VOL. IV. NO. 11 AUGUST 1933

The Medical Practitioner

A Monthly Medical Journal

EDITED BY

Dr. M. S. Krishnamurthi Ayyar, M. B. & C. M.,

Retired Sanitary Commissioner, Travancore State.

AND

Dr. V. Rama Kamath,

Member, Madras Medical Council.

CONTENTS.

THE Medical Practitioner

Annual Subscription { Inland Rs. 2. / Foreign Rs. 3. } Single Copy As. 4.

VOL. IV.] AUGUST, 1933. [NO. 11

ADVERTISING.

The British Medical Association which held its annual session recently passed a resolution allowing the advertising of public medical services, i. e., services organised by a group of doctors to give medical aid to the public who subscribe towards the scheme organised by such doctors. Such service may be an out-patient or in-patient department for general or special diseases, the subscription collected from the public being utilised by those who run such public service schemes. The necessity for this change in the angle vision of that most orthodox Association seems to be pelf which prevailed over prestige. In London and other important cities in Great Britain there exist contributory schemes connected with public hospitals, run in such and similar names as Hospital Saving Association, in addition to Health Insurance Schemes and other schemes, the contributor of which by paying a nominal subscription becomes entitled to treatment in the out-patient departments of the big hospitals even if he be rich enough to pay for the services of a doctor. The British Medical Association in its righteous indignation against the Hospital Saving Scheme went in fact so far as to authorise the employment of agents to bring the public medical service schemes to the notice of potential subscribers. The action of the British Medical Association is certainly a big climb down from the very high notions of Medical Ethics. Ethics, whether it be concerning the medical profession or any other, is really a code of conventions which, however much hoary they may be at one time, have to yield to times and circumstances. Consequently these conventions should lose much of their significance.

In India affairs of the medical profession are quite different. It is entirely under the control of paid service with the Surgeon-General at its head. There does not exist a medical association of the solidarity and influence of the British Medical Association who have been not only able to guide the destinies of the medical profession but dictate a code of Ethics to be incorporated in the statute of that country, the British Medical Act. It should also be said that paid medical service in Great Britain is an insignificant minority and that there is not such an office as the Surgeon-General or the Inspector-General of Civil Hospitals presiding over the medical services. When the Medical Acts were passed, the Government had to depend upon the advice and guidance of the Heads of the Medical Department who had no original ideas as to what shape the Medical Acts should take in this country and copied everything from the British Medical Act and with it the code of Medical Ethics. Even in the matter of copying the British Act they were not faithful. They have sedulously omitted from the Act such portions which would have made the Medical Councils real democratic institutions as the British Medical Council is. The result has been that the Medical Councils exist only in name. They are ineffective for the purpose for which

they were brought into existence as the Surgeon-General and Inspector-General of Civil Hospitals wittingly or unwittingly have been usurping the powers of the Council as was pointed by us in these columns some time ago when we discussed the necessity of reforming the existing Medical Councils in India. Even in the matter of breach of the Medical Ethics there does not seem to be uniformity in the method of its application. The members of the profession in service are dealt with by the Surgeon-General or Inspector-General departmentally for such breaches and escape the punishment of their names being erased from the Medical Register, while their brethren in private practice if complained against have to undergo the ordeal of a trial by the Medical Council and stand the risk of his name being erased from the Register. Practically, the Medical Acts, as now worked upon, with the Official President as the Head of the Medical Councils, are a menace to the growth of the independent medical profession instead of a boon to protect its rights and privileges and help its growth, as is the case in other civilised countries.

In the matter of publicity also the existence of paid medical service has made it possible for the members of such service to get more publicity for the professional work they do. In addition to the eulogy usually seen in administration reports of the public hospitals about the work of those who run them—which perhaps cannot be helped, and hence not so objectionable—it is customary to find reports of good work turned out by medical officers in lay newspapers on the occasion of the opening of new wards or extension to hospital buildings and the latest development in the publicity by State-paid doctors is the report of lectures delivered by them in which the lecturers give a description of the nature of services rendered to their patients and the success achieved. There were instances in Madras when announcements were made in the lay newspapers of the opening of special departments for the treatment of patients, calling upon the public to take advantage of the services of the doctors employed by the Government for conducting such special departments.

We do not wish to sit in judgment if the publicity gained and earned by medical men in charge of public institutions amounts to advertising either direct or indirect. But we are bound to say that State-paid doctors are distinctly in an advantageous position in the matter of publicity which is inherent in the positon they occupy. All of them are whole-time officers of the State and are paid quite adequately. They are in addition enjoying unhampered privileges of private practice and, in some provinces such as Madras, they are even allowed by the Government to run public nursing homes and such institutions of public utility. Consequently the publicity these officers earn by virtue of the position they occupy indirectly or directly advertises them in their private capacity and adds to their gain. So if the times and circumstances now prevailing in Great Britain has persuaded the British Medical Association to change the old notions of advertisement and made them pass a resolution allowing the advertising of public medical services as referred to above, it is high time for the members of the independent medical profession in India to consider the desirability of proper publicity of the nature of work done by them to relieve human suffering. If public medical services could be run and advertised by a group of medical men, why not such services be conducted and advertised by one individual, so long as the advertisement is not contrary to public interest and discreditable to the profession? A medical man advertising himself as healer of all diseases may be discreditable to the profession and contrary to the public interest. But if a medical man advertises in lay papers his name and qualifications, in what way will it be injurious either to the profession or to the public? We will go even a step further. Supposing a doctor has specialised himself in a particular branch of Medicine or Surgery in a recognised institution here or elsewhere, why should he not mention it publicly? Such harmless advertisements couched in dignified language without exaggeration will certainly have a very beneficial effect, as such publications in the lay press will prevent the public from being deceived by quacks, who usually by persuasive and exaggerating language have been able to deceive the suffering humanity in this country.

Sometime ago the Madras Medical Council appointed a Committee at the instance of Dr. V. Ramakamath who moved a resolution at the Council that there

was a desirability to change the code of Medical Ethics to suit the local conditions and we wrote in these columns about the necessity of permitting members of the profession to advertise in a harmless and dignified way and that, if necessary, such advertisements may be first sent to a committee of the Medical Council for the purpose of censoring them before publication. Unfortunately nothing came out of this resolution nor could that be expected at present when the Council has a majority of nominated councillors with the Surgeon-General as the President. The Committee appointed by the Council to consider Dr. Kamath's resolution permitted only one change in the existing rules of Ethics. Registered medical practitioners were not permitted to publish the scale of fees for services rendered to their patients. The Madras Medical Council on the recommendation of the Committee referred to above permitted registered practitioners to publish the scale of fees in their consulting rooms. The members of independent medical profession should thank the Madras Medical Council for this small mercy and should now consider seriously about the desirability to bring about a change in the existing Code of Medical Ethics in India which, as adverted to above is a copy of that published by the General Medical Council and suggest such changes which, while being in no way contrary to the public interest and not discreditable to the profession of medicine, might help them to make a living.

The Indian Medical Association, an All-India body of medical men consisting of members of medical profession of all grades, meets in Bombay next Xmas. There will be also a conference of the members of All-India Medical Licentiates Association also meeting in Bombay during Xmas week. We trust both these bodies will discuss about the desirability of revising the Code of Medical Ethics to suit present times and circumstances so as to enable the members of the independent medical profession to live a good and contented life in the midst of unequal and unhealthy competitions brought about in the profession on account of the existence of the paid medical service, not to mention about the rivalry they had to contend against charlatans and quacks, of a variety of systems of medicines in this country.

Original Articles

TATTOOING OF THE CORNEA

BY

DR. G. JOSEPH GNANADICKAM,

SWEDISH MISSION HOSPITAL, TIRUPATTUR, RAMNAD DISTRICT.

Tattooing of a corneal scar to the colour of the rest of the black of the eye is an operation of considerable cosmetic value and is of a very ancient date. In Indian eyes, it is a simple process as any dark stain is good enough and the Indian Ink has been for a long time a convenient material. It is still used by many in this country.

There are many practical disadvantages with the Indian Ink method of tattooing. The stain is not always permanent. A scar looking quite black immediately after the operation may appear faded in a few days, many of the ink particles having been washed out from their more superficial puncture holes and consequently it has been necessary now and then to redo the operation many times. Secondly the severe Trauma caused to the corneal tissues is likely to lead to serious consequences. At least after-pain it causes to the patient can scarcely be avoided. Lastly, it cannot be uniformly used on all maculae, especially if the cornea be thin or there be iris inclusions in the scar.

In 1925, Knapp suggested a new staining of the cornea by impregnating Gold into the Corneal Stroma. Gifford aud Steinberg tried to improve the effect with the addition of Silver. Instead of these two, Krautbauer introduced Platinum, using Hydrazin Hydrate as a reducing agent.

After an interesting experiment with all these three noble metals,* we have been able to obtain gratifying results from Gold and Platinum Chloride combined, the reducing agent being the Hydrazin Hydrate. Our experience has been more or less similar to that of different investigators in

* Dr. F. Kugelberg published his results with Gold and Silver in the journal of the All-India Christian Medical Association, July 1928.

the West and there have been many papers in the English Medical Literature in the last five years but the fact that the old tedious, often unreliable and sometimes dangerous operation with the ink is still practised by many in India is my only excuse for a fresh paper on the subject. It will be seen the technique is as simple as it is safe and can be usefully tried by any one with a little experience in eye work.

The drugs required are Gold Chloride solution 2%, Platinum Chloride solution 2% and Hydrazin Hydrate solution 2%. All these have to be prepared in distilled water. The first two stand any length of time provided they are kept in amber coloured bottles. They require no sterilisation as they are antiseptic in action themselves. The Hydrazin Hydrate solution has to be prepared freshly at least every week. It is economical to prepare it just on the day of operation in this way:—One drop of the original Hydrazin Hydrate solution is added to fifty drops of distilled water in a small cup and this gives the required solution for use in its approximate strength. The Gold Chloride can be purchased from any photographic dealer and Platinum Chloride from Messrs. Burroughs Welcome & Co. Hydrazin Hydrate is a preparation by Merck.

The instruments required are a speculum and a small sharp spoon, or an old cataract knife. Perhaps, in restless eyes, a fixation forceps may be needed in addition. We use sterilised cotton wool swabs mounted on kuchees for applying the drugs to the cornea.

The operative technique is as follows:—The eye is anaesthetised with sol. Cocaine 4% or sol. Pantocaine 1%. I prefer the latter as it causes no injury to the corneal epithelium while on the other hand it hastens in a way its regeneration.

With the speculum in, the eye is given a wash with saline or any indifferent sterile solution. The epithelium over the area of the macula is carefully scraped off with the spoon or the knife—or as a matter of fact, any sharp instrument will do for the purpose. It is always wise to first outline the margins of the area to be stained before the central portion is touched. This will prevent any unwary denudation of the epithelium over the normal cornea; for it must be remembered that every raw surface, on the cornea will take up the stain. After the margins have been limited, the rest of the area of the macula to be tattooed is cleared off its epithelium and a little of the most superficial layer of the corneal stroma also is scarified. The latter may not be necessary on a thin cornea, especially where there is a small staphyloma in addition. The scraping should leave a smooth, even surface. The appearance of the tattooed area depends largely on the evenness of the surface.

After this is done, a cotton wool swab (mounted on a kuchee preferably) is soaked in the Gold Chloride solution and pressed over this raw surface. It is better, but not absolutely always necessary, to see that the excess of the fluid does not spread all over the eye. By practice one can easily learn to take just the quantity required in the swab. This swab is made to be in contact with the raw surface on the cornea for about $1^1/_2$ to 2 minutes. A gentle pressure helps the fluid to permeate into the corneal tissues a little more quickly. The denuded surface acquires by now a slightly yellowish tinge.

The Platinum Chloride solution is next applied quite in a similar manner for a minute or two.

The Hydrazin Hydrate solution is now applied over the area thus treated—this also with a similar swab—and the whole macula is immediately turned black. It is not necessary to apply any pressure here. A gentle swabbing is enough to reduce the Gold and Platinum Chlorides.

The eye is next gently washed with saline or any indifferent fluid and bandaged. No antiseptic drops or dressings are necessary.

The after treatment is practically nil, except to keep the eye clean with a drop or two of Sol. Zinci every morning. The bandage is taken off as soon as the epithelium covers over. The full regeneration of the epithelium takes place in 2 to 5 days depending on the extent of the area denuded.

Nervous people may complain of a slight pain in the first few hours after the anaesthesia fades away. It is easily relieved with Aspirin. Beyond this complaint, the operation is not as a rule followed by any untoward reaction or discomfort.

The principle in the operation is to impregnate the Gold and Platinum Chlorides into the corneal stroma and reduce them into Gold and Platinum respectively with the powerful reducing agent, Hydrazin Hydrate. (Previously Adrenalin and Tannic Acid were used instead of Hydrazin Hydrate, but the resulting stain was not so dark.) The Gold deposits gradually migrate into the deeper layers. Microscopical sections of tattooed eyes show that they occupy about the middle third of the cornea. The platinum precipitates on the other hand do not get down so deep but remain at the anterior third. The object of using both Gold and Platinum combined will thus be evident. The resulting stain is deep, dense and dark.

The results of the operation are permanent in uncomplicated scars. In some cases, a slight fading away of the colour is seen after a few months due to the migration of the pigmentary particles, but that is not marked enough to need a retattooing.

In vascular scars, however, we occasionally see one or more small white patches on the tattooed area from the absorption of the stain by circulation. A second or very rarely a third tattooing may be necessary in such cases.

The special advantages with this operation is its adaptability to any corneal scar. The best results are of course obtained in free, uncomplicated maculae. But, scars with iris inclusions, vascular leukomata and scars with a thin cornea can also be tattooed by this technique, whereas the ink and needle method is fraught with unnecessary risks in such cases.

In the many hundred cases of tattooing with the Gold and Platinum that we have done in this hospital, there was only one instance of a complication and that in the beginning of our trials. It was a case of an adherant luekoma with a thin cornea. A mild iritis started up within a few days of the operation, but it subsided in two weeks. The irritation was probably due to the migration of the Gold particles into the anterior chamber. Perhaps, if we had been less vigorous in the scarification of the corneal stroma, this complication would not have arisen. It has been suggested that where the cornea is thin, tattooing with Platinum alone may be advisable as it has no tendency to migrate deeper, but our further experience has shown that Gold can also be used in such cases without risk provided the scarification is slight, depending on the nature of the corneal thickness.

There is no complication worth mentioning in the operative process itself. In vascular scars, there may be a light bleeding. This has to be swabbed off before the Gold Chloride is applied.

In restless eyes, the fixation forceps may be used. The conjunctiva may get stained if the tattooing solutions flow over the pinched surface, but it sheds off the stain the next day.

The comparative simplicity of this operation and its freedom from complications should certainly enable any one with a little knowledge in eye to freely try it. One who is still using the old ink and needle method will soon discover how safe, simple reliable and less painful this tattooing is in comparison with the old one.

THE LEPROSY CLINIC.

By

DR. I. SANTRA, L.M.P.,

MEMBER, INTERNATIONAL LEPROSY ASSOCIATION, PROPAGANDA OFFICER, BRITISH EMPIRE LEPROSY RELIEF ASSOCIATION (INDIA COUNCIL).

The leprosy clinic aims at making the N1 and N2 cases free from all active signs, sterilising the 'C' cases, becoming a feeder of cases needing special treatment to the nearest leprosy hospital and relieving it of its non-infectious cases. It treats and teaches the lepers how to live to their own advantage without spreading infection to their dear ones. If the doctor in charge has time, he can examine contacts and tell the villagers what to do and what not to do to avoid leprosy. From its working the state can get an idea how long will it take to control leprosy in a given area.

The chief advantages of a leprosy clinic are its cheapness, and the voluntary exercise that it imposes on the patients. This exercise is essential to counteract overdosing that may happen in absence of technical tests for which the general dispensary man may have no time. The annual expenditure per patient per year is about Rs. 2 in a clinic attached to a dispensary. The patient by attending a leprosy clinic avoids becoming a burden on the state. He supports his family and pays his tax. There are certain villages in India where the incidence is from 10 to 20 per cent. It is impossible and unnecessary to take away all

these men to an asylum. The only way to deal with them is to treat them at a clinic. Where shall we have our clinics? Will they be separate establishments or attached to dispensaries?

If we examine the form for the monthly statement of diseases treated in the dispensaries of India, we find a separate column for leprosy which proves that leprosy treatment is a recognised part of routine medical work. If lepers are not treated, it is due to the fact that either they do not know that the treatment is available or the doctor does not know how to treat. At present propaganda done in villages and the training arranged for doctors are removing the above two obstacles to treatment. Therefore let us now make an arrangement to treat lepers near their homes. Let leprosy clinics be attached to every dispensary situated in endemic areas, with provision for treating the cases during certain fixed hours on a certain day or days in a week.

It may be necessary to have a central clinic where the propaganda-treatment-survey work may be carried out, but I think it is a mistake to detach leprosy work from the general medical work. A clinic with a separate staff has the following disadvantages:—

1. Separate finance—In case of retrenchment this is liable to be affected as it has been now in Bihar and Orissa.

2. It creates the general impression in the minds of doctors, patients and the public that the treatment of leprosy is a special department needing the establishment of special men.

3. A scrupulous doctor may tell the public that leprosy is so vile a disease that the work has to be separated from the general work. Once such belief is entertained, it will be difficult to introduce leprosy treatment into the ordinary dispensaries.

I fully realise the efficacy of a special clinic working under a district leprosy board or district leprosy committee but what I want to impress is this, that unless every dispensary does its share we cannot control leprosy. During my second visits to clinics attached to dispensaries, I found many of them had dwindled away. Doctors told me that patients stopped coming. But when I went to the villages patients told me "Doctor said the party who came to treat leprosy is gone." Let every doctor be made to understand that under the terms of his service he is expected to treat leprosy just as he would treat cases of cholera or small-pox. In a certain province when I requested the I. G. to give an allowance to dispensary doctors for doing leprosy work, he said "No allowance should be given because it is their duty." I think that is the right attitude. Recently in a certain district I found that the leprosy work has collapsed because the District Board has not been able to continue the allowance it gave to the medical officers for leprosy work. Therefore the first step is to obtain for the leper his right of receiving a decent treatment. Once this is achieved the foundation of the leprosy clinic is laid on rock.

We will suppose that after a survey of the surrounding villages, a leprosy clinic has been attached to the dispensary. The clinic should have a map showing the villages with their number of lepers marked in each. A register has to be maintained containing all the details of cases detected. At the end of every year this register should be revised showing how many cases have been arrested, how many sterilised and how many new cases detected by the health department, number dead, number left and new immigrants. Thus the leprosy clinic will practically be worked by the medical and health department, the treatment side being under the former and the preventive side being under the latter. With such an arrangement we can have an idea whether leprosy can be controlled in a certain area and if so, how many years it will take to control it.

We have seen the leprosy clinic in all its aspects but it is wise to remember that it has its limitations. It is not practicable to have clinics in hill areas as in Kulu and the Chin Hills. Lepers in certain parts of Bombay Presidency are so widely distributed and so far away from any communication that it has been said that even in the dry season travelling dispensaries will hardly reach them. Therefore increasing the number of clinics will always call for the extention of leprosy hospitals.

I shall close this paper by answering a few questions that might be asked about the leprosy clinics.

Can leprosy be properly treated in a clinic attached to a dispensary with no facilities for laboratory work? I believe it can. Clinical judgment is the main requirement for successful treatment, but necessary laboratory tests can usually be arranged for at the nearest government laboratory. Are not the patients in a leprosy clinic very irregular in attendance and will not many of them stop coming after a few months or a year? Even at the best clinics with the best doctors regular attendance is very difficult to maintain. Patients have their own way of determining a cure. On the disappearance of visible lesions they think that the disease is cured and therefore stop coming. Villagers have to look after their fields during rains and harvest season. Therefore it may be advisable to substitute the injections with Chaulmoogra pills during the period the patient cannot come.

Can satisfactory treatment for severe reaction be carried out in clinics? This is often a difficulty but provision ought to be made at each clinic for hospitalising at least two patients.

Let us not despair. Higher education has been introduced in India for the last hundred years. Yet 91 per cent of the population are illiterate. Reformers have been working since the days of Ramananda from the 14th century but what reform have we in India? Have the reformers and educationalists ceased to work? Let us have faith and proceed in our noble work to make India free from leprosy.

Abstracts

A SOLUTION TO SOME OF OUR MEDICAL ECONOMIC PROBLEMS.

BY

HYMAN GOLDSTEIN, M.D.,
New York, N. Y.

The medical profession must muster its forces and begin organizing its members into one strong economic organization, to use its united strength in meeting its responsibilities. Medicine is passing through very trying times and the changing conditions present an economic problem that needs immediate solution.

First, we must get up a plan of practical organization. I will suggest that each city call a general meeting of the economic committees from all local medical societies including the country medical society and elect a president, vice-president, treasurer and secretary, and a board of governors consisting of the chairman from the numerous economic committees and alternates appointed by them from their respective committees.

Second, The board of governors shall meet once monthly or more often if need be, to formulate principles, policies and programmes for the main economic body or unit. The latter shall meet monthy to consider and discuss these programmes. The board of governors shall also arrange an occasional economic programme for the local medical organizations and for the county medical society at its regular meeting. Such economic units shall be organized in every county in each state which shall function similarly to the county economic unit. Each should communicate with the other from time to time. There should also be an annual convention of the combined economic units throughout the states at meeting places suitably arranged. Through this means we will get immediate action on all economic problems affecting the medical profession and at ways and means of solving them. We will also have true majority representation and solid medical expression by virtue of this consolidation and concentration of medical organization.

Thirdly, each county medical society through its committee on law and legislation

can designate four members residing in each assembly district to interview the leaders of the political parties in power in the respective districts on legislative matters as they affect the medical profession from time to time. The assemblymen and state senators can be sounded immediately as to what stand they will take in voting for such legislation whether for good, or for bad. From this information we can know how to act, where to exert political pressure and make our power felt to achieve results favourable to medicine, favourable to the public and in safeguarding the public health. By such strong representation from the medical profession in taking an interest in community affairs, the political parties will gladly co-operate with us, respect and honour us, and feel delighted to see us manifest such interest. They will have no excuse in saying "what interest in community health have we shown, or desire to show in public welfare as to health and rightful living." This will give us our big chance. These group or legislative units can appoint one or two members from each state senatorial district throughout each county, which committee or smaller group can arrange a legislative or law programme as will benefit the medical profession. They can operate together with the legislative and law committee of their respective county medical society. They shall combine with and take part in the annual programme at the annual convention with the state economic groups in question.

Fourthly, thus, working harmoniously, by the economic groups taking care of our medical economic problems on the one hand; and the assembly and senatorial districts groups taking care of the legislative matters on the other; enable the county medical societies and state medical societies to receive full co-operation by the majority representation of the medical profession in this work.

Let us not speak only of hard times and starvation. Comparing our conditions to that existing in Eastern Europe we are living in apparent luxury. Those who cry aloud about hard times and lay supine and helpless, have been pampered with a measure of prosperity in the past. We must learn how to help men to help themselves. We should get up a constructive economic programme to lift us out of this rut and muddy confusion in which we wallow, rather than sit aside, do nothing and complain.

Medicines' chief concern about its own affairs must be for the individual physician. It must offer an opportunity for the fullest development of skill, intellect and medical knowledge for the doctor, so that skilled and adequate medical service can be made available for all; as well as the right to make a living sufficient for reasonable comfort for himself and his family. The doctor demands independence in order to give honest, painstaking individual service. The sooner the public is made to realize this, the sooner will both, the public and the medical profession benefit by it. The competency of the profession as a whole depends on the competency of its members. The good of the patient must always be the first consideration in the relationship between the doctor and the patient. Therefore medicine should always strive to retain position and success for the physician, which shall be free from any sort of dependence.

PROBLEMS AND REMEDIES.

Strong organization of doctors is the first requisite. Proper publicity is another. The public should be made acquainted with our work in the public health programme. We should amend the Hippocratic Oath along with the progress of medicine and bring it up to date. Is the dignity and ethics practiced by the American Bar Association and legal profession, United States Supreme Court and lesser Courts of the land, even the President of the United States and his Cabinet, and the publicity they receive in respect to public policy and public confidence, beneath ours? What have we to hide that they have not? And .why should we have anything to hide to stimulate the gullible public to hold us in suspicion, causing them to lose confidence in Allopathic medicine and patronize chiropractors and other cults. The public is entitled to be informed on what are the standards of education required of us as compared with standards required for all cults, which latter should be exposed. In almost every instance these cult schools turn out so called doctors in a few months or one to two years with no definite knowledge of the framework of the body, its physiology, its pathology, or, diagnosis and etiology of disease, and yet they are

permitted to practice upon the human body. However, we must be careful to exclude dishonest methods of publicity for self exploitation that would serve to demoralize medicine. Proper publicity is a stimulus that pushes men on to their best endeavours, and should be encouraged. It also helps to hold secure full public confidence.

Dispensary care for the sick poor is a means for the purpose of teaching, clinical research work and development of medical skill. The tendency now on the part of dispensaries is to obtain income from this sort of practice, actually practicing medicine for pay without any remuneration for the doctors. How does this compare with having prison labor products compete with legitimate business. Industries and governments prohibit this, why not we? To my mind this is demoralizing and unwholesome competition, and should be strongly opposed. Either the clinic physicians should be reasonably compensated for their time and services, or dispensaries should not charge for the services which should be for the deserving poor only. In such cases, like the free ward cases in the hospital all patients should be properly investigated, and those who can afford private treatment discouraged from the use of the dispensaries.

Practice of foundations that advertise to the public, medical centres, pay-clinics, hospitals, universities, corporations and other organisations engaged in the practice of medicine for pay, is in complete opposition to the principles underlying the welfare of medicine. It utilizes taxes, endowments and other sources of income for purposes of unfair competition with the physician, and tends to destroy the very foundation of ethical practice such as the free choice of the physician by the patient and independence of the physician; substitutes perfunctory routine for skilled, conscientious service, and utilizes the prestige of the institution through advertising or unfair publicity, which is actually a false prestige so far as medical service is concerned, because it is based on factors having little or nothing to do with the competency of the medical body itself. It takes advantage of objectionable methods of publicity, and it is a demoralizing form of unfair competition with the doctor. Governmental practice of medicine in any form for pay and contract practice has the same objections, encouraging inferior quality of medicine, quantity of medicine, thus encouraging mediocrity. This is particularly true in the various pay-clinics as they are managed to-day.

Solicitation of patients is reprehensible and undignified. And yet, nurses from prominent hospitals who patronize certain stores and crafts in various neighbourhoods, invite the owners to visit various departments in the dispensary or hospital, assuring them that she will see to it that only the chief doctor or professor will treat them, knowing full well that these patients can well afford private treatment. This has happened to several of my cases in children who were previously under my care and referred to me for consultation by physicians. This practice should be prohibited in all institutions, and the nurses soliciting such practices should be punished accordingly. A warning of this should be given in all hospitals and at all nurses commencement or graduation exercises. This is even worse than neighbours lifting cases from doctors, for at least some other doctor gets the case, which also should be discouraged. Patent medicines and corner medicine vendors should be exposed in the harm it may do to the public, through proper publicity in public health education. A condition must be diagnosed before it can be treated. The laity must know that a very serious disease may be incubating and progressing in them while they are subjecting themselves to various advertised remedies, and medicines from corner vendors, as also from other sources of quacks and cults. This is one of the contributing causes of increased morbidity and mortality rates, and unemployment through illness. Proper medical legislation emanated from us and sponsored by us should take care of this menace, and guard public health.

A great number of cases in hospital wards are patients who cannot pay the semi-private or private rates plus extras and medical care, yet they are able and willing to pay a moderate fee for medical care, a minimum charge say $. 5·00 for all laboratory work and a small proportionate charge for X-rays necessary plus the nominal bed rates. The hospital authority, or one in charge, when admitting a ward patient, should inform the patient of these facts. If the patient

desires this partial private service and choice of physician, or whomever happens to be on service, arrangements should be made and moneys collected for this service by the hospital, which shall be paid to the doctor in charge of the case. There shall not be any privileged patients, and the general good care and medical service for all patients whether they pay or not shall be jealously guarded. The hospital will thus receive more income from the laboratory and X-ray sources of revenue, the physicians will be compensated, which means independence and more ambition for good work from increased income, and the patient will feel he was properly cared for and he will feel satisfied and happy that he could pay for such services. I am strongly in favour of such a plan.

Workmen's Compensation patients should be not be denied the free choice of physicians. This sort of practice, the denying the patient free choice of the physician, is not only in direct violation of our medical oath and code of ethics, and completely undermining the foundation of medical practice, but also places much of this service in the hands of corporations who hire physicians for a mere stipend, have clerks bandage and treat cases, and laymen get the substantial part of the insurance company's money, which is supposed to go to the physicians for medical services. In New York State this practice by corporations is rampant although it is illegal. Hospitals should not be permitted to have their internes treat compensation cases and receive payment. Hospital income from this source is unfair competition with private practice. This should be discouraged in all hospitals. The visiting physicians treating the cases should be paid.

Insurance which provides funds to be used in illness should be encouraged. But any form of *insurance for illness*, governmental or corporation practice of medicine, should be discouraged for reasons already mentioned. However, if State Medicine has to come, let us have a programme ready that will be favourable for the doctor and for the patient, one that will not take away the initiative ambition, and independence from the individual practitioner. It should not be prepared by politicians for political aggrandizement against the interests of the physician. A plan for hospital insurance of which there are several, may be favourable, in that the patient has the free choice of the physician for whose services he must pay. It is also a step forward to the inauguration of the open hospital.

I am in favour of increasing the personnel of hospital staffs. This will permit opportunity for every physician willing to serve, to broaden medical knowledge and experience, and it will offer additional adequate medical service to the patients. The staff positions shall be protected by having an able spokesman from the medical board as its representative on the lay-board in every hospital. This will eliminate reorganization of medical staffs through conniving and scheming. Open hospitals is to be recommended when properly supervised. The standards of medical education should be federalized; we should have American Medicine, similar to European Medicine, and not individually New York, New Jersey and Connecticut Medicine, etc.,

Our State and County Medical Societies, by virtue of this strong consolidation of physicians in the medical profession, which can be an example for other states throughout the Union to follow, can furnish the principles, policies and progressive amendments to our ethical code for better medicine for our guidance.

(Medical Mentor, April, 1933.)

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.

Iritis: The inunction of equal parts of Olive Oil and Guaiacol over the abdomen has been attended with marked effect. The patient is put on bed between blankets and every care taken to avoid chill. Over the abdominal wall an area of about a square foot is painted with the above solution and covered with oiled silk or any other impervious material over which a layer of cotton wool is placed and firmly bandaged. In the evening of the day in which painting is done, the patient is given a dose of Calomel, 2 or 4 grs, and the following morning a saline purge. The paint may be repeated after an interval of 2 days. If Atropine is not well borne Dhaturin, Scopolimin, 2 grs. to an oz., in solution may be substituted. In stubborn cases sub-conjunctival injection of 10 to 15 mms. of Cyanide of Mercury (1 in 5000) with a few drops of 1% solution of Acosine to mitigate pain, has very good effect in clearing the exudation. A similar injection of physiological saline solution is also useful. Locally 5% solution of Dionin helps as a resolvent. It may be continued with Atropine and reinforced with 2% solution of Holocine.

In Syphilitic Iritis Sulfarsenol and Benzo-Bismuth by the intra-muscular route should always be given and in the interval between the injections Mercury and Potassium Iodide should be given by mouth.

In Rheumatic Iritis full doses of Salicylate of Soda should be given.

In Gonorrhoeal Iritis in addition to the local treatment, Gonococci vaccine in the form of Rheantine may be given by mouth, with good results. Hyoscine 1/400 grain dropped into the eye is reported to bring about midriasis quicker than Atropine; but the action of Atropine has been found to be more lasting. Instillation of Hyoscine drops are rather painful. So before using them the conjunctiva may be anaesthetised with Cocaine.

Jaundice: CATARRHAL: Vichy and Carlsbad waters, Podophyllin, Euonymin, and Iridin in small doses or Alkalies in the form of Soda, Potash and Ammonia salts exert decidedly beneficial action in simple jaundice. Iodoform in 1 to 5 gr. doses has been tried by some. Theocin-Sodium—Acetate in 2 gr. doses is useful. Dext-rose may be given by mouth or rectum. If Alkaline treatment does not produce the desired effect, Dilute Nitro-muriatic Acid may be given in 10 mms. doses mixed with water before food, and 20 gr. doses of Ammonium Chloride with a dram of Extract Glycyrrhizae Liquidum in 2 ounces of hot water may be given at bed time.

For Pruritus accompanying Jaundice, a solution of 2½ drms. of Ichthyol, 3 drms. of Absolute Alcohol and 2 ounces of Ether, may be rubbed over the body. Thyroid ½ gr. doses has also very good effect.

In the suppressed haemolytic form which is characterised by the absence of tactile sensation over the liver and spleen, lack of Urobolin in the urine, and hyper-chromic stools, Liver extract is good.

Jaundice of the new born is always fatal. Administration of Hexamine and Soda Salicylas to the mother during pregnancy seems to have had very good results in preventing infantile Jaundice.

Notes on Therapeutics, Diagnosis and other Medical Subjects.

ANAESTHESIA IN TROPICAL SURGERY.

BY

C. GRANTHAM-HILL, M.B., (CAMB).

The difficulty of obtaining good general anaesthesia for surgical operations has always been one of the constant trials of medical work in the tropics. This difficulty is particularly marked in a country such as the Anglo-Egyptian Sudan, in which there are great variations of temperature and humidity, a shortage of experienced medical staff, and a backward and primitive race supplying the majority of the patients. There is, amongst native Sudanese patients, an almost universal dread of losing consciousness under an anaesthetic, a dread compounded of fear of the unknown and a belief that the soul actually leaves the body and may have difficulty in finding it again.

There is sometimes also a tincture of doubt as to what mutilation may be in store for the unconscious and helpless patient. The relief with which the information that an operation can be performed without loss of consciousness and without pain is received by such patients contributes greatly to that hopeful outlook which is of such enormous value in the treatment of the African native.

The technical, as apart from the psychological, difficulties of general anæsthesia may be summarized as follows:—

CHLOROFORM, the most dependable of available anæsthetics, is nevertheless dangerous in unskilled hands, and few native medical officers become really dependable in its use. Further, its toxic effect in prolonged anæsthesia is a very real danger, particularly in view of the commonness of hepatic and renal deficiencies in tropical patients.

ETHER, is very unreliable owing to the great variation in its rate of evaporation following atmospheric changes. It loses bulk rapidly in hot weather, and is apt to explode. Its use needs considerable skill, especially when in combination with chloroform, for the relative strength of the two drugs is continually changing as the ether evaporates. Closed ether appliances seldom survive the climate for more than a few months, on account of the loss of elasticity of the rubber bags or connections. Ether readily causes bronchial irritation in hot, dry weather. The most useful mode of administration is by the rectum mixed with olive oil.

NITROUS OXIDE.—Both nitrous oxide and oxygen are impossibly expensive, as they have to be obtained from Europe, and cylinders lose half their contents in transit.

ETHYL CHLORIDE is definitely dangerous unless given in measured quantity from a rubber bag, which rapidly loses elasticity.

AVERTIN has the very grave objection that skilled attention is needed for at least half an hour before operation, and often for 24 hours after it. It is therefore almost ruled out as a routine anæsthetic in the primitive conditions of nursing found in most parts of this country.

The solution of many of these difficulties has been found to lie in the increasing use of local and spinal anaesthesia; the following are the most striking of the many advantages:

(1) The minimum of shock with the maximum of relaxation.

(2) The almost complete absence of post-anæsthetic vomiting. This is of great value both from a physical and a psychological aspect. The patient usually sleeps well, and can take fluids and solid diet much earlier than after general anæsthesia.

(3) Preparatory and after-treatment are simplified. Many cases can be admitted and sent home on the day of operation, thus economizing beds.

(4) One skilled assistant the less is needed.

(5) The co-operation of the patient during the operation is often of great assistance—e.g., a timely cough in locating a hernial sac and the movement of fingers in a tendon suture.

These advantages are, of course, familiar to all surgeons, but work at a distance from the refinements of skilled assistance and nursing lends them such added value as to warrant the emphasis used.

SPINAL ANAESTHESIA IN ABDOMINAL OPERATIONS.

Spinal anaesthesia is the anaesthesia of choice for major abdominal operations on patients who are not profoundly shocked, cachectic, or very old in other words, for those who are reasonably good 'risks', and can tolerate the inevitable drop in blood pressure. After considerable experience of stovaine, novocain, and spinocaine, we have found neocaine, given by the method described by Koster and Kasman, the most reliable. Over 200 operations have been done under this anæsthetic in the Khartoum and Omdurman Hospitals without any untoward event referable to the drug, and with uniformly satisfactory results. Briefly, the method used is as follows:—

After a preliminary injection of morphia, the interval between the first and second, or second and third lumbar vertebræ is punctured with a fine needle and a quantity of cerebro-spinal fluid is drawn off and mixed with the crystalline neocaine in the glass ampoule in which it is supplied. The solution is then injected slowly through the needle which has been left in place.

For an adult of average weight: 10 m.g., of neocaine in 4 c.cm., of fluid give anaesthesia up to the umbilicus; 15 mg., of neocaine in 6 c.cm., of fluid give anæsthesia up to the costal margin; 20 mg., of neocaine in 8 c.cm., of fluid give anæsthesia up to the clavicle.

Immediately after injection the patient is placed in the Trendelenburg position to counteract the cerebral anæmia which follows the invariable drop in blood pressure, and the operation may start within five minutes. Complete anæsthesia lasts for about an hour; if the operation is not completed within this time, novocain may be injected into the peritoneal edges, or a little chloroform given. If there is nausea or retching the head of the table is still further lowered and, if they persist, ephedrine is injected, though this is not often needed. After return to the ward, the head should be kept low until the pulse has recovered its volume. No cases of headache have occured in this series. This is attributed to the use of a fine needle. The following case illustrates some of the advantages of this form of anæsthetic.

A male native, aged 35, was admitted with a history of sudden onset two hours previously of epigastric pain of an agonizing character, with vomitting and collapse. For two years previously there had been intermittent pain when the stomach was empty. There was board-like rigidity of the upper abdomen, a subnormal temperature, and pulse-rate of 80, the pulse being of fair volume.

A preparatory injection of morphia, gr. ¼ had little effect upon the pain, but 15 mg., of neocaine in 6 c.cm., of cerebro-spinal fluid intrathecally produced complete relief from pain and a flaccid abdomen in five minutes. The patient retched once or twice while the abdomen was being opened, but subsequently went to sleep; a perforation in the posterior wall of the duodenum was closed, and a gastro-jejunostomy was performed under advantageous circumstances. Except for some paralytic ileus on the second and third days, the patient made an uneventful recovery.

A constant feature in abdominal cases thus anæsthetised is the contracted state of the intestines (except where there is paralytic or obstructive ileus); the abdominal contents not required can be packed away with case, thus facilitating intra-abdominal manipulations.

LOCAL ANAESTHESIA IN ABDOMINAL OPERATIONS.

In abdominal work local anaesthesia is most useful: (1) in operations not entailing much handling of viscera—e.g., straightforward appendicectomies, colostomy, ventral hernia; (2) in cases where, owing to shock or debility, the patient is a doubtful risk under spinal or local anaesthesia; and (3) in infants. The technique, in outline, consists in:—

(1) Infiltrating the line of the incision by sub- or intra-cuticular injection of 1 per cent novocain, made up with fresh adrenaline, 5 drops to the fluid ounce.

(2) Blocking the cutaneous nerves by a zone of infiltration into the muscle layers, particularly in the neighbourhood of the nerves (intercostal, ilio-hypogastric, ilio-inguinal).

(3) Anæsthetizing the peritoneum. This is best done after exposure of the transversalis fascia, or posterior sheath of the rectus, when novocain can be injected beneath it, in contact with the peritoneum.

Novocain injected into the mesentery will usually relieve pain due to manipulation of viscera.

The quantity required is usually between 1 and 2 fluid ounces of the 1 per cent solution, but more can be used without danger provided that; fresh, unboiled adrenaline solution is added in the strength mentioned; and care is taken that no appreciable quantity is injected directly into a vein.

A native boy of 9 was admitted wih a history of colicky pain in the abdomen, beginning with vomiting 12 hours previously. Examination showed a tumour just above the umbilicus and visible small gut peristalsis. There was faecal vomitting and collapse. After an injection of morphia and local infiltration with 1 per cent novocain, a right paramedian incision allowed a 12 in., intussusception of the jejunum to be delivered and reduced by manipulation. The intussusception had started at a tumour of the gut wall the size of a walnut; this (a lymphosarcoma) was resected, and an end-to end anastomosis was done at a subsequent operation under a spinal anæsthetic.

(To be continued.)

News and Comments.

A Farewell Sermon: Major-General Sir John Megaw, retiring Director-General, Indian Medical Service, is reported to have just concluded an enquiry about the physical condition of the people in rural areas throughout India. In the course of a report which has been now got ready, he pointedly refers to the gloomy aspect of village life regarding health conditions and concludes that "the whole social structure of India must inevitably be rudely shaken, if not completely destroyed." An extract of the report appears in the correspondence columns.

May we ask Sir John Megaw, who is responsible for these depressing conditions in India's villages? It cannot be anybody else except the Government of the country and the blame must be shared by all who constitute the Government. It is most unfortunate that the Director-General, Indian Medical Service, who is the chief adviser to the Government of India in all matters concerning the health of the people in India and is one of the chief units of the Government, could not find out the depressing conditions in India's villages, till the eve of his departure from this country. Sir John Megaw's conclusions smack like the outbursts of a cruel parent who would not properly feed or clothe his children and yet expected them to be sturdy.

We have been mentioning repeatedly both in these columns and elsewhere that the village doctor should be made the pivot of all village reconstruction work and that without him village reconstruction work must be a failure. Governments of almost all the provinces have realised the need of subsidising village practitioners but unfortunately subsidised medical relief has been made another department under the Surgeon-General or Inspector-General, and the subsidised practitioners treated as the worst menial subordinates.

Sir John Megaw's advice could have been better appreciated if he prescribed a scheme of village reconstruction to remedy the evils pointed out by him. If high-salaried appointments as that of Director-General, Surgeon-General and Inspector-General, are to continue along with the costly medical officers under them, there will be little or no money for village reconstruction schemes to put an end to the depressing conditions in India's villages. We trust that Sir John Megaw will carry with him his report about the existing village conditions in India and formulate a scheme which without additional financial responsibility on the part of the Government, would bring about the desired results.

Sir John Megaw retires as Director-General, Indian Medical Service, to occupy yet another office in the Council of the Secretary of State for India, an unique position from where he could work out the salvation of India's villages and make his farewell sermon an earnest reality.

The Indian Medical Council Bill: From the account of the proceedings of the Select Committee of Indian Legislative Assembly reported in newspapers, it is plain that the question of including the Licentiates within the purview of the Bill, has been given up and with it the All-India Medical Register. Some minor alterations regarding the constitution of the Council seem to have been recommended by the Committee. Representatives on the Council would include one nominee from each provincial Government, one representative elected by the Senate of each University from among the members of its medical faculty and one member to be elected from among the medical graduates or persons holding equivalent qualifications. The committee had recommended that the President of the Council be nominated for the first four years of its life and thereafter to be elected. Regarding reciprocity a four years' term has also been fixed within which period if the foreign Medical Councils do not recognise Indian University qualification, the recognition given to the foreign qualifications should automatically cease.

Though it may be perhaps too early to judge whether the Select Committee has changed the Bill to give satisfaction to the profession and the public, until the full report is published, we will not be far wrong in presuming that the report would be on the whole a very unsatisfactory and disappointing document. Nowhere in the civilised world during the Christian era a Medical Act was passed for the benefit of only a section of the medical profession nor was there a medical council without a

CLINICAL NOTES AND PRACTICAL SUGGESTIONS

ARSENOXYL.

An Important Factor in Regard to Arsenical Treatment of Syphilis.

The most important factor in the Arsenical treatment of Syphilis is the combination of the arsenical remedy with those proteins in the body which form the theoretically assumed "Arsenoxyl". Without this arsenoxyl formation there is no antisyphilitic action by arsenic that is worth practical consideration.

In the very beginning of the history of effective treatment of Syphilis by arsenic the recognition of this arsenoxyl formation (whatever may be the real interpretation of the reaction) was the turning point.

Its discovery showed the way and permitted experiments to be carried on in a rational manner. Ehrlick first discarded Atoxyl as absolutely useless because in a test tube it had no effect on spirochaetes. Only after Levatiti, McIntosh, Thomas and Breinl had demonstrated the difference between the action of Atoxyl in a glass vessel and its action in an animal was Ehrlick in a position to proceed rationally with his classical six hundred and six experiments. All this happened so long ago that we are in danger of forgetting this essential. This reaction affects us in our daily practice in two ways—

First it should keep in our minds the fact that this reaction must take *time*, and therefore any device to ensure that the arsenic is retained in the body long enough to ensure its being completed requires a prominent place in our thoughts.

It is found, for instance, that when organic arsenicals are given intravenously there is a rapid elimination of the arsenic in the urine during the next 12 hours. Given intramuscularly this immediate excretion of arsenic in the urine is very much reduced. There is a much better opportunity for arsenoxyl formation.

Harrison showed that intramuscular injections of arsenicals were 12% more curative of lues than intravenous injections of the same drug in the same dosage.

The second way in which this reaction claims our attention in our daily practice is in regard to the new compounds being offered to us daily.

Any organic arsenical will be good enough to clear up symptoms temporarily, but do they form Arsenoxyl? Only careful trials conducted through several years can decide. A large number of cases must be followed up with Wassermann tests for two years after treatment, before the effects of a new drug can be adequately assessed. Fortunately we have in Sulfarsenol a drug which has adequately proved itself effective after many long series of Wassermann tests.

It can be given intramuscularly or hypodermically as well as, if necessary, in a vein.

Given with Arseno-Solvent Sulfarsenol is painless, and we know that its curative effects are always satisfactory.

A regulator of Utero-Ovarian functions.

It is well-known that a woman's health is closely associated with the regular development and adequate functioning of her sexual system. The series of morbid changes that follow the absence of this development and integrity of the functions result in a variety of symptoms, which if neglected might sooner or later be the starting-point of the most painful disorders or even most obstinate diseases. In nine cases out of ten the cause dominating these troubles is insufficiency of the ovarian function together with the hypofunction of the Pituitary. With the advent of more exact knowledge of the ovarian follicular hormone and also of the Pituitary a satisfactory method of standardising preparations containing these is available and accurate animal experiments with this made it possible for forming the basis of clinical applications. As a result it has been found that application of this hormonetherapy, particularly the combined one, is of considerable benefit in disorders due to hypofunction of the ovary and the Pituitary of the human female.

The practical application of this therapy can only be accomplished by Opocrin Ovaro-Pituitary, a preparation introduced sometime back as a combination of Ovary and Pituitary (whole gland). Considerable experience with it has enabled medical opinion to crystallise regarding its value.

It possesses decided merit as a tonic, sedative and regulator of the Utero-ovarian functions. It has now passed its trial stage and has become the favourite remedy with many physicians and gynaecologists.

Opocrin Ovaro-Pituitary, as its name implies, is composed of the extract of the whole Pituitary and the Ovary in the proportion of 0·05 gm., of the former to 10 cgms., of the latter in one opocrin. It is also available in the form of ampoules where the success of the glands are found in combination of 15 to 60 cgms. When one understands the co-relation of the Ovary with the Pituitary one can realise how rational the treatment with this Opocrin would be in cases of hypofunction of these glands. It is generally recognised that the hormones of the Ovary are not the only ones in restoring hypofunction to normal. It is the hormone of the anterior Pituitary which initiates the production of the follicular hormone which causes the development of hypertrophic and proliferative changes in the uterine mucosa. Another hormone of the anterior Pituitary effects lutenization and formation of the luteal hormones of the Corpus Luteum and the normal activity of these glands is thus induced.

The ovarian extract in this Opocrin exercises a profound influence on the function and the development of the sexual organs either of under-developed, immature or castrated or senile females. It has a marked tonic influence on the organism as a whole. By responding to the demands of a true substitution therapy with its high content of ovarian substance this Opocrin supplies the physiological stimulus to the whole sexual apparatus of the female. This is effected by the supply of the ovarian hormones. Further, it produces proliferative changes in the endometrium in order to build up the particular type of engorged mucosa. In senile or castrated females this extract has a striking biological effect.There is not only increase in weight but higher red-cell count and greater haemoglobin percentage. In fact reactivation is brought about by it as is seen from increased activity, high metabolic rate and general well-being.

As the lack of Ovarian hormones is in most cases due to the lack of Pituitary hormones, which are responsible for the production of the former, the extract of the whole gland (Pituitary) is incorporated in this Opocrin. It therefore contains the hormones of both the anterior and the posterior gland. It has a stimulating effect on the arterial system. It increases the blood-pressure by contracting the arterioles and this effect is more lasting than that of Adrenalin and is not followed by slowing of the pulse. It also stimulates the non-striated muscles. It causes contraction of the plain muscle-fibres of the alimentary canal, generative and urinary organs, trachea and the bronchi and the alveoli of the lactating mammary gland. It markedly decreases the output of urine. This is effected not by direct action of the kidneys but by regulating the water-exchange between the capillaries and the tissues. The alpha-hyphamine hormone brings about the oxytocic action and the beta-hyphamine, the pressor activity. These hormones increase coagulability of the blood by accelerating the speed of the initial changes in the phenomena of blood-clotting and hence its usefulness in haemorrhages.

Coming to the clinical applications of the Opocrin Amenorrhoea is the one that strikes us first. Opocrin Ovaro-Pituitary by supplying the stimulus essential for initiating the flow induces menstruation in cases of Primary Amenorrhoea. In these cases the primary fault is the lack of anterior pituitary hormone and hence the efficacy of this glandular compound. It is also useful in conditions due to hypo-ovarian function with inadequate follicular hormone production. It is a rational and effective therapy in Amenorrhoea resulting from uterine atrophy. Here it supplies the extra quantity of hormone required to stimulate the thin atrophic endometrium due to hypo-ovarianism. Thus various types of primary Amenorrhoeas, due either to hypo-ovarian function with insufficient follicular or luteal development or due to varying degrees of uterine atrophy, respond satisfactorily to this line of treatment.

Secondary Amenorrhoea is also a good field for the application of this Opocrin. If there is hormone deficiency this glandular product supplies it and brings about the flow thus tending to re-establish the normal cycle. When however there are causes

other than hormone deficiency working or when the trouble is functional this treatment would not be of much use. Exhaustive clinical examination and the employment of uterine stimulants and general tonics would accomplish much in such cases.

It is on account of the balanced proportions of the glandular extracts in this preparation that it furnishes the best means for the treatment of Dysmenorrhoea. As it contains the active principles of both the Pituitary and the Ovary it exerts its influence in such a way that the hormone complex of the blood is brought to normal. In addition to this the defect or the interference of the neuro-muscular mechanism is corrected and hypoplasia of the myometrium is remedied by means of its tonic action on the uterus. Besides the alleviation of pain there is also observed general improvement in the patient's condition with this line of treatment.

In order to combat the morbid symptoms of Menopause and to facilitate the change into the new condition to which the internal secretory mechanism has to adjust itself Opocrin Ovaro-Pituitary is of considerable benefit. If the menopause is accompanied by asthenia and lowered tension this Opocrin is particularly useful. The diminished metabolism, Obesity, skin-affections and other similar derangements which follow this disturbed chemical balance soon disappear with this treatment. In short this Opocrin regulates effectively the endocrine function which is disturbed in such conditions.

This glandular compound can be advantageously indicated in such other conditions as asthenia, lowered metabolism, depressed functional conditions, low blood pressure and exhaustion. Although these conditions are of most diverse character they are the result of the defect of the Pituitary and the Ovary. The inter-dependence of these Endocrine glands has made it possible for this Opocrin Ovaro-Pituitary to act well in such cases and ameliorate these conditions.

The painful breasts, a condition often met with in Gynaecological practice and erroneously termed Mastitis, are soon relieved by the administration of Opocrin Ovaro-Pituitary. This complaint is the result of desquamation of the epithelial cells in the ducts and acini accompanied by the hyperplasia of the connective-tissue. Intramammary pressure is thus raised and modulations are formed. Ovaro-Pituitary, by reason of the hormones contained in it, controls this hyperplasia and desquamation and thus relieves pain and tenderness and oligomenorrhoea as well.

Hyperemesis Gravidarum has been successfully treated by means of this glandular product. It supplies the hormones in the organism which is deficient in them or which requires greater supply of them on account of certain metabolic changes. This Opocrin is decidedly a more rational treatment than the administration of narcotics and nerve-sedatives which only suppress the symptoms for the time being.

As the whole substance of the Pituitary Gland is incorporated in this Opocrin it can be used for a variety of indications of obstetrics and Gynaecology. This preparation, particularly the ampoule, is of great value in cases where the pains are lacking or are very ineffectual. Immediately following delivery one ampoule of this product can be injected intramuscularly for effective contraction of the uterus and bring about haemostatic action. The ampoule of this glandular product is also useful in cases of incomplete abortion where there is profuse haemorrhage and a relaxed uterine wall. If this injection is given five minutes before curetting not only does the haemorrhage stop but the obstetrician gets a rigid uterine wall for scraping.

As it is believed that Pituitary has a powerful constringent effect on the uterus and as it increases the coagulability of the blood the injection of this product would be beneficial in uterine haemorrhage arising from diminished uterine contractibility. Good results are obtained either by subcutaneous or intramuscular injection in Menorrhagia due to anaemia, hypertrophy of the endometrium, fibroids, retroversion etc. In these cases the extent and the duration is much reduced and the intervals lengthened. Uterine haemorrhage either at puberty or the climacteric can be effectively checked by means of these injections.

One of the striking advantages that this Opocrin Ovaro-Pituitary offers over other similar products so far available is its freedom from [illegible]. This is due to the fact that this preparation has no impurities. Again, this remedy by reason of its full content of active hormone ensures adequate

dosages. The preparation is standardised according to the recognised methods. The Opocrins are prepared in such a way that they resist the action of the gastric secretions and dissolve well in the intestines. Its activity is therefore ensured even when given by the oral route. No ill-effects have ever followed its use.

The following two cases amongst a large number are given below in which Opocrin Ovaro-Pituitary was used with markedly good results. Other practitioners and specialists will only confirm these experiences, the writer is certain, if they give this product a more extensive trial.

1. A young girl of 16 came to me for treatment of Amenorrhoea for the last two years. She was suffering from vague pains all over the body. She was complaining of severe backache, headache and vomiting. Her skin was cold and she was not able to take proper nourishment on account of the dyspeptic symptoms which troubled her. Menstruation first appeared at the age of 14. After that she had no menstruation at all. Treatment with Opocrin Ovaro Pituitary was commenced. She took 6 Opocrins in all per day. This was continued for three months at the end of which there appeared the menstrual period for the first time after two years and this lasted only for two days. Treatment was again started with a break of a few days. After four months of this regime she began to get the periods but at irregular intervals. After six months of this treatment with occasional breaks she began to get regular periods unaccompanied by any symptoms such as pain, vomiting etc. All these disturbances disappeared altogether and her general condition was much more satisfactory than in the previous months.

2. Another case was of a young woman who had persistent vomiting in her second month of pregnancy. It resisted all medication such as hypnotics, narcotics and nerve-sedatives. I prescribed Carnrick's Corpus Luteum Capsules after a thorough evacuation of the bowels. The patient unfortunately could not stand the smell of the capsules which when taken near her mouth for swallowing she felt a very bad sensation of nausea. I therefore advised her to take Opocrin Ovaro-Pituitary. She took 8 opocrins per day. Next day her vomiting was much better and she could without much trouble take liquid diet. The treatment was continued and on the third day she was able to retain everything even solids. The treatment was given for two more days and all her symptoms such as heart-burn, eructations etc., vanished. Opocrin Ovaro-Pituitary can therefore be considered an effective therapeutic measure in all cases of Hyperemesis Gravidarum.

Treatment of diseases of Uric Acid Diathesis.

The progress made by medical research during recent years has completely changed the outlook about the pathology of Uric Acid Diathesis. It has been now determined that the Uric Acid and Urates cause a certain amount of fermentation which results in Gout, but it is not yet known how and where this Uric Acid is formed. Still the opinions vary as regards the origin of Uric Acid. Some claim that it is the final product of oxidation of well-known group of purines known as nucleo-proteids while others assert that it is not the result of oxidation of such substances in general, but is solely derived from purine. Whatever theory may be correct, it appears quite clear that Uric Acid is exclusively regulated by ingestion and subsequent oxidation of nucleo-proteids in the organism. However there is another fact which must not be lost sight of and which would come in our way of the wholesale acceptance of this latter theory; and that is that all the nucleo-proteids that are introduced into the organism are not converted into Uric Acid. The origin of Uric Acid therefore is not only of exogenous nature, that is caused by chemical transformation of nucleo-proteids, but also of endogenous origin, that is, caused by the destruction of organic cells in the daily bodily changes. How these nucleo-proteids or nucleins are transformed into Uric Acid is still not quite certain. It is said that liver is the organ where these changes take place.

Nucleins are changed by means of oxidasis into purines, which are known as Xanthin and Hypo-Xanthin. These latter are converted into Uric Acid by means of Xantin-oxidasis. The urolithic ferment then divides Uric Acid into its last decomposing products and sets up fermentation. More than one half of these bases resist this fermentation and thus Uric Acid is eliminated in the urine in these individuals. Where the action of these ferments is not adequately resisted fermentation is set up and Uric Acid diathesis is the result. The chief characteristic features in this diathesis is that the food being rich in nucleins there is excess of Uric Acid and Urates. Secondly, there is accumulation of the same in the blood and the tissues and lastly the organs are not capable of controlling the production of such substances and of eliminating them.

To relieve all these disturbances viz., checking the production of these nucleins and elimination of Uric Acid the profession has now a product at its disposal known as Urogenine. It fulfills all the requirements demanded of it because of the physiological soundness of the principles on which its composition is based. Urogenine is a soluble granulated combination of Urotropine, Piperazine, Lithium, and Sodium Benzoate and Tartaric Acid. Each teaspoonful of these granules contain 50 cgms., of active principles. We can see from the nature of these constituents why Urogenine is considered as a specific in all disorders arising from Uric Acid diathesis. Of late the practical results with this remedy have confirmed its theoretical accuracy. It is readily soluble in water and forms a pleasant and a refreshing drink.

We have said before that the changes in Uric Acid diathesis bring about a fermentation. Now this fermentation is always associated with an alkaline reaction. Urogenine being an alkaline remedy, increases the alkalinity which serves to dissolve and eliminate Uric Acid deposits. By means of Urotropine in it, it exerts a powerful antiseptic and bactericidal action because of the formation of nascent formaldehyde, the liberation of which takes place readily in the acid medium created by Benzoates of Sodium and Lithium. These latter, which form the constituents of Urogenine, are converted into hippuric acid and are very helpful in reducing the congestion of the mucous membrane of the urinary tract. Piperazine promotes the elimination of uric acid and urates while Tartaric Acid acts as a good refrigerant, laxative and an alkaline diuretic.

From this composition we can understand the properties of Urogenine. Under its influence the hyperacidity of urine is neutralised and the urates deposited either in the joints or elsewhere are eliminated or dissolved. The excretory functions are stimulated and the cellular activity of the renal epithelium is enhanced. Urogenine therefore is the most approved remedy in Uric Acid diathesis, as it acts as an effective diuretic, analgesic, antiseptic and an excellent eliminator of uric acid.

All conditions arising from Uric Acid diathesis and metabolic derangement are amenable to treatment by Urogenine. The first disorder that strikes us is Gout. When administered in acute Gout complete subsidence of the attack takes place rapidly by encouraging the elimination of uric acid and by its decongestive and anti-arthritic action. The tension and inflammation of the joints is relieved by a few days' treatment and toxic products either through faulty metabolism or dietetic errors are removed. The temperature drops, pain is relieved and arthritic symptoms soon subside. Rapid recovery thus takes place. In Chronic Gout too Urogenine is efficacious, but the treatment must be prolonged before any good results show themselves. This product has also been observed to be a good prophylactic inasmuch as during intermission periods of Gout it helps to reduce the possibility of the attacks, diminishes their acuteness and in many cases may absolutely prevent them.

Acute articular Rheumatism yields rapidly to treatment by Urogenine. The action of elimination of Uric Acid from the blood is hastened because of the increased excretory activity brought about by Urogenine. The blood concentration of Uric Acid is diminished and that of the urine is increased. Further, because of its antiphlogistic and analgesic properties, polyarthritis with rheumatic basis soon improve. The red colour of the skin over the joints disappears, the swellings subside and the pains are relieved. The flexibility of the joints is restored in a surprisingly short time.

Much comfort and even cure can be afforded to patients suffering from Gravel if they are treated by Urogenine. Prolonged administration of this product dissolves uric acid calculi or if they are small are eliminated through the urine. Its regular exhibition besides stopping the symptoms, such as pain and flow of blood during

micturition, sudden stoppage of the flow of urine, brings about elimination of the calculi rendering the whole of the urinary passage thoroughly antiseptic. From this we can also see its beneficial results in renal colic where it not only relieves the symptoms but prevents further attacks if the treatment is continued sufficientiy long. Its use therefore in patients with a marked tendency to such complaints has been always found beneficial.

The remarkable results achieved by Urogenine in attacks of Sciatica of Gouty or rheumatic origin convince one of the efficacy of this remedy in this affection. Even in cases of long-standing, success can be obtained with this treatment in a comparitively short time.

In Cystitis, bacilluria and prostatitis, Urogenine has been found useful as it is a true genito-urinary analgesic. It soothes the mucous membranes, allays pain and burning in the bladder and brings about good antisepsis of this whole tract. Moreover it reduces inflammation and aids recovery.

In pyelitis and pyelo-nephritis beneficial results of Urogenine are manifested because of its strong antiseptic and bactericidal action.

Referring to the advantages that Urogenine presents, the more outstanding among them are :—

1. It is a safer and a quicker remedy than any other in Uric Acid complaints and metabolic disorders.

2. It does not derange the stomach, neither does it affect the heart or the kidneys.

3. It can be exhibited for prolonged periods and has absolutely no contra-indication.

4. It is reliable and entirely free from any by-effects.

5. It is agreeable.

6. It has no tendency to irritate either the renal tissue or the urinary tract.

Urogenine is at the disposal of the medical profession for a long period and the fact that its position as an excellent remedy for Uric Acid complaints has remained established so far, is a proof positive of its efficacy and its specific qualities.

Two of the many cases treated successfully with Urogenine have been given below.

1. Mr. T. M. aged about 50 had been a subject of Gout for more than four years. He was seen by me sometime in December last suffering from severe arthritis of the ankle. The joint was swollen and tender and unusually hot. There was oedema round about the joint for some distance which pitted on pressure. Temperature ranged from 101° to 103°. The patient complained of agonising pain in the affected joint which had kept him awake for two nights. At the commencement I prescribed an alkaline mixture with salines and diuretics. After two days of this treatment with dietetic regime I started giving him Urogenine. The dose recommended was two teaspoonfuls dissolved in water thrice daily before food. After receiving this treatment for two days his temperature was reduced, the pain subsided, the tenderness passed away and after one more day he was able to walk with the affected foot. He began to get good rest at night and was feeling very much better and comfortable. He continued taking Urogenine even after he was free from the acute attack and to this day he did not suffer from any recurrent attacks of Gout which used to trouble him off and on.

2. This was a case of a young man of 30 who was suffering from frequent attacks of muscular rheumatism. His lumbar muscles used to be affected which gave him a good deal of pain. His was a case of Uric Acid Diathesis. Once he suffered from wry-neck probably of rheumatic origin. All other medicinal forms of treatment including Sodii Salicylas and Colchicum preparations proved of no avail. He was advised to take Urogenine, which he took regularly and without interruption. After about a week of this regime not only was there complete cessation of acute attacks, the disappearance of acute pains and all other attendant symptoms, but he felt generally better and more energetic. The treatment was continued after the attack was over and he finished three bottles. This resulted in the prevention of the recurrence of these troublesome attacks. So far i.e. for about three months he had not a single complaint arising from this diathesis, which means that he is entirely free from it.

A blood-regenerating Tonic.

In a poor country like India, where starvation is rather the rule than an exception

and where infectious diseases are pandemic, it is not surprising to find that the hemoglobin content of the blood of an average individual is much below the normal standard. This poverty of blood not only gives rise to innumerable symptoms such as mental and physical depression, loss of energy etc. but subjects the individuals having it to all sorts of infectious diseases as their resistance and the vitality is much below par. Over and above this anemias are so very rampant that seven persons out of ten are suffering from it, specially secondary anemias. Fortunately it is amenable to treatment. Various clinicians in their arduous search for an ideal blood-regenerating tonic have tried numerous substances. It was Halliburton, the famous physiologist, who demonstrated that rats when fed on raw fresh blood showed remarkable increase in hemoglobin and in the corpuscular element of the blood. This was corroborated by the researches of Abderhalden who showed that both Hemoglobin and Hematin when administered through blood are properly absorbed and lead to an increase in the hemoglobin of the blood. The administration of such a preparation of Hemoglobin not merely brings about rapid increase in the normal constituents of the blood, but eliminates all the untoward gastro-intestinal symptoms following the exhibition of old-fashioned inorganic or even organic salts of Iron. Such an ideal preparation is Hemoplase (Lumiere) which is Hemoglobin in its natural state.

Hemoplase is a palatable preparation of the protoplasmic extract from the globules of blood of healthy animals. It represents all the essential elements elaborated by the living cells and diastatic ferments. In fact it is Hemoglobin in its natural state. It is a combination of the albuminoid substance of the blood with its ferruginous principle which is directly and immediately assimilable without any fatigue or disturbance. This preparation is absolutely reliable as it is prepared with true nascent and crystallised Hemoglobin obtained by means of a special scientific process. It is therefore a perfect, highly scientific preparation of an invariable quality.

That Iron is the greatest hematinic so far known to the Medical World cannot be disputed. In Hemoplase this Iron is present in a non-astringent, non-constipating and easily assimilable form. Its therapeutic action therefore in anemic conditions specially due to organic deficiencies is of great value. Hemoplase helps to nourish and stimulate the living cells in all the tissues. As a result of this the entire organism is stimulated and the vital functions are adequately toned up and there is the sensation of general well-being. The administration of this product is followed by proper reconstitution of the blood and the viscera as manifested by an appreciable increase in erythrocytes, and in the richness of the corpuscles. Cachexia and all its external signs disappear and there is rapid increase in body-weight. All these effects are due to the excellent resorption and rapid action of Hemoplase.

Hemoglobin, we are all aware, plays a decisive part in the life process. Hemoplase carries this in the natural state directly into the blood and hence its utility in a variety of conditions. It thus influences the vitality and the number of red-blood-corpuscles and brings about the return of appetite and strength. The rich and the vigorous blood thus secured circulates in the organism, nourishes the cells and restores the enfeebled and anemic organs. The nutrition is improved and the nervous system is stimulated.

It is because Hemoplase supplies Iron in the form of Hemoglobin it can be prescribed in all secondary anemias which follow a number of diseases such as Malaria, Kala-Azar, Puerperal and continued fevers. It is also indicated in anemias resulting from prolonged lactation. Bright's disease, Pneumonia, Typhoid and Influenza. In fact, Hemoplase can be given in all cases of deficiency of red corpuscles due to any cause whatever. It revivifies the blood and makes up for the wastage of Hemoglobin. Hemoplase is nothing but Iron in the form of readily assimilable organic compound practically in the same form in which it is present in the body. It stimulates the hemopoetic organs and makes up for the deficiency of Iron in the blood, which forms the salient feature of all anemias. It is thus a powerful hematinic.

Chlorosis which is most frequently met with amongst girls at puberty can be best treated by means of Hemoplase. This remedy is by far superior to others containing Iron as the increase brought about in the total contents of Hemoglobin and the corpuscles is absolutely permanent.

In addition to this it increases the resistance of the corpuscles and does not in any way modify the leucocytes. The most remarkable thing about Hemoplase in Chlorosis is that its action is permanent.

Hemoplase is beneficially indicated in that fell disease known as Tuberculosis, not because it has any specificaction on the Tubercle Bacilli, but it is the best means of fortifying the blood, and a healthy organism with vigorous blood in the surest way of resisting the infection. It acts as a good stimulant and a tonic and exerts a certain anti-toxic action by transferring to the affected part the active elements of the blood corpuscles. It never causes in this affection any inflammatory or toxic symptoms. The general stimulant and tonic action is clearly evident as is manifested by the return of appetite, strength and increase in weight.

In Cachexias of whatever origin Hemoplase can be employed with success. The favourable results are due to the intensive regeneration provoked by this product. The Hemoglobin as furnished by Hemoplase is readily absorbed by the red-corpuscles It is not eliminated by the kidneys and hence there is no risk of the patient suffering either from Hemoglobinuria or Albuminuria.

Due to the improvement in the blood-picture and the increase of body-weight, Hemoplase can be used with advantage in Convalescence. Nothing helps the enfeebled and the exhausted organism more than Hemoplase as it restores strength and stimulates the organs in an effective manner.

The additional advantage of this product is that it stimulates the appetite.

Certain cases of Nervous Debility which are refractory to Iron and Arsenic preparations respond well to Hemoplase treatment, because of the general restoration and improvement in the blood it brings about.

As Iron is essential for the formation of Hemoglobin and as the majority of the ordinary preparations of Iron effect after long-continued use the stomach and intestines causing constipation, damage to the teeth and skin eruptions, Hemoplase is always preferable. It contains Iron in such a form that none of these by-effects are experienced and that it is perfectly assimilable. Its administration therefore excludes all these disadvantages. Being an elegant preparation it is usually liked by all sorts of patients. It is practically always well-tolerated and does not affect the gastro-intestinal canal. Its excellent absorption in patients with gastro-intestinal disturbances is a great advantage. It does not deteriorate on keeping. Hemoplase constitutes a remedy superior in value on account of its rapidity of action, gastric tolerance and absence of any contra-indications.

In view of the fact that Hemoplase contains ferments and lipoids the method of administration most advisable is the intramuscular one, but we come across patients who for some reason or other refuse injections and for them it is available in pill-form, which can be prescribed by the oral route.

———

medical register. Yet such an anamoly will soon be worked out in India and find a place in the statute book.

We have pointed out more than once that for the sake of bringing about an uniform standard of education even for medical graduates there was no need for a separate All-India Medical Council. The existing provincial councils have power to regulate medical education and at present all these councils are presided over by either the Surgeon-General or Inspector-General of Civil Hospitals and nothing could prevent these to adopt a standard of medical education for graduates even to the dictation of the General Medical Council. So far the Medical Councils have been doing little or nothing to control medical education as unfortunately the President of these Councils were the advisers of Government on all matters, "medical" even including medical education and no reference was ever made (we could say with authority at least in Madras) by the Government to these bodies. Such references usually should start from the head of the medical department on behalf of the Government and when the heads of these departments were the Presidents of the Medical Councils these heads usurped all the powers of the Council.

The people's representatives in Indian Legislative Assembly will be certainly guilty for being the cause of sanctioning a wasteful yearly expenditure of over 80 thousand rupees to run an All-India organisation, the Indian Medical Council, with no benefit either to the profession or to the public. Before closing we would point out yet another anamoly in calling this Council Indian Medical Council which does not denote the purpose for which it has to exist. A suitable name would be The Indian Medical Graduates' Council, which name was suggested by us long ago at the very early stage when we had occasion to criticise this Bill.

Is the Government of U. P. Bankrupt? Dr. S. L. Sharma, President, the U. P. Branch of the All-India Medical Licentiates' Association has circulated an appeal to the Medical Licentiates in the United Provinces to subscribe liberally towards a fund of Rs. 15,000 which Dr. Sharma intends to give to the Government of that province to enable them to equip a pathological laboratory in the Agra Medical School for the purpose of increasing the course of studies from 4 to 5 years. The Principal of the Agra Medical School seems to have assured Dr. Sharma that in case the latter was able to collect this amount for the purpose referred to above, the Principal would immediately begin the 5 years' course. We admire the zeal and enthusiasm of Dr. Sharma and would have suggested to him to enlarge the field of the collection including amongst the subscribers of the fund the public of U. P. in case the school management and administration was transferred to a democratic School Committee. This aspect of the question apart, does Dr. Sharma consider his brethren, all told, richer than the Government of U. P.? Whatever be the nature of the present financial stringency, Rs. 15,000 which is only a capital expenditure can certainly be found by the Government of the United Provinces, if they are really earnest that Medical Licentiates should get a higher standard of of education consistent with the times. This is a legitimate and modest demand on public funds. The Government of U. P. is certainly not so bankrupt as to collect a petty amount of Rs. 15,000 from the Licentiates to give them sound medical education.

U. P. Second Class Health Officers in Conference: We very much regret we could not publish the proceedings of the first conference of the Second Class Health Officers of the United Provinces, as the matter reached us too late and we had to be satisfied in publishing only the resolutions passed by the conference, which appear in the correspondence columns. But we will be failing in our duty if we do not take the earliest opportunity of congratulating Dr. Mit Singh, the President, The All-India Medical Licentiates' Association, U.P. Public Health Branch, for having not only successfully organised a public health branch of the Licentiates in U. P. but having convened the first conference of this useful band of public servants in the historic city of Lucknow. The Conference met on 29th July at the Provincial Hygiene Institute under the Presidentship of Dr. A. C. Banerjea, M.B.B.S., D.P.H., Dr. P.H. Asst. Director of Public Health. Dr. Mit Singh welcomed the President and taking advan-

tage of his official position narrated briefly the grievances of Medical Licentiates in Public Health Service. Dr. Mit Singh said that there were two classes of officers in the Public Health Subordinate service, Medical Officers in charge of travelling dispensaries and 2nd class Health Officers, and that usually the latter class of officers are recruited to the former, and, one of the Directors, Public Health, eulogised the services of the officers in charge of Travelling Dispensaries thus.

"These dispensaries have proved to be a most useful agency in dealing with the outbreaks of plague and cholera. They are coming to be recognised as an established institution in these provinces and are enjoying an ever-increasing popularity. In times of epidemics the demand for their services is so excessive that it is found impracticable to meet the demands. They are enjoying ever increasing popularity among the village people, and are of much benefit in bringing medical aid to the doors of rural population."

In spite of the splendid work turned out by these officers in rural areas the U. P. Government have done away with 13 units, as a measure of retrenchment and with them 25 medical officers were deprived of their work. Regarding Second Class Health Officers the retrenchment axe has its cut and 8 Asst. Medical Officers were the victims of the axe. Dr. Mit Singh pointed out that only 1½ per cent of 2nd class Health Officers were promoted as 1st Class Health Officers and appealed to the Government that atleast 30 to 40 per cent of posts of 1st Class Health Officers should be made open to the deserving 2nd Class Health Officers. He said that a great injustice had been done to the class he represents by removing from them the privilege of their being treated as Gazetted officers from 1928. Granting of study leave to those who are anxious to improve their knowledge was also pressed by Dr. Mit Singh and finally he brought to the notice of his audience the desirability of granting pension to the 2nd class of Officers or at least provide them with a provident fund as these officers being deprived of private practice,—a privilege enjoyed by their brethren employed under the Government on the curative side,—had no touch with the profession and consequently could not earn anything by way of private practice after retirement. Dr. Banerjea made a very sympathetic reply and wished his hearers to understand that what came out of his lips that day should be considered as his private views and not the views of the Asst. Director of Public Health.

Unlike the Government in other civilised countries the Government in India spend lavishly and proportionately several times more to pay the curing section of the Public Health Department and starve the preventive section of the same department. Consequently India continues to be a death trap for infectious preventible diseases. The unhampered privileges of private practice granted to the Medical Officers employed on the curative side naturally attracts the best men for that department with the result that those employed under the preventive side of the Public Health Department are not usually the best products of the medical profession and the few that join the Health Department have neither the zeal nor the enthusiasm as they are not paid adequately. Consequently Public Health in India continues to be as unsatisfactory as ever. It is really praiseworthy that the Licentiates belonging to the Health Department of the United Provinces have organised themselves into a band for the purpose of not only ameliorating their condition but render useful service to the Government and the public. From the reports of this Association by their energetic Secretary, Rao Sahib Dr. Chotey Lal at the Conference it appears to us that the Association is going about their business most constitutionally and loyally too. They deserve sympathy and encouragement not only from the Government but also the public of U. P. who, we hope, would realise that prevention is better than cure and that all those who prevent diseases should be appreciated the more, if not as much as those who cure them. Before closing may we suggest to all those employed in the preventive section of Public Health Department in other provinces to emulate the noble example of their brethren in U. P.

A Legitimate All-India Grievance: We learn that instructors in almost all the medical schools in India who have no

work in the hospital are posted for night duty in the Hospitals attached to the Medical Schools and the instructors that suffer most are those working in the Anatomy Department. These teachers have the most tiresome work from the early part of the day till late in the evening and will have scarcely any time or energy left in them to prepare for the work in the school in case they are forced to do night duty. Moreover they are not in touch with the professional work in the wards. This can also be said about the medical officers in charge of X-ray Department attached to hospitals. It is not fair in the interest of the patients or of the public to entrust doctors to do work with which they are not in touch with. We trust the Superintendents of the medical schools in India would consider about this legitimate grievance of their subordinates and find their way to relieve them from hospital duty. The entertainment of honorary clinical-assistants in some provinces such as Madras, would, we hope make the path of the Superintendents easier in the direction of this necessary reform.

Our Medical Economic Problems: In every province in India, politicians talk loud whether it be on public platforms or on the floor of the Legislative Councils that there is a dearth of qualified medical men to look after the teaming population in India. The qualified medical profession usually cries or laughs at the outburst of vehemence from the lips of those politicians for, many of them in spite of a great need for qualified medical service actually starve for want of employment. It is the want of "A solution to some of our medical economic problems" that is the cause of unemployment of qualified practitioners in India. The word 'employment' unfortunately is considered as service under somebody. We wish the members of the profession realise that the word 'employment' could be used for service not necessarily under any body. In our Abstract columns of the current issue we have published a thought-provoking article on "A solution to some of our medical economic problems" from the pen of an eminent American Doctor, Hyman Goldstein, M. D. His words really carry the weight of gold and we commend this article for the serious consideration of the independent members of the profession. If in a country like America, the medical profession is in want of an organisation for solving economic problems, the need for such an organisation in India, may well be imagined than described.

Employment of Lady-doctors: It is most distressing that the Government in this country are callous towards the growth and prosperity of the independent medical profession. General economic condition which forced them quite recently to apply the retrenchment axe discriminately or indiscriminately, does not seem to have any effect on those who constitute the Government. It is specially so in Madras. We find the Madras Public Service Commission advertising for the post of 8 Lady Sub-Assistant Surgeons. The Honorary Medical Officers scheme has been tried and found not only useful but economic. It may be argued that there is a paucity of honoraries amongst lady-doctors. This is not due to want of lady-doctors but their unwillingness to serve without pay. There are many amongst them who are without employment. We are quite sure the number will be more than 8, the number of Lady Sub-Assistant Surgeons now required by the Madras Government. Why not offer them an honorarium as a special case for a few hours' work in the hospitals? The honorarium may be even equal to the pay the Government offer to them in which case the Government will be at least relieved of an additional expenditure later towards their pension. This suggestion if carried out by the Government will encourage lady-doctors to take to honorary work and indirectly educate them to depend upon their own resources to get along as successful practitioners.

Convention or Exemption? We take it that the condition "British subject" is a necessary qualification for employment under the British Government. All the same there are a large number of non-British subjects now under the Madras Government especially so in the Medical Department. A lady practitioner who is one of the candidates to the post of Lady Sub-Assistant Surgeon, advertised by the Madras Public Service Commission, feels nervous if she, a British subject, has a chance of being preferred to non-British candidates. The cause of her nervousness

seems to be that till recently non-British subjects were entertained in the British Medical Department.

We refrain from giving any advice to this lady, awaiting an answer from the Secretary, Public Service Commission to whom we have asked a query whether entertaining of non-British subjects to posts under British Government is a time-honoured convention or an existing exemption ?

Subsidised Rural Medical Relief: It is superfluous to mention that we are very much interested not only in the Rural Medical Relief Scheme but also about the welfare of those who are rendering medical relief in rural areas. Recently we put before our readers a scheme discussing the same in our Editorial Columns. We are glad that our contemporary in Bombay, the official organ of the Bombay Medical Union, is interesting itself about rural medical relief scheme in Bombay and trust that this subject will be discussed at the All-India Medical Conference that meets in Bombay next Xmas week. The Government of Madras have recently amended the conditions of agreement between subsidised rural practitioners and Taluk Boards. At our request the Secretary, the Madras Provincial Rural Medical Practitioners' Association, has contributed an article commenting upon the old and new conditions of agreement which we have published in the Correspondence Columns of the current issue. We trust that those interested in rural medical relief will go through these comments and make useful suggestions in the working of this beneficial scheme which, if well organised, would solve the problem of rural reconstruction.

A correction: We are sorry that the information published by us in the June issue in these columns that only two out of the five Licentiates passed the 2nd M.B.B.S. examination Part II is incorrect. We since learn that 3 passed, out of whom one, Mr. M. D. Barve, from Nagpur stood first in rank amongst the successful candidates.

An Apology: We regret that due to other pressing matter we had to withhold some reports of the meetings of Medical Associations.

Correspondence, Reports, Etc.

Comparative Statement regarding the old and new agreement forms of the subsidised Rural Medical Practitioners.

By

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

Secretary, The Madras Provincial Rural Medical Practitioners' Association.

G. O. No. 1522 PH of 24 inaugurating a scheme of medical relief for the rural population by subsidising private practitioners who agree to settle in villages was issued on 22-10-24 and subsidising of the practitioners was begun from November of that year. It was my lot to take up to this pioneering work in February 1925. Even at the start, I recognised the benificial potentialities of the scheme, but felt that there was a great deal to be improved upon through effective organisation and agitation. Accordingly I issued an appeal for the formation of an Association at the end of 1925, and excepting for one single individual, the rest of the subsidised practitioners did not take up the idea. A second appeal was issued in January 1927 and this time the response was good. Subsequently, three conferences were held, the first at Trichy on 3-6-27, the second at Tanjore on 26-8-28, and the third at Madras on 31-12-30, and resolutions were passed for the acceptance of the Government. Government were kind enough to accept many of them, some in part, and some in full. The details of the scheme have been amended considerably, though not to the extent desired by the Association. It would be impossible to recapitulate all the work of the Association in a short article as this. As the agreement is the *Magna Carta* of the practitioner, I shall attempt to indicate the work of the Association by dealing with the two agreements para by para mentioning first the old conditions of the agreement followed by the conditions in the new agreement, with comments on each para.

1. (Old Agreement) "The practitioner will proceed at his own expense to the village of.....and there take up his residence."

1. (New Agreement) The wording in this para is the same as in the old.

2. (Old Agreement) "The practitioner will treat professionally and supply with the necessary medicines all the 'necessitous poor' who shall apply to him from time to time therefor such treatment being given and medicines supplied free of all charges at the residence of the practitioner."

N. B.—The term 'necessitous poor' in this paragraph shall be interpreted as referring to persons or members of the families of persons whose monthly income does not exceed Rs. 30.

2. (New Agreement) "The practitioner will, free of any charges treat professionally and supply with the necessary medicines from and out of the stock supplied to him by the Board, all the necessitous poor who may from time to time apply to him therefor at his dispensary."

The N. B. following this para is the same as appearing in the 2nd para of the old agreement.

Remarks: The Secretary of the Association requested the Government in July 1931 to add the words "from the stock supplied to him by the Board" after the words "necessary medicines." The advantage to the practitioner on account of this addition is obvious.

3. (Old) "Subject to the provisions of the paragraph (2) the practitioner shall be entitled to practise for his own benefit and to charge reasonable fees for services rendered."

3. (New) "Subject to the provisions of paragraph (2) the practitioner shall be entitled to charge fees for professional services rendered and medicines supplied."

4. (Old) "The practitioner shall display in a conspicuous place on the outside of his residence a notice in the vernacular of the district, to the effect that it is the rural dispensary of the Taluk Board and he shall maintain at such dispensary the books and registers and shall make the statistical returns as set out in the schedule hereto, such returns to be forwarded through the President of the said Taluk Board to the District Medical Officer of... at such times as the said District Medical Officer may direct. Such last mentioned registers shall be open at all times to inspection by the said District Medical Officer or the President of the said Taluk Board or any other person or persons authorised in writing by both of them in that behalf."

4. (New) "The practitioner shall display in a conspicuous place on the outside of the dispensary a notice in the vernacular of the district to the effect that it is the rural dispensary of the Board and shall maintain at such dispensary the books and registers and shall make the statistical returns set out in the schedule hereto, such returns to be forwarded through the President of the Board (hereinafter called the President) to the District Medical Officer of (hereinafter called District Medical Officer) or the Principal, Indian Medical School, Madras (hereinafter called the Principal) according as the dispensary is an allopathic institution or an institution of Indian Medicine at such periods as the District Medical Officer or the Principal as the case may be may direct. Such registers shall be open at all times to inspection by the District Medical Officer or the Principal as the case may be, or the President or any person or persons authorised in writing by any of the aforesaid authorities, in that behalf. The practitioner shall submit promptly all such information as may be required by the Government of Madras (hereinafter called the Government) the District Medical Officer, the Principal, the President or any other person or persons authorised in writing by any of the said authorities in this behalf. He shall also observe the procedure which may be laid down by the Government in regard to the claiming of the subsidy due to him and the midwife, if any."

5. (Old) "The said District Medical Officer or any one deputed by him in writing shall be entitled to enter and inspect the dispensary and so often as he shall think fit."

5. (New) "The said District Medical Officer or the Principal as the case may be or any one deputed by either of them in writing shall be entitled to enter and inspect the dispensary when and as often as he shall think fit."

6. (Old) "The Board will from the date of opening the dispensary and during the continuance of this agreement pay to the practitioner the sum of Rs.....per annum payable by twelve equal instalments of Rs.....per mensem."

6. (New) "The Board will from the date of the opening of the dispensary and during the continuance of this agreement pay to the practitioner the sum of Rs.....per

annum in such instalments and in such manner and subject to such conditions as may be laid down by the Government in this behalf by general or special order."

7. (Old) "If the practitioner shall engage, maintain, and employ a qualified midwife in the village of..... the Taluk Board will pay to the practitioner an additional subsidy of Rs. 100 per annum payable by equal monthly instalments.

Remarks on 4, 5, 6 & 7: NAME. The words 'rural dispensary' do not seem to fit in with the scheme or its objective. It gives an erroneous impression to the people that all patients ought to be treated there free, and that a practitioner who demands fees from rich patients is really going out of the way. The practitioner being styled an independent one, should be entitled to name the dispensary in his own way, on condition that he exhibits in the place a notice to the effect that the 'necessitous poor' will be treated free from and out of the stock of medicines supplied to him by the Taluk Board. This idea was included in a memorandum presented at the time of the deputation on 4-4-1932.

SUBSIDY. The original subsidy fixed was Rs. 400, Rs. 500, and Rs. 100 per annum to an L.M.P., a medical graduate and a midwife respectively. By G. O. No. 2047 PH dated 6-10-25 Government allows the Taluk Boards to augment the subsidy from their own funds. By resolution B III of the I Conference the Association requested the Government to enhance the subsidies to Rs. 150, Rs. 100 and Rs. 15 per month for a medical graduate, an L.M.P., and a midwife respectively. Government increased the subsidy for the L.M.Ps. to Rs. 500 per year and the midwifes' to Rs. 300 per year, vested the power of appointing midwife to the President Taluk Board and deleted clause 7 of the old form of the agreement. By resolution VI of the III Conference, the Association requested Government to vest the power of appointment of the midwife in the practitioner; Government would not concede to this but directed that the midwife should attend the rural dispensaries during office hours. (G. O. No. 1388 PH dated 28-6-32.)

DISBURSEMENT OF THE SUBSIDY: In the early years of the inception of the scheme there was a lot of delay on the part of the Taluk Boards in disbursing the subsidy. On representations made by the practitioners, Government ordered that the subsidy should be disbursed before the 10th of the succeeding month. Still subsidies were delayed for frivolous and vexatious reasons. By G. O. No. 1932 PH dated 9-9-32 Government directed the payment of the subsidy on bills prepared by the practitioners countersigned by the District Medical Officers on the certificate of the President, Taluk Board, to the effect that the practitioner had executed an agreement with the board and treated the poor free. The present practice involves a lot of delay, trouble and risk in cashing the bills. It would be better if the D.M.O., draws the bills and remits the subsidy.

7. (New) "The Board will supply the practitioner free of cost medicines of the value of not less than Rs. 360 per annum on the basis of the standard recommended in G.O. No. 761 PH dated 7-4-25. The Board will also supply the practitioner with the necessary outfit for the use of the midwife, if one is employed in the dispensary. The medicines required by the midwife should be supplied from time to time from the stock of drugs supplied to the practitioner by the Board."

8. (Old) "The Taluk Board will supply the practitioner free of charge with medicines costing not exceeding Rs. 360 per year, on the basis of the standard recommended in G. O. No. 761 PH dated 7 4-1925.

Remarks on 8 (Old) and 7 (New): The standard recommended in G.O. No. 761 PH was only meant as a basis for the first year of the working of the dispensary. Still on representations made by the practitioners the Surgeon-General allowed the supply of any drug or equipment on the recommendation of the D.M.O. By resolution BI of the 1st Conference the Association requested the deletion of the words 'not exceeding' and the substitution of the words 'not less than' and Government complied with this request. By resolution VII of the IInd Conference, Government were requested to direct the Taluk Boards to necessarily equip their rural dispensaries with a set of midwifery, dental and other surgical instruments mentioned in G.O. No. 761, and cite such supply in the agreement itself. Government have not

passed any order on this. Every subsidised practitioner should be supplied with the most necessary instruments; their cost should not be included within the Rs. 360 and a lump sum should be provided therefor at least once in five years to purchase new instruments or replace old ones.

It was also requested by the Association through resolution VII of the IIIrd Conference that the cost of drugs supplied should be proportionate to the attendance, and that the midwife's requirements should be supplied separately by the taluk boards. Government would not accept the resolution but directed that the cost of the midwife's outfit should be borne separately by the taluk board. A lot of correspondence passed on this point between the Surgeon-General and the Secretary of the Association and at a personal discussion on 1-11-1932, the Surgeon-General advised the Secretary to make further representations in the light of experience gained at the end of a year.

8. (New) "The Practitioner may for sufficient reasons and with the previous sanction of the President, Taluk Board avail himself of leave of absence from duty for 15 days in the aggregate in a year. He shall not in the absence of special reasons leave the station without obtaining the previous permission of the President. When for this reason this is not possible he may leave the village in anticipation of such sanction but shall intimate to the President in writing the fact of his departure from the village and shall also state the reasons for such departure. He shall send a report to the District Medical Officer or the Principal as the case may be whenever he leaves the station. In all cases he shall send a report to the President and the District Medical Officer or the Principal as the case may be as soon as he returns to duty. The President may grant leave to the practitioner in excess of the 15 day's limit laid down above, provided the President obtains a substitute or the practitioner arranges for a medical practitioner approved by the President to be in charge of the dispensary during his absence. The substitute so appointed will receive a portion of the said subsidy, proportionate to the period during which he is in charge of the dispensary. In the event of the practitioner being absent from duty for more than.....months, the President may under the provisions hereinafter contained terminate this agreement; provided however, that if the President is satisfied that such absence is due to illness the practitioner will be allowed to have a lien on his appointment for a period of six months from a date to be fixed by the President."

9. (Old) "The Practitioner may for sufficient reasons avail himself of casual leave for 15 days in a year subject to a maximum of 10 days at a time inclusive of recognised holidays. He shall send a report to the President, Taluk Board, when he proposes to absent himself from the station and as soon as he returns. He will not be entitled to any other kind of leave."

Remarks on 8 (New) and 9 (Old): LEAVE: The number of days that may be availed of in a year was very low, and the Association requested Government by resolution A V of the Ist conference and IX of the 2nd conference to allow every practitioner leave for one month in a year with the privilege of accumulating it in a period of three years to cope with such circumstances as ill-health, marriage, family difficulty, etc. Government have realised the necessity for long leave and would concede him the privilege to avail of such leave on loss of subsidy with a lien on his *locum tenens*, but would allow leave on full subsidy only for 15 days in a year, to be availed of in full if need be. Very little has been conceded this way. As for the conditions, the Association regards that they are very restrictive, and ignore the independent status of the practitioner. It is not always possible to foresee from afar, the necessity of going on leave; even if one is aware of his need he does not get a reply in time intimating such sanction. The new conditions imply that the President may also refuse the leave asked for, or sanction a portion of it. In this respect, the practitioner is literally at the mercy of the President, and it is apprehended that the power vested in the President will be abused. The Secretary requested the Government and the Surgeon-General to stick to the old procedure generally and to deal with recalcitrant or negligent practitioners in the manner proposed in clause 8 of the new Agreement. The Surgeon-General was not in favour of complying with the Secretary's request.

9. (New) "The practitioner shall not be liable to transfer from one dispensary to another. If after obtaining the opinion of the District Medical Officer, or the Principal as the case may be, the Board considers that the dispensary is not working satisfactorily it may close the dispensary after giving three month's notice in writing to the practitioner."

Remarks on 9 (New): This clause is new. The Association would however request that it be provided in this clause, that in case the unsatisfactory working of a dispensary, is due to causes other than any incompetency or negligence on the part of the practitioner, the Board may close down the dispensary at the particular place and shift it to another place with the same practitioner.

10. (Old) "This agreement shall be subject to termination by either party on giving to the other of them six calendar months' notice in writing to that effect."

10. (New) "The practitioner shall if required either by the President or the officers of the Health Department attend to inoculation work. He shall be paid by the Board for the services so rendered a remuneration at the rate of 9 pies per case of inoculation subject to a minimum of Re. 1 per day and a maximum of Rs. 5 a day and shall also be paid travelling allowance for journeys if any beyond five miles undertaken by him in connection with such work. He shall also attend fairs and festivals duty if required by the President or the Officers of the Health Departmnet. He will be paid by the Board a daily allowance of Rs. 5 and travelling allowance for journeys if any beyond five miles."

(*Remarks on 10 New*): This clause is result of the representation of the Association. The matter was personally discussed with the Hon. the Minister at the time of the deputation on 10-10-27, with the D.P.H. and Secretary to Government L.S.G. on 3-4-30 as a result of which G. O. No. 1955 PH dated 7th august 1930 was issued allowing a daily remuneration of Rs. 5 for a practitioner. The Secretary in his individual capacity, suggested to the Government that as time and speed of inoculations were very important in times of epidemics, every subsidised practitioner be allowed to carry on inoculations without waiting for any direction from the President or the Health Officer, and that his remuneration be assured at one anna per inoculation without any limit as to the maximum remuneration for a day. Government would not accept the suggestion except that of the remuneration on a capitation basis, and that too at a lower rate than requested. The maximum was also fixed.

Remarks on 10 (Old): As clause 10 of the old Agreement gave the exclusive power to the President, Taluk Board, to oust a practitioner without assigning reasons, the Government directed at the request of the Association (Vide Resolution B II of the Ist Conference) the addition of the words, 'But the Taluk Board will not be entitled to terminate this Agreement under this condition unless it finds itself unable to maintain the dispensary on account of financial stringency.' A further safeguard for the practitioner would be that in cases of closure the Taluk Board obtains the previous sanction for it from the Government after acquainting them of facts and figures.

11. (Old) "Provided that the Taluk Board shall be entitled to terminate this agreement at any time without notice in the event of any breach by the practitioner of any agreement on his part herein contained or in the event of the practitioner's name being removed from the medical register mentioned in Section 11 of the Madras Medical Registration Act of 1914."

11. (New) "Save as otherwise provided this agreement shall be subject to termination by either party on giving to the other of them six calendar months' notice in writing to that effect; provided however that the Board shall be entitled to terminate the agreement under this clause only in the event of its being unable to maintain the dispensary on account of financial stringency. The Board shall also be entitled to terminate this agreement at any time and without notice to the practitioner in event of any breach by the practitioner of any agreement on his part herein contained or in the event of the practitioner's name being removed from the medical register maintained under Section 11 of The Madras Medical Registration Act IV of 1914 or in the event of the practitioner being absent from duty for more than.....months. In the event however of an alleged breach by

the practitioner of any agreement on his part, the Board shall first frame definite charges in writing, obtain the explanation of the practitioner in writing and then proceed to pass orders in the matter. Before terminating his contract in such cases the President shall obtain the concurrence of the District Medical Officer or the Principal as the case may be. If however the President and the District Medical Officer or the Principal as the case may be, disagree, the matter shall be referred to the Government whose decision shall be final and binding on all parties. An appeal shall lie to Government at the instance of the practitioner in all matters in which a reference to Government has not already been made and the decision of the Government thereon shall be final.

12. (Old) "In case of any dispute arising as to the meaning of these presents or in respect of any matter or thing arising thereunder the same shall be referred to the Government of Madras whose decision shall be final and binding on both the parties."

12. (New) Same as in para 12 of the Old Agreement.

Remarks: According to the old agreement, a President could merely and arbitrarily say that there has been a breach of the agreement on the practitioner's part and oust him without notice putting him on his defence. This was placed before the Government, and they were requested, 'that no rural practitioner will be sent away except on due notice or after full enquiry and notice, in case of any breach of contract, an officer not below the rank of a District Medical Officer shall enquire into any allegations (giving the rural practitioner sufficient opportunity to present his case) and report to the Surgeon-General an appeal against whose decision will lie to the Government'. (Resolution B II of the Ist Conference), as a result of this, by G.O. No. 2185 PH dated 3-11-1927 Government ordered the addition of the words, 'In the event however of an alleged breach by the practitioner of any agreement on his part, the Taluk Board should first frame definite charges in writing, obtain the explanation of the practitioner in writing and then proceed to pass orders on the matter' at the end of clause 11 of the old Agreement. The stipulation that the concurrence of the District Medical Officer should be obtained before ousting, in clause 11 of the New agreement is a modified compliance of the resolution above quoted. As it is, there is no manner or means for the practitioner to learn that the President has obtained the concurrence of the District Medical Officer.

Second Class Health Officers' Conference, Lucknow.

Resolutions passed at the annual General meeting of the All-India Medical Licentiates Association, Public Health Branch, held at Lucknow on 30th July, 1933, under the Presidentship of Dr. A. C. Banerjea, D. R. P. H., etc., Assistant Director of Public Health.

1. That this Association places on record its deep sense of regret at the sad, sudden and untimely demise of Dr. Ram Das Kunwar, Medical Officer of Health, Hardwar, and conveys its sympathies to the members of his family.

2. Resolved that the Medical Officers in charge of travelling dispensaries be allowed to tour for 20 days in a month during non-epidemic period and in the remaining 10 days they should concentrate and organise Public Health activities in a definite circle near the Head-quarters where they be allowed to return in the evening.

3. Resolved that the Association requests the Government to throw open at least 11% of the cadre of the 1st class Medical Officers of Health to the members of the 2nd class Medical Officers of health with 14 years Public health service without any examination.

4. Resolved that the Government be moved to allow an annual increment of Rs. 5 and Rs. 10 to the new entrants in the cadre of the medical officers in charge of travelling dispensaries and 2nd class medical officers of health respectively.

5. That this association requests the Director of Public Health to exercise his influence and support the cause for acquiring the concessions of contributory provident fund for the services in the absence of any old age provision in the form of pension or regular provident fund.

6. Resolved that the privilege of study leave be extended to L. P. H. medical officers of health desirous for post-graduate studies in India or abroad.

7. Resolved that in cases where the Medical officers in charge of travelling dispensaries are required to travel beyond 15 or 20 miles from the halting place, they may be allowed mileage according to T. A. rules.

8. Resolved that in view of the fact that the efficiency of officers, more particularly in the transferred departments, depends upon their prestige as has been fully experienced since the time the second class medical officers of health have been excluded from the gazetted list, the Government may be requested to bring on the gazetted list all second class medical officers of health drawing Rs. 260 P. M. and above in case of old incumbents and Rs. 200 P. M. and above in case of new entrants.

9. Resolved that the L. P. H. Officers be allowed to occupy P. W. D. irrigation and Forest Dak bungalows and inspection houses when travelling on duty.

10. This branch has learnt with deep concern the proposed exclusion of the Licentiates from the purview of the Indian Medical Council Bill and requests the Government of India to include the Licentiates within the purview of the proposed Medical Council.

11. The bill for Rs. 23-14-6 for postage for the year 1933 be passed and the bill be submitted to the General Secretary for payment.

12. The following office-bearers were elected for the year 1933-34.

(1) Dr. Mit Singh President. (2) Dr. S. M. H. Joffrey, (3) Rai Sahib Dr. Chhotey Lal, Vice-Presidents. (4) Dr. Indra Narain Saxena, Secretary. (5) Dr. H. H. Blanchfield, Joint Secretary. (6) Dr. R.N. Tandon, Treasurer.

13. The following gentlemen were elected on the Executive Committee.

(1) Dr. Sheo Prasad Saxena. (2) Dr. Prakash Chandra. (3) Dr. A. H. Qureshi. (4) Dr. Mohd. Mirza Azam Birlas. (5) Dr. Ayodhya Singh Dixit. (6) Dr. Bhagwat Sarup Gupta.

14. Resolved that this Association thanks the Government for conferring the title of Rai Sahib on Dr. Chhotey Lal Saxena in recognition of his meritorious public services.

15. Resolved that the Association is thankful to the Director of Public Health for concessions recently allowed to medical officers in charge of travelling dispensaries.

16. Resolved that this Association thanks Dr. J. T. Cornelius for placing at the disposal of the Association the use of the Provincial Hygiene institute for holding the session of the annual general meeting.

17. Resolved that the Association thanks the outgoing office-bearers for the zeal, enthusiasm and interest displayed by them in the discharge of their respective duties during the year at great personal sacrifice and inconvenience.

18. Resolved that the Association is very much thankful to all the gentlemen who have afforded help and taken the trouble in making the function a success.

19. The budget for the year 1933-34 was passed.

Depressing Conditions in India's Villages.

REVELATIONS OF SIR JOHN MEGAW'S ENQUIRY.

Sir John Megaw, Director-General of Indian Medical Services and lately Surgeon-General to the Government of Madras, has some interesting observations to make in the course of a small inquiry which he has been able to institute on certain aspects of public health in India with reference to Indian villages in particular.

In the course of a report which he has now got ready he draws pointed attention to the gloomy picture of rural areas at present so far as physical conditions are concerned. Sir John's inquiry seems to have been based on replies to a questionnaire he issued to a large number of Doctors whose dispensaries are situated in typically agricultural villages scattered all over India. The broad conclusions drawn by Sir John Megaw from these replies,

which have been carefully sifted by tests, are: (1) India has a poorly nourished population, (2) the average span of life is less than half of what it might be, (3) periods of famine or scarcity of food have been occurring in one village out of every five during the ten years' period in which there has been no exceptional failure of rain, (4) in spite of an excessively high death rate the population is increasing much more rapidly than the output of food and other commodities. (4) young girls who ought to be still at school are forced to become wives and mothers and many of them are doomed to die in child-bearing. (6) the epidemics of cholera, plague and small-pox are commonplace occurrences and (7) there is little evidence that the educated classes of community have realised the full gravity of the situation; at any rate, they have made no constructive proposals for investigating the problem or for working out a plan for its solution.

Sir John Megaw estimates the total number of cases of certain diseases for the whole of India as follows: Population: 353 millions: rickets, 239800; night blindness, 3,671,200; syphilis, 5,506,800; gonorrhoea, 7,589,500; leprosy. 41,300; tuberculosis of the lungs, 1,553,200; other forms of tuberculosis, 635,400; insanity, 282,400; congenital mental defects 317,700; blindness, 1,941,500.

The questionnaire issued to village doctors bore upon vital factors affecting the future of villages such as the rate of increase in population, death-rate food supplies, diet and physical condition of the villagers. This inquiry shows that the average area of land per head of agricultural population ranges from 1.45 bighas in Bengal to 5.27 in the Central Provinces but the yield of crops varies so greatly in different parts of the country that the actual area cultivated conveys little information as to the real income of each family.

NEED FOR RADICAL CHANGE.

It is in regard to the physical condition of people in the villages that the picture presented by the details supplied by the village doctors is most depressing. "Taking India as a whole dispensary doctors regard 39 per cent of the people as being well-nourished. 41 per cent poorly nourished and 20 per cent as very badly nourished."

"It is clear," he says, "that growth of population has already begun to outstrip increase in production of necessities of life so that even the existing low standards of economic life must inevitably become still lower unless some radical change is brought about. The outlook for the future is gloomy to a degree not only for the masses of the people who must face intensified struggle for bare subsistence but also for the upper classes whose incomes depend on the production of surplus of crops and other commodities. If the entire product of the soil is needed to provide for the urgent needs of the cultivators nothing will be left for the payment of rents or revenue, nothing to exchange for other commodities or even for purchase of railway tickets and the whole social structure of India must inevitably be rudely shaken, if not completely destroyed."

(THE HINDU)

Rules framed by the British Medical Association for advertising public medical service schemes:

1. The public medical service must be approved by the profession in the area as being in the public interest, a decision to this effect to be taken by a specially summoned meeting of the local profession.

2. The service may be advertised but not any individual practitioner.

3. Membership of the service must be open to any local registered medical practitioner.

4. Subscribers electing to choose non-cooperating practitioners can receive payment towards the discharge in part or in full of their medical accounts.

5. All prospective subscribers when approched are advised to consult their own doctors, the phrase "consult your own doctor" to appear on all propaganda of the service.

List of postings of Sub-Asst. Surgeons for the month of July, 1933.

No.	Names of Sub-Asst. Surgeons.	From	To
1	Dr. V. Sivasambu Pillai	Govt. Hd. Qrs. Hl., Palamcottah	L. F. Dy., Tiruchendur.
2	„ K. P. Chidambaram	Leave	L, F. Dy., Marungapuri
3	„ S. Somasundaram Pillai	L. F. Dy , Marungapuri	L. F. Dy., Jayakondan.
4	„ D. Madhavan	Leave	Govt. Hd., Qrs. Hl., Chittoor.
5	„ S. Sabapathy Pillai	Leave	Govt. Hd. Qrs. Hl., Cocanada.
6	„ K. R. Ganesa Mudaliar	Govt. Hd. Qrs. Hl., Cocanada	Govt. Genl., Hl , Madras.
7	„ A. P. Srinivasa Rao	Govt. Hd. Qrs. Hl., Kurnool	L. F. Dy., Maddikera.
8	„ T. Gnanayya	„ „ „ Trichinopoly	Dt. Hd. Qrs. Hl., Tanjore.
9	„ P. S. Sankaranarayana Iyer	Dt. Hd. Qrs. Hl., Tanjore	Govt. Hl., Kumbakonam.
10	„ S. Sengaliappan	„ „ „ Madura	L. F. Dy., Harur.
11	„ R. Srinivasa Iyer	Leave	L. F. Dy., Thatthiangarpet.
12	„ M. Varantharumperumal	L.F. Dy., Thathiengarpet	Govt. Hl., Ariyalur.
13	„ V. Vijiaraghavan	Govt. Hl., Kumbakonam	Dt. Hd Qrs. Hl., Tanjore.
14	„ V. Gnaniah	Govt Hd. Qrs Hl., Salem	L. F. Dy., Uttangarai.
15	„ M. Adinarayanaswami	Govt. Hd. Qrs. Hl., Cocanada	Munro's Hl , Gooty.
16	„ P. Narasimha Rao Naidu	Munro's Hl. Gooty	c/o D. M O„ Ganjam.
17	„ P. Sekhara Menon	Leave	L. F. Dy., Mannarghat
18	„ P. K. Kumaran	Agency Duty	Govt. Hd Qrs. Hl., Calicut.
19	„ P. Balasundaram	Govt. Hd. Qrs. Hl., Calicut	L. F. Dy., Sriperumbudur.
20	„ L. Jaganatha Rao	L. F. Dy., Sriperumbudur	Hd. Qrs. Hl., Ellore.
21	„ M. Virbhadra Rao	Govt. Hd. Qrs. Hl., Cocanada	Govt. L. F. Dy , Poorumamilla.
22	„ Ch. Krishnamurthi	Govt. Hd, Qrs. Hl., Masulipatam	L. F. Dy., Jaggayyapet.
23	„ P. K. Gopala Panikkar	L. F. Dy., Ginjee	c/o Residency Surgeon, Trivandrum.
24	„ O. Govindan Nair	Residency Hl,, Trivandrum	Agency Duty, Vizianagaram.
25	„ R. Ramachandran	Agency Duty	L. F. Dy., Ginjee.
26	„ A. Parasayya Naidu	Leave	L. F. Dy., Kuppam
27	„ B. K. Thathachari	L. F. Dy., Chittoor	Agency Duty
28	„ K. Nurasimham	L. F. Dy., Addatigala	Hd. Qrs. Hl., East Godaveri Dt.
29	„ T. Vaidhiswaran	Leave	Pasteur Institute, Coonoor.
30	„ D. Kirubhaimani	Dt. Hd. Qrs. Hl., Tanjore	Agency Duty, Ganjam.
31	„ M. Kunhikrishnan Nair	Agency Duty, Ganjam	Dt. Hd. Qrs. Hl., Tanjore.
32	„ Miss D. J. Elijah	Govt. Hd. Qrs. Hl., Masulipatam	Govt. Hl., Gudivada.

List of Postings of Second Class Health Officers for the month of August 1933.

No.	Names of Second Class Health Officers.	From	To
1	Dr. C. V. Vaidyanathan	Bodinayakauur	Ellore.
2	„ A. A. Astagiri	Cochin	Berhampore.
3	„ M. S. Govindarajulu	Vizagapatam	Chittoor.
4	„ T. C. Thavu	Chittoor	Cochin.
5	„ C. S. Ramachandra Pai	Cochin	Coimbatore.
6	„ M. Perumal Raju	Berhampore	Vizagapatam.

Reg. No. M. 2528.

Printed at THE INDIA PRINTING WORKS, "Sri Nivasam" Mylapore and Published by the Managing Editor, DR V. RAMA KAMATH, 147, Purasawalkam High Road, Vepery, Madras.