumbar puncture and which is due to low blood pressure Pitutrin ½ cc. by injection.

(R. A. Neurology).

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## Notes on Therapeutics, Diagnosis and other Medical Subjects.

### BACTE PHAGE THERAPY IN BACILLARY DYSENTERY.

Bacillary Dysentery is a disease caused by specific bacilli, B. Shiga, B. Flexner and B. Hiss which mostly attack the mucous membrane of the large intestine.

ETIOLOGY: Indirect or direct contagion from man to man is the cause of the spread of the infection.

Direct contagion takes place usually amongst people of insanitary habits and amongst less civilised population.

Indirect contagion: (i) This is caused by the common house-fly. When this pest prevails we find the infection setting in a remarkable manner. The fly sits on the food-stuffs and by its habit of regurgitation prior to feeding or by its faeces contaminates the food which is taken by people.

(ii) Another medium of infection is water in which the bacilli can thrive for more than three weeks.

(iii) Dust may be another medium which may carry infection as it is often mixed with powdered faeces.

The organisms responsible for the infection are as stated above, Shiga Bacillus, Flexner Bacillus and Hiss Bacteria.

The Shiga-bacillus is more frequently the cause of the disease and most severe forms are due to these bacilli. This bacillus is believed to be an energetic producer of toxins, while B. Flexner produces toxins only to a slight extent. Moreover the toxins formed by B. Flexner are endotoxic in character. On the other hand the toxins of Shiga bacilli are ectotoxins or simple types possessing high antigenic properties.

The other type is Hiss Bacteria from which the toxins are not easy to separate. The later have poor antigenic properties.

SYMPTOMS: Frequent passage of loose, scanty stools mixed with blood and mucus. There is generally griping, tenesmus and dysuria—the usual symptoms of the inflammation of the large intestines. Pyrexia of a high or a moderate degree may be present. Vomiting may or may not occur from the onset. The general constitutional symptoms are very much evident because of the absorption of the toxins.

THE STOOLS vary in number and character. At first they may be too numerous to count. They consist mostly of viscid blood-stained mucus and they are generally odourless. Later the stools assume a more purulent character and contain less blood. After the disease has thoroughly established itself the foecal character appears again.

According to the clinical picture various types of Bacillary Dysentery are seen.

(*a*) MILD OR CATARRHAL TYPE: This type is grafted on to a mild form of diarrhoea. The motions which are at outset bilious and watery give place gradually to mucoid and less faeculent character. This is accompanied by griping and straining. Most of these cases are due to Flexner bacilli.

(*b*) ACUTE BACILLARY TYPE: The onset here is abrupt and the stools consist of nothing but blood-stained mucus. They are frequent but not copious and are accompanied by griping and tenesmus. Fever is present. The patient looks anxious. The tongue is either white or yellow. These symptoms end abruptly after a week or the attack may pass on to a chronic condition.



(*c*) CHRONIC BACILLARY DYSENTERY: The stools in a large number of cases do not assume the normal form for a long time. The old symptoms often reappear after any dietetic in-discretion. The patient suffers like this for months or years, the motions always containing slime or at times blood. There might be extreme emaciation and anaemia might develop.

PATHOLOGY: We need not enter here into the details of pathological lesions but we will confine only to some salient features. The "Snailtrack" ulceration of Dysentery is mostly confined to the large intestines. The characteristic lesions are seen in the lower part from the sigmoid flexure to the anal canal. The ulcers are distributed transversely to the long axis of the gut. They are serpiginous in out line with undermined margins. The basis consist of granulation tissue. Later there is usually acute diffuse necrosis of the mucous membrane of the large intestines due to the toxins of the bacilli.

COMPLICATIONS: (1) *Dysenteric Rheumatism* may come on during the acute stage. There is effusion in the joints and the ligaments, mostly sterile, especially of the knee and the ankle. There is pyrexia. The condition usually clears up after a week leaving no deformities.

(2) Acute Conjunctivities and Iridocyclitis may ensue as a result of Dysenteric toxemia.

(3) Anaemia and Sprue may later follow the acute stages of the disease.

DIAGNOSIS: Bacillary Dysentery can be diagnosed by its acute onset, by the presence of temperature, general tenderness all over the abdomen, specially marked over the sigmoid flexure and the character of the stools. Microscope usually does not show the bacilli and one has to have recourse for culture test.

#### TREATMENT.

PROPHYLAXIS: So far as preventive measures are concerned careful attention should be paid to the food which should be wholesome and uncontaminated. The drinking water should be boiled. As regards medicines one should not be satisfied only by clearing the bowels at intervals by means of Castor Oil and other aperients. The prevalence of this type of Dysentery is so general and wide spread that these measures are not sufficient. For these reasons taking of Bacte-Dysenteri-Phage, one ampoule in half a glass of cold water (preferably Vichy or plain water made alkaline by adding 3grs Soda Bicarb to each ounce) once every three days on an empty stomach as a precautionary measures ensures a more certain protection. During epidemics and in countries where there is risk of Dysentery it is highly advisable to ensure proper prophylaxis by taking this Bacte Phage as it is quite a specific against this complaint.

CURATIVE: Bacte-Dysenteri-Phage when administered immediately is very effective. Its value is equally great in all types and forms of Bacillary Dysentery. One ampoule of 2 c. c. should be mixed with half a glass of water if possible Vichy, and should be given every four hours and in very severe cases at the interval of three hours. It has been noticed that nervous disturbances and general prostration disappear a few hours after the administration. Tenesmus, griping and abdominal pain soon cease. Frequency of stools is likewise diminished and blood and mucus gradually disappear from them. If the administration of this Phage is instituted right at the start, that is, at the appearance of the first bloody stool or even at the commencement of diarrhoea the symptoms and the stools all clear up within two or at the most three days.

For the treatment with this Phage no other adjuvants need be orally administered. Rectal injections and irrigations are also unnecessary. It is found that they are not retained on account of the tenesmus. Treatment with Bacte-Dysenteri-Phage alone given by the mouth is followed by equally good results. In acute cases if the treatment is not started early the course may extend for some more days. However late the treatment may be commenced still it is evident from the results that this Bacte Phage has a very definite value in cases of Bacillary Dysentery. If the symptoms persist even after continuous treatment of two or three days then it is quite certain that it is not a case of Bacillary Dysentery. Be-

sides the simplicity of ingestion of this Phage, it entirely eliminates the necessity of lavages and injections which are generally not liked by the patients. Its anti-spasmodic action—which means relief from pain and tenesmus, is a quality which needs particular stress. It can be taken even by infants and children who tolerate this medication exceedingly well. It is absolutely non-irritating and innocuous. For children over two years the same dosage as to the adults should be employed while under two years an ampoule of the Phage should be combined with three tablespoonfuls of cold or tepid water (Vichy water is preferred in every case) and one tablespoonful of the mixture should be given every hour until the symptoms disappear.

During the course of the treatment it should be noted that the diet should be light and varied.

TREATMENT OF CHRONIC BACILLARY DYSENTERY: In cases which pass on early into chronic state this Phage by the mouth is equally satisfactory as in acute cases. Mild chronic cases persisting for months are specially amenable to this form of treatment. It is observed that in these patients there is rapid amelioration of the subjective and objective symptoms, diminution of pain and diarrhoea, healing of ulcers and disappearance of bacilli from the evacuations. Dietetic measures should be rigorously enforced here also.

The advantages presented by this Bacte Dysenteri Phage are so many that it has replaced all the older forms of treatment in Bacillary Dysentery.

(1) During this treatment no other medication is necessary.

(2) It has completely eliminated the necessity of uncomfortable irrigations and painful Emetine injections.

(3) This Phage can be easily taken by the mouth in fact it is not to be injected.

(4) The treatment is tolerated well even by children and infants and is possible even where the patient is up and about.

(5) It is absolutely harmless.

(6) The possibility of a liberal dietary is attained earlier under this treatment than with any other medication.

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## LACTOSE IN CONSTIPATION.

Several requests for information have made me realize and regret that I omitted from my article in Clin. Med. and Surg. for May, 1932, (page 346) the details of the dosage and the method of administration of lactose in the treatment of constipation.

Dr. Edwin Boros, of New York City, had a large experience with this method and I have his permission to present his technic.

"The patient receives two tablespoonfuls of lactose in one-half glass of cold water, one half hour before breakfast. The use of cold water is preferable, because it has a tendency to stimulate the gastric-colic reflex. This is followed at 10 A.M., by the ingestion of a moderate amount of figs, prunes, dates or grapes. Six to ten prunes, figs or dates is the usual average necessary, or a half-pound of grapes, if desired, may be taken; the effect of prunes is enhanced by soaking them, previous to ingestion, in water for two hours, so as to encourage early fermentation by the fermentative organisms present. In this way, by the time the sugar has reached the small intestine, the process of fermentation has already begun. At 4 P.M., the 10 A.M. program is repeated, and prior to retiring, two tablespoonfuls of lactose are again administered.

"The addition of fats in large amounts is especially recommended in the undernourished, constipated individuals, whereby we gain the added physiologic irritation of the small intestine produced by the soaps which are formed.

"There is considerable gas formation with the use of lactose, and its propelling action should not be curtailed by suppressing it, but on the contrary, the patient should be encouraged to aid in its escape through the rectum. An occasional diarrhoea, resulting from the lactose administration, can readily be controlled by reduction of the dosage. As a rule a few days are required before noticeable results are manifest."

Ordinary milk sugar is relatively insoluble and is somewhat unpalatable to many people. The recent discovery of another form of this carbohydrate, *beta lactose*, which is much more soluble and pleasant to take (it may, in fact, be used as a table sugar), has obviated some of the difficulties which have, heretofore, attended this method of treatment.

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# News & Comments.

**Licentiates' Conference:** As announced in these columns, the annual Conference of the All-India Medical Licentiates' Association came off on the 20th instant and closed on the night of the 22nd inst.

The Hon'ble the Rajah of Bobbili, Chief Minister to the Government of Madras, opened the Conference. Dr. U. Rama Rau, Chairman of the Reception Committee, welcomed the visitors and the delegates and Major-General C. A. Sprawson, Surgeon-General with the Government of Madras, presided over the Conference on the first day, and for the rest of the days the Presidential Chair was occupied by the Chairman of the Reception Committee. As we went to the press earlier than the date of the Conference, it was not possible for us to publish even extracts from the Addresses delivered by Dr. U. Rama Rau, Chairman of the Reception Committee, the Hon'ble the Rajah of Bobbili, Chief Minister, and Major-General C. A. Sprawson, Surgeon-General. The positions occupied by all the three in the Conference and their individual importance in public life demand a careful reading of their speeches before they are commented upon. So we reserve our remarks till after their Addresses are published in these columns.

The All-India Medical Licentiates' Association is a registered body and has a Memorandum and Articles of Association with Rules and Regulations, and Bye-laws which have the force of law. Those who are responsible for running the spectacular show of the annual conference have to respect the existing constitution of the Association. It is reported that the existing constitution is very defective and unworkable, that no work of any importance can be achieved, and that the office-bearers of the Association have failed to do their part. At the open Conference on the 22nd night it looked as if those responsible for conducting the proceedings were not aware at that time that the Association was a registered body and that the existing rules and regulations had to be respected in spite of their inherent defects. We feel constrained to say nothing more about the 25th session of the All-India Medical Licentiates' Conference beyond the fact that all those present at the Conference were hunting after offices more than serving the purpose for which such annual Conferences are held. Elsewhere we publish a letter from Dr. V. Rama Kamath, the General and Publicity Secretary of the Conference, and he in his capacity as a member of the Association and having been an important office-bearer of the Conference, is expected to know and say more than we possibly can in our editorial capacity.

**Government Committee on Honorary System:** Who is who, in the Committee nominated by the Surgeon-General and approved by the Government, should be made known to our readers so as to satisfy their curiosity and anxiety to know if anything worthy of the purpose for which this Committee was appointed can be expected out of the deliberations to be arrived at by the Committee. The Committee consists of the Surgeon-General, Lt. Col. Fraser, D.M.O., Coimbatore, Dr. A. Lakshmanaswami Mudaliar, Second Obstetric Surgeon, Government Maternity Hospital, Madras, Dr. Miss. A.B. Hardy, Asst. Superintendent, Lady Willingdon Medical School for Women, Dr. K. C. Paul, Honorary Physician, Government Royapuram Hospital, Dr. K. B Bhujanga Rao, Private Practitioner, and last but not of least importance Diwan Bahadur R. N. Arokiaswami Mudaliar, M.L.C., Ex-Minister, who was in charge of medical portfolio. The Surgeon-General is said to be the Chairman of the Committee.

The Government is very well represented and has an overwhelming majority consisting of three officials with 4 votes, the Surgeon-General as Chairman having a casting vote. Dr. Paul is an honorary physician holding his office at the sweet will of the Surgeon-General, who is the appointing authority and also the person exercising disciplinary control over honorary officers. Dr. Paul is therefore a quasi-official and has to exercise his vote in a manner consistent with his position. So his one vote has to be divided into two halves, one half to the Government and the other half to the non-official position. Then comes Dr. Bhujanga Rao, whose vote would have been more secure on the non-official side, if, as announced by the Government through their mouthpiece, the Hon'ble Mr. B. Muniswami Naidu, the then Minister in charge of

medical portfolio, the Government requested the existing associations to select their representatives instead of asking the Surgeon-General to make his choice. We mean no disparagement to Dr. Bhujanga Rao, who, we trust, will acquit himself to the best of his capacity, knowing as he does that he has to serve the class who are the most aggrieved section in the medical profession. He does not hold any honorary appointment and is under no obligation excepting that he is the nominee of the Surgeon-General. As suggested in these columns, last month, it is up to him to know the views of his comrades through their Association where he occupies an important position being a member in the Executive Committee of the Madras Branch of the All-India-Medical Licentiates' Association. Will he do it and make up for the lapse of the Government? The most redeeming feature in this Committee, is the presence of Mr. R. N. Arokiaswami Mudaliar whose progressive views on honorary system are well known to the public as could be gauged from his speeches on the floor of the Legislative Council. But it has to be said that those responsible for nominating him would have honoured themselves if Mr. Arokiaswami Mudaliar was appointed as the Chairman of the Committee on account of his past position as Minister. The fact that he is the only lay man in the Committee against six medical men of whom 4 are Government officials and only two non-officials, is yet another point that ought to have weighed with the Government to appoint him as the Chairman. We will be failing in our duty if we do not mention that sometime ago Lt. Col. Fraser, one of the Government nominees in the Committee, when requesting His Excellency the Governor of Madras to open one of the wings of the Coimbatore Head Quarters Hospital, expressed in strong terms that it was a very wise policy on the part of Government to appoint honorary medical officers in state hospitals to the mutual advantage of the honoraries as well as that of the Government. In the light of what we have said from the facts before us we trust that the Committee would bring forward a report worthy of the purpose for which it is appointed.

**Is it a warfare**?: Our readers are aware that the Government of Madras issued notice to a dozen or more Civil Surgeons terminating their service after 25 years on account of the Retrenchment Formula. The Civil Surgeons who received such a notice first put up a fight that they formed a different cadre from the Civil Assistant Surgeons and as such the Formula could not be made applicable to them until they finished 25 years service as Civil Surgeons. One or two went a step further and protested that they held special appointments in the grade of Civil Surgeons and that under any condition the Formula cannot be made applicable to them. During this stage of controversy, we opined in these columns that Civil Surgeons and Civil Assistant Surgeons should in equity if not for anything else considered as one homogenous group as the Civil Surgeons were recruited from among the Civil Assistant Surgeons after approved service and as such could not be treated as a separate service. We are told that this was the view of the Madras Provincial Medical Association or at least the view expressed by its President. It is also said that the Government ruled later by a G.O. that the Civil Surgeons and Civil Asssistant Surgeons formed one homogenous cadre and that those holding special appointments could not be treated as exceptions. This was evident also from the recent publications of the Civil Medical List.

The Civil Surgeons were not baffled or enervated by the loud noices made by the "Government Gun" of homogeneity. They declared as loudly that the special rule which gave power to the Government to terminate the service after 25 years related specifically to individual cases and could not be for a moment, made applicable to all and that, as a measure of retrenchment, that being a special provison in the new Fundamental Rules to remove individuals who in public interest could not remain in service—in fact it is contended that the special provison had to be utilised as a punishment against individuals who could not be removed otherwise for want of legal and other technicalities. The Madras Government demurred and would not listen to the objections raised by the Civil Surgeons though it was plain that law and reason was on the side of the contending party of Civil Surgeons. But the definition of "right or wrong" being in the hands of the Government they could dictate especially



to those under their employ what is right and what is wrong. Fortunately in this particular case the Madras Government could not say the last word as to the reduction of cadre and the existing rules forced them to take at least the formal sanction of the Government of India. The atmosphere at the Central Government being naturally different from that prevailing in Madras, the plea of Civil Surgeons seems to have been upheld. Having lost a straight battle, we are told, that the Madras Government are digging trenches. We learn that they have addressed the Government of India that the Madras Government is determined to reduce the cadre in the Provincial Medical Service as a far sighted economical measure and that the Government of India should yield to their request; and in case the Civil Surgeons could not be sent out in the way suggested by the Madras Government, the Government of India should take back all the Military Assistant Surgeons now under the employ of the Madras Government. We hope that the adage "out of evil cometh good" will become true and a long wanted reform will be brought into effect out of this warfare and that the Madras Government will not hesitate to change the venue.

**Bombay Medical Council**: We cannot congratulate the Bombay Medical Council on the decision arrived at by them at the last October session, in erasing the name of one Dr. V. R. Kulkarni, L.C.P.S from the Register for having engaged himself as a canvasser under a firm dealing in proprietory goods. The Council "adjudged him guilty of infamous conduct in a professional respect". To our mind "infamous conduct in a professional respect" is quite distinct from "breach of medical ethics" and the punishment for both cannot be identical. The former is certainly a grave offence and the latter cannot be treated as an offence in the manner "infamous conduct in a professional respect" should be. All the provincial medical councils including that of Bombay have slavishly copied the "Warning Notice" as appearing in the British Medical Register with little or no regard to the conditions prevailing in India. We refer our readers to the "Warning Notice" and also to the Code of Medical Ethics as published by all the provincial medical councils in India. It will be seen that under the "Warning Notice" are published under different heads what really constitutes "infamous conduct in a professional respect" the highest punishment for which is the erasing of the name from the Register. Under the published Code of Medical Ethics appear several items for which no punishment has been specifically mentioned and therefore the breach of medical ethics mentioned under those items does not constitute an offence of the nature of "infamous conduct in a professional respect". Under the Code of Medical Ethics published, advice is given "that when a member is requested to attend a patient already under the care of another practitioner (the case not being of emergency) he should decline to do so except in consultation with the practitioner in attendance or in case the consultation be not agreed to, until the practitioner in attendance has been informed (in writing if possible) that his services are not required." The breach of this ethics cannot be less harmful to the profession than the one for which Dr. Kulkarni was punished by the Bombay Medical Council. The alleged breach of ethics to which Dr. Kulkarni fell a prey and the one just referred to above are published under the heading "The Code of Medical Ethics" and according to the decision arrived at by the Bombay Medical Council the breach of ethics in attending on a case already under the care of another practitioner should be punished as severely. But in Madras when a reference was made to the President of the Madras Medical Council about this breach, the President opined that there was no penalty for the breach of medical ethics and said that the only remedy was a social boycott by the profession. The President, General Medical Council, Great Britain to whom the breach of such ethics was referred to, was also of opinion that "it is improbable that the council would take action in such a matter". Advertising and canvassing for the purpose of obtaining patients may according to the "Warning Notice" come under "infamous conduct in a professional respect" and not "taking any part in the manufacture or sale of a proprietory food or medicine" which comes under the Code of Medical Ethics and if there can be no penalty for breach of one item of the Code of Medical Ethics there cannot be any punishment for the breach of another item under

the same heading. Even in Great Britain the General Medical Council did not punish practitioners for "infamous conduct in a professional respect" until and unless a warning was issued to the profession regarding matters which, the Medical Council thought, deserved a penalty. It took several years even for the General Medical Council to take notice of "infamous conduct in a professional respect" and they did so after publishing the "Warning Notice" referred to above. While, in India the "Warning Notice" published in England has been taken as law by the provincial medical councils but even then it is preposterous that the Bombay Medical Council should confuse issues between "infamous conduct in a professional respect" and "breach of medical ethics" which cannot for a moment be considered as an offence demanding the highest punishment. So, we are bound to say that there is a grave miscarriage of justice. The fact that the Bombay Medical Registration Act does not provide for an appeal to the Government against the decision of the Medical Council as is the case in Madras, makes their judgment still more harsh if not cruel. We are told that Dr. Kulkarni requested the Council to give him three months' time when he could relieve himself from the obligation of a contract with the firm under whom he was employed at present and that the Council was adamant and decided to erase his name. Under the circumstances, the highest the Bombay Medical Council should have done, was to warn Dr. Kulkarni. We wish the Bombay Medical profession takes up this case and with the help of the peoples' representatives in the Bombay Legislative Council amend the Bombay Medical Registration Act to provide for an appeal against the decision of the Medical Council in penal cases or else there cannot be security of justice to the profession by the Bombay Medical Council.

**The Indian Medical Council Bill**: As we are going to the Press we read telegraphic message from the Special Correspondent of 'The Hindu' to the effect that Sir Fazli Hussain and Mr. G. S. Bajpai would, early in February, call in a Conference of party leaders in the Legislative Assembly to canvass support to the Indian Medical Council Bill as introduced in the Assembly. The special correspondent had also telegraphed Government replies to the criticisms and these replies, instead of justifying the attitude of the Government, had made it still plainer that the object of the Bill is nothing more and nothing less than placating the General Medical Council, Great Britain. It is said in the replies that the Government had been contemplating since 1919 to introduce a Bill of this nature and could not and did not do so on account of the then impending constitutional changes and that later the financial stringency tied down the hands of the Government. If the Government of India is honest, faithful and true to their conviction, they should realise that for identical reasons the present time is most ill-suited for introducing a contentious Bill which has been denounced throughout the country both by the public and the medical profession in unequivocal terms. Regarding financial stringency, never has this country with the rest of the world experienced a depression which is being suffered at present. Against the inclusion of the Licentiates within the purview of the Bill a new and most preposterous argument has been put forward by the Government that if the Licentiates are brought in the All India Medical Register along with other degree-holders, the Licentiates would naturally demand a fee of more than Rs. 2 a visit even in rural areas which the rural population could ill afford to pay. It is certainly not worthy of the Government to put forth a plea which on the very face of it will serve no other purpose than exploiting public opinion against the Licentiates. We trust that the public as well as the medical profession will join hands and demand with one voice that the Indian Medical Council Bill be withdrawn.

**Medical Council Election in U. P.**: The tactics and weapons used by the contending parties at the recent election for a seat to represent the Licentiates in Government service in the U. P. Medical Council, are alleged to be of a nature that even the successful candidate cannot be proud of his achievement. We do not wish to allocate the blame beyond mentioning that failure and success do not always mean what they denote on their surface. Actions and events good or bad will yield results in spite of such failure or success, and those who have been responsible for such actions will, sooner or later, realise, or others will make them realise, the effect of their actions. Those who have read stories of Ravana and the Kauravas in the Hindu Epics and similar stories in the Holy Bible and the Holy Koran, may well appreciate when we say success always does not lead on to success and failures more often suffered for good and honest purposes, will eventually open the highway for success. Having said so much about the election in U.P. Medical Council on reports we have in our possession, we congratulate the successful candidate, Rai Sahib Dr. Ram Narain Lal, the sitting member, who, we are told, was on the last occasion returned unopposed. We point out to him in the interest of the class whom he represents that this time he had 172 Licentiates on his side and his rival could on his individual capacity command a support from 127 brethren of his. It is also to be noted that Rai Sahib Dr. Ram Narain Lal is the General Secretary of the All-India Medical Licentiates' Association and the election was conducted using the weight of the position occupied by the candidates and their supporters in the All-India Medical Licentiates' Association. The recent annual Conference of the Association held in Madras must have, we presume, given to all concerned an insight into the working of this Association, and it is not for us to say anything more than appealing to all individual members belonging to this humble, yet noble fraternity to open their eyes so that the All-India organisation serves the Association as a whole and not individual interests.

**Trichy District Medical Association**: We congratulate the Association on their having completed one full year of good and useful work, a report of which was given by its energetic Secretary Dr. P.A.S. Raghavan at the annual gathering held on 23-12-32 under the presidency of Dr. S. Rangachari, who in a brief speech exhorted his audience that "medical men should not seek advice but gather experience"—a motto consistent with the new cult of J. Krishnamurthy who is revolutionising Theosophy. We wish the Association many years of usefulness under the guidance of its present President and Dr. T. S. S. Rajan, the origin-founder.

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## Correspondence, Reports, etc.

[We regret that for want of space we could not publish several reports and letters from our correspondents which will be published in the next issue. Ed.]

### The 25th All-India Medical Licentiates' Conference.

PERSONAL EXPLANATION.

I very much regret that I have been forced by circumstances beyond my control to make use of the columns of The Medical Practitioner for a purpose which might on the face of it appear to be personal. The 25th All-India Medical Licentiates' Conference is now an event of the past, but matters which are associated with the Conference before and during its session are likely to be noted for the purpose of being counted upon for fair or adverse criticisms. I had no hand in inviting the Conference to Madras. I enrolled myself as a member of the Reception Committee as a matter of duty, and later was selected by the Reception Committee to be its General and Publicity Secretary. Due to a domestic calamity and my subsequent ill health, I could not function to the extent I would have otherwise, though I faithfully discharged my duties to the utmost I could.

At the very first meeting of the Reception Committee which was presided over by Dr. U. Rama Rau, it was pointed out by me and by Dr. K. B. Bhujanga Rao that we were not justified in enrolling non-members of the Association as members of the Reception Committee, as, according to the existing constitution of the Association, non-members could not take part in the deliberations of the Conference. But those that gathered at that day's meeting decided to enrol non-members also. Later, about a week before the Conference met, the position and functions of the Chairman of the Reception Committee and the General Secretary, during the Conference session, were discussed by the Executive Committee of the Reception Committee, at two of its meetings, and it was agreed that the convention observed in 1916 at Madras, when the All-India Conference of Medical Licentiates met in Madras for the first time, should be not only followed but pressed on the existing office-bearers of the Association, as the Reception Committee has to serve both the Association as also the members of the Licentiate class who had enrolled them-

selves as members of the Reception Committee and who were not members of the Association.

It was also decided that the Agenda for the Conference should be drawn up by the General and Publicity Secretary in such a way that the interests of the All-India Medical Licentiates' Association do not clash. Accordingly the following resolutions were passed by the Executive Committee:

1. As there is nothing stated in the existing regulations and bye-laws of the All-India Medical Licentiates' Association regarding the position and the function of the Chairman of the Reception Committee and also of the General Secretary for the Conference, and as there is a large number of members of the Reception Committee who are not members of the Association and as there is an existing convention that the Chairman of the Reception Committee is the President for the official year, it is resolved that the Chairman of the Reception Committee should occupy the Presidential Chair and both he and the General Secretary be ex-officio delegates for the purpose of the Conference.

2. Resolved that a Committee consisting of the General Secretary of the Association, the Treasurer and the Secretary, Finance Committee, help the General and Publicity Secretary of the Conference to prepare the list of delegates for the Conference in general and also for the Conference with regard to the discussion of the items specially pertaining to the constitution of the All-India Medical Licentiates' Association.

3. Resolved that Drs. Ranganatha Rao, Bhujanga Rao, Venkappa, Gopal Rao, and Subbarayadu be selected as delegates to represent the Reception Committee at the ensuing 25th All-India Medical Licentiates' Conference.

It was also formally agreed that in case the office-bearers of the Association do not consent to allow the Reception Committee to run the show, the Reception Committee should continue to be hosts but should not take part in the proceedings of the Conference.

As soon as the General Secretary of the All-India Medical Licentiates' Association arrived in Madras, I forwarded to him the above resolutions and explained to him in person our understanding. He would not agree to abide by the resolutions; and at an informal conference held later, Dr. U. Rama Rau yielded to the General Secretary. Yet, as I was bound to obey the mandate I had from the Executive Committee, I, with the previous permission of the Chairman of the Reception Committee, circulated the Agenda prepared by me in consultation with him.

At the first meeting of the Subjects Committee, I explained my position and the responsibility of the Reception Committee to the non-members of the Association. Dr. U. Rama Rau was proposed by one of the members of the Reception Committee to the chair and this was opposed by the delegates of Bengal and U. P. *en bloc*, who were in majority, and after great confusion Dr. Rama Rau retained the chair. The delegates chosen by the Reception Committee were not allowed to represent the Reception Committee and they withdrew after protest. I told some of the members of the Reception Committee that were present that I too would withdraw and requested Dr. Rama Rau to do likewise, but my colleagues thereupon advised me to be present at the meetings of the Subjects Committee at least to watch the interests of the Reception Committee as Dr. Rama Rau preferred to continue to be the President. The situation was such that I thought that discretion was the better part of valour and was present at the meetings of the Subjects Committee on two days, but was not able to do my duty either to my Province or to the Association.

I request the members of the Reception Committee, especially those outside Madras who are not likely to know all about the Conference to excuse me if I have not in their opinion discharged my duties expected of me as their chosen representative at the 25th All-India Medical Licentiates' Conference. I hope to contribute a special article in the next issue of The Medical Practitioner wherein I shall give a detailed report of the events relating to the Conference.

V. Rama Kamath,
*General & Publicity Secretary.*



## Rural Medical Relief.

The following is an instance of how rural medical practitioners fare under their Presidents and what relief they get from the higher authorities:—

"The Transfer of Mr. A—— from the rural dispensary, ——, had to be made as a result of personal representations made by some of the Taluk Board members and owing to exigencies of service and the transfer made is chiefly one on public grounds."

The practitioner refused to move from the place; and gets the following letter:—

"Mr. A——is requested to hand over charge of the dispensary to Mr. B. forthwith and report his having done so, failing which, the undersigned will be driven to the painful necessity of taking due action against him for his insubordination and disobedience of orders.—— (Sd.)——, President, Taluk Board,——."

His services are dispensed with and he appeals to Government with the following result:

"The Government consider that the action of the President, Taluk Board,—— Y in transferring Mr. A.——rural medical practitioner from X to Z was irregular and contravenes the instructions contained in G.O. No. 1154 P.H. dated 14-6-1927, but having regard to the insubordinate conduct of the medical practitioner, the Government are not prepared to interfere with the action of the Taluk Board in terminating his services."

(By Order of the Government,
Ministry of Local Self-Government)
(Sd.) ——,
Deputy Secretary.

The following is the relevant portion of G.O. No. 1154 P.H. dated 14-6-1927:—

"ORDER:—The Surgeon-General is informed that the object of the scheme approved in G.O. No. 1522 P.H. dated 22-10-1924 was to induce *private practitioners* to settle permanently in rural areas and to build up a permanent practice there. The transfer of such practitioners from one dispensary to another will therefore frustrate the very object with which the scheme was inaugurated and *should under no circumstances be made.*

A subsidised practitioner is transferred from one dispensary to another, but the private practitioner as he has been declared to be taken his stand on G.O. No. 1154 P.H. dated 14-6-1927 refuses to move, his services are dispensed with because of his insubordinate conduct. Government are willing to wound but afraid to strike; they would fain interfere, had it not been for the insubordination of the practitioner. It is not clear as to how there can be any insubordination between equal parties to an Agreement. Assuming that an insubordination was there, it would be worth while considering as to who was guilty of it at the first instance, whether it was the practitioner who respected the Government Order and resisted the attempts of the President, Taluk Board, to violate it, or the latter. The President, to say that he made the transfer on public grounds, is, to say the least, disingenuous. If he was sure that the practitioner was guilty of any illegal act the proper course for him would be to dispense with the practitioner's services on that score after the usual procedure. The fact is that there was nothing wrong on the part of the practitioner, but the President simply wanted to bring to X another rural medical practitioner from B, and he could not do it in any other way.

Granting that the practitioner A had obeyed the President's order under protest, handed over charge of his dispensary to the new comer, appealed to the Government, and the latter ordered his reinstatement, the practitioner would still then be not reinstated, as the President determined to oust him, would brave any number of G.Os. It did happen so in another instance, where Government twice ordered the reinstatement of a particular practitioner unjustly ousted, on pain of the discontinuance of the subsidy, but the President, Taluk Board, did not; Government could do nothing in this instance but merely stop the subsidy in respect of the dispensary.

This is one of the many instances of what weight Taluk Boards attach to Government Orders, and on what frail a frame does the lot of subsidised practitioners depend. It would be time enough for the Government to adopt such measures as to bind the Taluk Board to stick to rules, consistent with and to achieve the objects of the scheme.

The saying that "one man's meat is another man's poison" becomes evident from this instance. One practitioner wants a

transfer, and another does not. If Presidents act against rules, one would not be far wrong in saying that they are induced and encouraged to do so by the practitioners of the first type by their slavish mentality in dancing to any tune sent by their Presidents, just for a few crumbs the latter would give them. It would be true to say that a greater blame attaches to the practitioners than on the Presidents, and the former would be consulting their interests better, if they would adhere to rules. There would certainly come a day when with the change in the personnel of the Board and its President, they would be singled out for maltreatment, and would have to rue for their past conduct. They are sure to fall from the graces of their Presidents, as courtiers do one day or other. So, to be forewarned is to be forearmed.

'Sufferer'.

## U. P. Medical Council Election.

In the course of an election manifesto Dr. Kunj Behari Lal Varma has sought unwittingly, I presume, to cast aspersions on the Finance Committee of the All India Medical Licentiates' Association. He has made use of a letter of the Ex-Editor who has had to resign and a resolution of the U. P. Standing Committee of the Association which will not bear examination. The Finance Committee of which I am the President is accused of being extravagant. The extravagance consists of an excess expenditure of Rs. 45/1/6 over the amount allotted for the year. Considering the work done by the Finance Committee and the correspondance involved the sum is mighty little. Owing to the vigilance of the Finance Committee the Association has today in hand a sum of Rs. 43,455/2/ as against Rs. 27,760/10/8 which it took over from the previous committee. I have no reason under the circumstances to be worried over the paltry increase in expenditure. I shall not say anything about the Editor except that he has at least made good the sum of Rs. 1288/12 which the Inspection Committee has found was due from him. The aspersions against the Secretary of the Finance Committee are thus grounded.

RAI BAHADUR HARI RAM SINGH,
Chairman, Finance Committee,
Delhi.

## G. O. No. 1932 P. H. Dated 9th September, 1932.

Hitherto every rural medical practitioner, used to get his subsidy, plus, the Local Board's contribution, if any, by money order from their respective Taluk Boards. This sort of payment of the subsidy worked satisfactorily in almost all the Taluk Boards. It seems that the Rural Medical Practitioners' Association, brought to the notice of the Government, that in certain Taluk Boards, the payment of the subsidy was being delayed, and was not prompt and regular. Of course, this will only be an exception and not the rule. Presumably upon this complaint the Government have ordered in the G. O., quoted above, that the bills claiming the subsidy, should be passed for payment by District Medical Officers and the rural Medical Pratcitioners will have to get it cashed, in the Government Treasury.

As the very name indicates the rural Medical Practitioners, are scattered in rural parts, and the Government Treasuries are in Taluk Head-quarter stations. There are many rural dispensaries which are over 30 miles away, from the Taluk Treasuries. Now it is more or less a problem for the rural medical practitioners, every month, to arrange for the cashing of the bill. In some cases, the cashing of the bill, involves one full day and an expense for conveyance of Rs. 2-8-0, every month. This is a great hardship to many of the Rural Medical Practitioners. The remedy has become worse than the disease. We can rather put up with a few days' delay, in getting our subsidy, than to spend Rs. 2-8-0 every month.

In some cases the Taluk Boards' subsidy exceeds Rs. 20/ and for that every month, an additional stamped receipt, in addition to the one for Rs. 41-10-0 have to be given. So there are 2 stamped receipts every month whereas formerly there used to be one. This is an extra expenditure.

Therefore either the old system of sending the subsidy by money order, by the Taluk Boards concerned may be ordered, or in the alternative, the Taluk Boards may be advised to give the necessary charges incurred, in cashing the bill, every month.

A. SUBRAMANIAM,
Rural Medical Practitioner,
Pudupalayam.



*List of Postings of Sub-Assistant Surgeons for the month of November 1932.*

| No. | Name of Sub-Asst. Surgeons. | From | To |
|---|---|---|---|
| 1 | D. Nallathambi Pillai | L. F. Dy, Kadayam | Govt. Hl, Nanguneri. |
| 2 | P. Narasappayya | Govt. Hl, Nanguneri | c/o P. D. B., Tinnevelly. |
| 3 | M. Goparaju | Govt. Hd. Qrs. Hl, Masulipatam | Govt. Hl, Rajahmundry. |
| 4 | S. T. Thiagarajan | c/o Munl, H. O., Negapatam | c/o P. D. B,, Tanjore. |
| 5 | B. S. Sahasranaman | Govt. Dy, Krishnadevipeta | L. F. Dy, Sathiyavedu. |
| 6 | U. Ramankutti Nayar | L. F. Dy, Satyavedu | Govt. Dy, Krishnadevipeta. |
| 7 | T. N. Devaraja Ayyar | Govt. Hd. Qrs. Hl, Trichy | L. F. Dy, Musiri. |
| 8 | R. Krishnaswamy Ayyar | L. F. Dy, Musiri | Govt. Hd. Qrs. Hl, Trichy. |
| 9 | N. Sundara Rao | Govt. Hd. Qrs. Hl, Masulipatam | Munro's Hl, Gooty. |
| 10 | A. M. Krishnan Nambiar | Leave | L. F. Dy, Peyyanur. |
| 11 | C. R. Narayana Ayyar | L. F. Dy, Peyyanur | c/o P. D. B., Malabar. |
| 12 | T. A. Gopalakrishna Rao | L. F. Dy, Trithala | Central Jail, Salem. |
| 13 | M. A. Seshan | Central Jail, Salem | L. F. Dy, Harur. |
| 14 | K. Varadarajan | Estt. of the Asst. Agent, Bhadrachalam | L. F. Dy., Kunnavaram. |
| 15 | A. Susaimarian | Leave | Govt. Hd. Qrs. Hl, Madura. |
| 16 | B. V. Suryanarayana | Govt. Hd. Qrs. Hl., Nellore | Govt. Hl, Kandukur. |
| 17 | K. Suryanarayanamurthi | Govt. Hl, Kandukur | Govt. Hl, Kanigiri. |
| 18 | K. Panduranga Prabhu | Leave | Govt. Hd. Qrs. Hl, Ooty. |
| 19 | S. V. Krishna Rao | Govt. Hd. Qrs. Hl, Ellore | c/o Inspr. Genl. of Prisons. |
| 20 | T. C. Sitaram | Govt. Hd. Qrs. Hl, Cuddalore | c/o P. D. B., Tanjore. |
| 21 | C. Ramamurthy | Central Jail, Rajahmundry | Govt. Hl, Kanigiri. |
| 22 | Md. Ayubkhan | Govt. Hd. Qrs. Hl, Cocanada | Govt. Hd. Qrs. Hl, Ellore. |
| 23 | I. V. Narasimham | Leave | L. F. Dy, Vayalpad. |
| 24 | C. Narayana Menon | c/o Special Asst. Agent, Parvathipur | Govt. Hl, Cochin. |
| 25 | V. N. Narayana Ayyar | Leave | Cauvery Mettur Project Headworks Hl, Mettur. |
| 26 | S. N. Nilakantan | Cauvery Mettur Project Headworks Hl, Mettur | c/o Principal, Madras Forest College, Coimbatore |
| 27 | P. V. Subba Rao | Leave | c/o P. D. B., Kurnool. |
| 28 | S. Venkataramayya | L. F. Dy, Chegalamarri | Munl. Hl, Nandyal (Tempy). |
| 29 | M. B. Victor | Leave | Govt. Hd. Qrs. Hl, Coimbatore. |
| 30 | P. J. Asirvatham Pillai | Govt. Hd. Qrs. Hl, Ramnad | L. F. Dy, Sankaranayinarkoil. |

## Reader

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