THE Medical Practitioner

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

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ALL INDIA MEDICAL CONFERENCE.

As was apprehended by us last month the All India Medical Licentiates' Association did not hold their annual conference at Indore and we have therefore dealt in these columns about the activities of the conference held at Delhi by the Indian Medical Association. Government officials in high position taking part in the Conference was a notable feature this year in the activities of the annual gathering of the Indian Medical Association. Sir Fazl-i-Hussain Member in charge of Medical Portfolio opened the Medical Exhibition held in conjunction with the Conference. Lt. Col. Paton, I.M.S. the Civil Surgeon, Delhi served as a member of the Reception Committee and was its Vice-Chairman. So it is to be said that the conference of the Indian Medical Association commenced its sittings under an auspicious augury. The Conference met on the 26th December and continued its sittings for three days. Col. Bola Nath C.I.E., retired member of the Indian Medical Service presided. The Presidential address was of an unique nature and differed materially from the routine followed by the Presidents of the conferences held for the last eleven years. All those years the Presidents of the annual gatherings discussed about the affairs of the profession and medical administration in detail without finding a remedy for the root causes of the unsatisfactory conditions prevailing in this country in matters medical on account of the existence of a foreign Government. Such Presidential addresses were followed by the passing of pious resolutions which could not be given effect to on account of the fundamental defects in the medical administration. It is a very happy coincidence that the Indian Medical Association chose as their mouthpiece Col. Bola Nath who being one of the senior most members of the Indian Medical Service, could practically demonstrate the drawbacks in the medical administration in India which were mainly responsible in hampering the growth and welfare of the medical profession. He belonged to a service which though responsible for the introduction of a scientific system of medicine, was also equally responsible for the unsatisfactory affairs now existing in the medical administration and the medical profession in India. The Military training of Col. Bola Nath coupled with his vast experience of the organisation of the Indian Medical Service stood in good stead to enable him to express his views boldly and with an authority entitled to respect both by the Government and the public. Col. Bola Nath has in a telling manner referred to the history which led to the unsatisfactory conditions now prevailing in the medical administration and has as effectively discussed in his address what the profession should do to bring about reform. Col. Bola Nath began his address dealing with the origin and growth of the Indian Medical Service, how the members belonging to this service started their career as humble barber surgeons of the East India Company and gradually and steadily grew into a service

guiding the medical destinies of the people of India soon after the East India Company laid down their pen and took the sword to govern India. Though the medical profession is not interested in the Army Medical organisation except to the extent the latter interfered with Civil Medical Administration, Col. Bola Nath did a good turn to the country by pointing out the wasteful expenditure now incurred in Military Medical Service by having recourse to Station Hospital System instead of the Field Service System which system, Col. Bola Nath said was more suitable to Indian conditions.

The trenchant remarks of Col. Bola Nath about the unsatisfactory working of the Civil Medical Administration in this country would be highly appreciated. He said that all the defects in the medical administration were due to the intermingling of the civil and military departments. Though he was very optimistic about the future of the medical profession in India, he warned the audience that the work before them is fraught with insuperable difficulties. He wished the profession to know that the Government of India, like other Governments in the world, was a conservative body. It was reluctant to move forward unless pushed by persistant and accumulated public opinion. He opined that the Government being alien and bureaucratic the task of bringing about reforms was exceedingly a difficult one. Consequently any number of resolutions passed by successive conferences on important subjects affecting the profession and the public could not have any effect. Yet, in the face of all the difficulties, the forces of reform, said Col. Bola Nath, were marching steadily and he exhorted the profession that they should take advantage of the fact that Health and Education were transferred subjects and administered by popular ministers and though the present day ministers were not strong enough to assert popular views in the administration, Col. Bola Nath said that time would not be far when they would have ministers of grit and action. He pointed out to the profession the necessity of organising presistent agitation in all the provinces and for this purpose branches of the Indian Medical Association should be formed not only in big cities but in minor towns and even in villages and we are glad that at a later stage of the conference, Col. Bola Nath offered his services free of charge to the Indian Medical Association to organise the work of the Association throughout India.

We agree with Col. Bola Nath that the Indian Medical Association should first concentrate its activities in remedying the root causes rather than passing resolutions requesting the authorities to do what the Association desires in the interests of good medical administration and that of the profession. Many of the grievances set forth in such resolutions could not be remedied even by the authorit[illegible]cerned on account of the inherent[illegible] the Government administratio[illegible] should be made by all[illegible]t right fundamental defects. Such de[illegible]ave been pointed by Col. Bola Nath under three heads—1. Removal of the Military Service from the Civil Medical Department. 2, Amending the Indian Medical Council Act in such a way as to enable India to fix her own medical standard independent of outside authorities and 3. Securing of the solidarity of the medical profession.

To remedy the first defect mentioned above, Col. Bola Nath pointed out that the communique published by the Government of India fixing the number of officers of I.M.S. for civil employ at 302, 200 being for reserve and 102 as residuary officers, should be the first plank of agitation so that the reformed Government of India if and when formed would be able to direct its attention to the very unsatisfactory arrangements which deprive the sons of the soil the chances of getting themselves employed in medical service. Attempts should be made to compel the military to surrender the 102 residuary posts and make the transfer of power contemplated in the reforms scheme a reality. It may be recollected that the Services Sub-Committee of the first Round Table Conference recommended that the Indian Medical Service should be abolished and that the appointment of Civil Medical Service should be entrusted to the Public Service Commission bearing in mind the requirements of the Army and of the British officials and their families in India. The Joint Parliamentary Committee have expressed their opinion to

the contrary. The Secretary of State therefore will retain the power to lay down the number of Indian Medical Service officers which the Provinces should employ. It is therefore essential that the profession should lead an agitation immediately pointing out the desirability of entrusting to the popular ministers full discretion as to the requirements of Civil Medical Service in the Provinces.

The second fundamental reform advocated by Col. Bola Nath was with regard to Indian Medical Council. It is now proved without any shadow of doubt that the real purpose of the Government of India in passing the Indian Medical Council Act was to enable the British Medical Council to have a control over the professional education of the graduates. The British Medical Council pressed for an Inspector of Education of their own and this also they got, thanks to the Indian Medical Council and Sir-Fazl-i-Hussain. Medical Councils exist and should exist to serve the profession as a whole and not a section of it. One important function of such council is to maintain a high and uniform standard of medical education. As the medical licentiates who form the largest bulk of the qualified medical profession in India, are excluded from the purview of the All India Medical Act no purpose of All India nature is served by this Act. The Medical profession should therefore agitate either to repeal this Act or mend it in such a way as to serve the whole profession. The agitation regarding this matter need not be postponed. The profession has at present a splendid opportunity. The destinies of the Indian Government will now to a certain extent be in the hands of representatives of the people who are considered to be progressive and nationalistic. Dr. Ansari one of the ex-Presidents of the Indian Medical Association, is the Chairman of the Congress Parliamentary Board with Dr. B. C. Roy as his lieutenant. Drs. Deshmukh, Khan and Rajan form an important unit in the Legislative Assembly to represent the medical profession and to guard its interests. Almost all these doctors have shown their appreciation and sympathy to the medical licentiates, Dr. Rajan being himself a licentiate hailing from Madras. It is a reasonable expectation of the profession that the trio will be able to influence their comrades in their party and outside and do the needful either to mend or end the existing Indian Medical Council Act.

The third reform does not lie in the hands of the authorities but in the profession itself. Membership of an association is a hall mark indicating that all those belonging to that association should enjoy equal rights and privileges. So it should be the duty of the Indian Medical Association which has taken upon itself the responsibilities of an All Representative Indian Organisation to do all that is possible for them to do away the caste distinctions now prevailing in the profession. If solidarity in the profession is once secured, the profession can get easily the goodwill and support of the public with whose help and co-operation the Provincial and Central Legislative Bodies could be made to yield to the demands of the profession in matters of medical and sanitary reforms. What these reforms should be to bring about harmony, contentment and prosperity in the profession have been mentioned by us repeatedly in these columns and need no reiteration.

Original Articles

*PHRENIC EVULSION IN THE TREATMENT OF PULMONARY TUBERCULOSIS.

By

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HISTORY.

A simple phrenectomy was first proposed by Stuertz in 1911 for the treatment of severe unilateral tuberculosis of the lower lobe of the lung. He advocated the operation for those types of tuberculosis in which an artificial Pneumothorax was impossible on account of the presence of pleuritic adhesion, believing that healing would be promoted by effecting a collapse and rest of the deceased lung portions.

Schapelmann later in 1913, confirmed this view as a result of animal experiments and stated that he believed a diaphragmatic paralysis would also favour healing in apical tuberculosis.

* Paper read at the Fourth Andhra Medical Conference, Bezwada and specially contributed to The Medical Practitioner.

In 1913, Sauerbrach without knowledge of Stuertz having proposed this operation published a report of three operated cases. It was subsequently found that the operation was of doubtful value as the hemi-diaphragmatic paralysis was not permanent in a large number of cases. So, the operation was abandoned for a time. It was not until after the publication of the anatomical research on the Phrenic nerve by Felix in 1922 that the operative procedures on the Phrenic nerve received renewed attention.

The operation proposed by Stuertz consisted only of a simple section of the Phrenic nerve. Felix explained the return of function following a simple Phrenicotomy by demonstrating that in fully 25 to 35 per cent of all persons, anamolies of the phrenic nerve existed in the form of accessory fibres which usually join the main stem of the phrenic nerve below the site of resection proposed by Stuertz and that they therefore continued to enervate the diaphragm. This work was confirmed by R. C. Metson and Plenk who found an atypical formation of the phrenic nerve in 28 per cent of 112 cadavar dissections.

Anatomy of the Phrenic Nerve.

The Phrenic nerve arises chiefly from the fourth cervical nerve but receives a branch from the third and another from the fifth. The fibres from the fifth occasionally come through the nerve to the subclavius muscle. It is formed at the lateral border of the scalenus anterior and running obliquely across the front of that muscle, descends to the root of the next beneath the sternomastoideus the inferior belly of omohyoideus and the transverse cervical and transverse scapular vessels. It next passes in front on the subclavian artery between it and the subclavian vien and as its enters the thorax, crosses from the lateral to medical side of the internal mammary artery within the thorax, it descends nearly vertically in front of the root of the lung and then between the percardium and the mediastinal pleura to the diaphragm where it divides into branches.

Anatomy of the Accessory Phrenic.

Accessory fibres arise most commonly from the fifth cervical either nearer or with the nerve to the subclavius muscle. If arising with the nerve to the subclavius the accessory fibre usually separates from it just before the nerve to the subclavius enters the muscle. The accessory branch then continues downward passing in front of the subcalvian vien to join the main stem of the phrenic just behind the sternal end of the first rib at a point about 10 or 12 cm. below the usual site of operation.

While accessory fibres most commonly arise from the fifth cervical, they may also spring from the third, fourth, sixth, seventh, eighth or even the first thoracic. In order to interrupt impulses coming from accessory branches as well as any communicating cervical sympathetic fibres of the phrenic nerve, Felix proposed an evulsion of the phrenic nerve after having cut it, by winding it round the artery forceps and withdrawing it. By this method, one is frequently able to extract the entire nerve even with its diaphragmetic filaments. The longest nerve evulsed in the series measured 40 cms. which included the main trunk and its terminal diaphragmatic filaments. One feels confident of complete interruption of all impulses if 10 or 12 cms. of nerve have been evulsed.

Indications for Phrenic Evulsion Operation.

The operation was originally performed chiefly as a preparatory operation to Thoraco-plasty, with the object of testing the ability of the other lung to stand the strain of the increased respiratory work to be borne by it or with the object of giving the patient an opportunity of readjusting himself to the changes in the circulation and respiration resulting from the sudden collapse of one lung after Thoraco-plasty.

During the past five years, phrenic evultion gained much ground as a substitute to Pneumothorax treatment in cases where either pleural adhessions are preventing this treatment or where it is contraindicated on account of disease in both the lungs where one lung is much less affected than the other. Generally speaking, the indications for Phrenic evulsion are the same as for Pneumothorax treatment, although the indications can be extended also to cases unfit for Pneumothorax treatment ; cases of bilateral nature aud where the patient is weakened to such an extent as not to be in a fit condition for Thoraco-plasty, cases which are met with in large numbers and

where only Phrenic evulsion with or without gold treatment is indicated.

It was formerly thought that Phrenic evulsion should be done as a substitute to Pneumothorax treatment only in those cases where the lesion is confined to the base of the lung, as the paralysis of the hemi-diaphragm could not have any effect on lesions in the apex of the lung. But actual clinical experience has shown that as good results have been obtained in cases with apical lesions, while bad results have been observed in cases with basal lesions. X-rays after the phrenic evulsion have clearly demonstrated dimunition in cavities near the apex.

There has been much controversy on the question of the use of the Phrenic evulsion operation as an accessory to Pneumothorax treatment in order to supplement an incomplete Pneumothorax. In many cases, actual experience has shown that where an incomplete pneumothorax has shown only partial improvement, a phrenic evulsion done to supplement it, was instrumental in bringing down the temperature to normal and in improving the general condition of the patient in every way.

In India where it is difficult for patients to continue Pneumothorax refills outside the few places where the treatment is given, the Phrenic evulsion operation should be used in many Pneumothorax cases complicated by adhesions. This will produce a permanent minor collapse preventing the lung from a too sudden re-expansion. There is a general concensus of opinion that effusions are less frequent if the diaphragm has been paralysed and that there is less rapid absorption of gas with the result that the intervals between the refills can be lengthened. The diminution of movement is responsible for both these benefits. Possibly also the removal of the drag on adhessions when such are present, is also beneficial. Lastly in conjunction with artificial Pneumothorax it is of great advantage to paralyse the dome of diaphragm before permitting a long collapsed lung to re-expand.

Phrenic evulsion is also done for the relief of symptoms. The diaphragmatic paralysis makes cough easier. This leads to freer expectoration and prevents stagnation of secretions. The value of hemi-diaphragmatic paralysis in easing the cough needs particular emphasis, in as much as when the base of the lung is adherent to the diaphragm, there is set up at times an intolerable irritating cough which is dry and incessant. After phrenic evulsion in these cases, the result was always gratifying.

In cases where a patient brings out blood from a cavity situated in the base of the lung, Phrenic evulsion would certainly be beneficial in stopping the blood if artificial pneumothorax is impossible or incomplete.

(To be continued.)

PAIN IN GYNAECOLOGY.

By

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Pain in Gynæcology is the one symptom which should be approached with the greatest caution, as it is most likely to be masked. It is so easy to ascribe a cause to a lesion at the site where the pain is felt and treat that.

The origin of pain may be due to :—

1. Irritation of nerve endings by local injury, inflammation or growth. Here we have deep tenderness over the affected area, as in inflammation of Pelvic Peritoneum.

2. Irritation of nerve endings at a distance causing referred pain to another area. The link of the nerve supply may pass through inflammed Iliac glands, which cause pressure. In Pelvic Cancers we have pain down the legs for this reason.

The ovaries, uterus and adenexia are associated with 10th Dorsal to 2nd Lumbar segments and lower down with 1st to 4th Sacral. Occipital headache may be associated with troubles affecting the 10th Dorsal nerve. The sources of this headache may be found to be a retroverted uterus. When the uterus is replaced the headache disappears.

3. Phsycological causes : It is difficult to estimate the degree of pain as the sensitiveness to pain varies in different individuals and the same individual at different times. Examination of pulse and pupils may guide us in estimating this kind of pain.

Pain may be localised or diffuse. The important points to be noted are:—When was it first noticed? Is it constant or intermittent? Why is advice being sought now? The character of the pain is important. The varieties with which we have to deal are :—

(a) Backache due to weakness of abdominal and pelvic supporting structures such as occurs in fibroids, cancer of cervix, and retroversion. Backache which is worse in bed is not gynaecological that relived by rest in bed is due to the latter cause.

(b) Bearing down forcing pain due to displacement of or pressure on vaginal walls, as in prolapse through a torn vaginal outlet or when the cavity of the vagina is distended.

(c) Iliac fossa pain extending down one or both the thighs as in Cancer or Salpingitis.

(d) Lower abdominal pain—as in Salpingitis and Payo-Salpingitis.

(e) Dragging pain in the back as in endocervicitis due to leucorrhoea with erosion of cervical mucous membrance.

(f) Shooting and darting pains in vagina are rarely physiological. At vulva they are due to local infection or growth. At urethral orifice they are due to nervous exhaustion.

We will consider pain under the following headings.

1. Menstrual.
2. Sexual.
3. Pregnancy, extra-uterine.
4. Displacement
5. Growth.
6. Inflammatory.

Menstrual:—(A) Dysmenorrhoea may be associated with developmental peculiarities of the uterus:—

i. Menstruation with a uterus with no exit results in monthly attacks of severe lower abdominal pain extending down the legs and arround the back with sickness and collapse.

ii. Menstruation into a one horned uterus with partial development of the other, results in pain which gradually subsides after the menstrual flow as the tension in occluded cavity becomes less by absorption of fluids; this condition may not be diagnosed for some months unless a rectal examination be made then a tender swelling will be detected on one side while the uterus is pushed over to the opposite side.

(B) Dysmenorrhoea in young unmarried women may be either accompanied by general nervous disturbance or the pain localised in the lower abdomen and back with no nervous disturbance.

(C) Membranous Dysmenorrhoea.

(D) Dysmenorrhoea in married women is nearly always due to congestion. If the pain is premenstrual or menstrual it is relieved by flow. If intermenstrual it is due to pelvic inflammation due to gonorrhoea or such infection or post-portem toxemias.

In Dyspareunia one needs to ascertain whether it is a new symptom or that existed from the beginning of married life. This pain produces a protective reflex spasm of the levator ani which closes the vaginal orifice. Pain which is a new symptom may be due to a definite lesion—a septic fissure, urethral caruncle, inflammation or new growth of vulva or vagina or uterine appendages. In my experience, by far the greater number of patients who seek advice for this pain have prolapsed tender ovaries. They will say that the same pain is experienced on digital examination.

In Extra uterine Pregnancy pain may not exist until bleeding occurs into the tissue sorrounding the ovum or into the peritoneal cavity causing a rise in tension. This sudden rush of blood into the peritoneal cavity gives rise to acute pain with fainting; oozing of blood into the peritoneal cavity gives rise to sharp pain but less severe. Pain will also occur when the uterus contracts during the expulsion of a decidual cast.

When blood is in the tubal walls and more or less encysted in the peritoneal cavity the pain is dull and continuous. It is dull with recurring sharp pain due to incomplete tubal abortion in which blood may run into the peritoneal cavity on several occasions through the abdominal ostium of the tube.

In Displacements we shall consider retroversion, prolapse, and subinvolution. In retroversion 9 out of 10 patients will complain of "Backache" and that this is worse during the monthly period. Some patients with retroversion, state that they only have pain during the monthly period, while a few will say menstrual period the only time when they are free from backache.

With a prolapse which is almost associated with distension or displacement of vaginal wall the pain is usually described as dragging in the lower abdomen and

groins. Bearing down pain is also commonly complained of especially in prolapse of the second decree.

(c) With subinvolution, dysmenorrhoea is less common. The pain here is a dull chronic ache over the sacrum and in one or both illiac fossae due to the drag of the uterus on its supports. The pain is worse on exertion and for this reason so many of these women, who remain untreated become chronic invalids.

Under the heading Growths we may consider—Malignant Ovarian or Paraovarian cysts and Fibroids. Uncomplicated ovarian cysts are not painful.

(a) In tumours displacing the vaginal wall, those low in the pouch of Douglas which bulge forwards the posterior vaginal walls we have the bearing down pain of prolapse just mendoned.

(b) The pain due to torsion of the pedicle of an ovarian cyst is usually referred to the side of the twisted pedicle and may be acute colicky with collapse.

(c) The pain of intercystic haemorrhage may be dysmenorrhoea or intermenstrual pain.

No pain may exist with fibroids which extend half way between pubis and unbilicus. Pain occurs with degeneration and infection which interfere with normal function and cause pressure on rectum or bladder. Dysmenorrhoea in these cases may be severe due to excessive contraction of uterus called forth in efforts to expel clots due to excessive menorrhagia or increased congestion. Bearing down pain occurs in patients with polypoid submucous fibroid in the effort of the uterus to expel it. Backache is complained of by patients who are found to have a large single interstitial fibroid in the anterior or posterior wall of the uterus.

Pain in Cancer of Cervix or of uterus is not the first symptom nor is it an early symptom. It occurs in the late stages of unoperated cases or where recurrence exists after operation. This pain may be of indefinite variety according to the amount of pressure on nerves by undetected secondary lesions e.g. Lumbosacral, lower abdomen and back, both hips, or shooting down the thighs.

Inflammatory pain occurs in chronic endo-metritis giving rise to a chronic aching pain which may be felt in one or both illiac fossae and back. The endo-metrium is so thick that it acts as a foreign body and produces excessive contractions giving rise to pain. Excessive haemorrhage also forms clots in the uterus which over stimulate it causing contractions and giviug rise to pain. In Salpingitis with or without ovarian abscess, the pain complained of is almost always located to the left iliac fossae and is shooting down the thigh even if the disease is bilateral.

Abstracts

THE XIth ALL-INDIA MEDICAL CONFERENCE, DELHI.

PRESIDENTIAL ADDRESS

BY

COL.-BHOLA NATH, C.I.E.

In the course of his presidential address Col. Bhola Nath, I.M.S. (Retd.). C.I.E., said:—

Briefly stated, the aims and objects of the Indian Medical Association are to try to ameliorate the condition of the Medical profession in India. With this object, the Association meets in Conference every year to discuss matters of medical interest. In this, the Indian Medical Association is following the footsteps of its senior sister—the British Medical Association, the only difference between the two being that the one is working for the good of the profession in England, and the other in India. The constitutional activities of the Association are perfectly legitimate and that being the case, I fail to see how a quarrel can arise or exist between the I.M.S. and I.M.A. The I.M.S. man is a part of the medical profession in India—a limb of the same body medical and it passes my comprehension how one limb can have a quarrel with another limb of the same body. The I.M.S. has made the profession what it is to-day in India. The I.M.S. is running the medical machinery of the Government, they should be in a better position to appreciate your difficulties and be able and willing to help the profession in its onward march. At least that is my faith.

ORIGIN OF THE I. M. S.

The I.M.S. started its career in the humble barber surgeon, who cut the hair and

pulled the teeth of John Company's employees on board the Company's troop-ships. Then came the crown troops to guard and protect the Company's life and property and with them came the army surgeon, the prototype of the present representative of the military service. By and by the Company discarded the quill pen of a shop-keeper and grasped the sword of a Conqueror and in place of the humble tradesman emerged the ruler of a province. Province after Province was added to the dominion of the new power. The extension of dominion brought new responsibilities to the shoulder of the new ruler, and new departments of State came into being. Of these, the medical relief of sick was entrusted to the care of the army surgeon as a collateral charge in addition to his military duties. The army surgeon had now his interest vested in his civil work.

The Medical Administration of India as we find it to-day, may be compared to some medieval village which was built without plan or design by some bygone chief in medieval times. In the course of ages, the village has grown into a town, by adding suburbs of modern villas and antiquated hovels. But in all this extension, it has retained its medieval character, its crooked streets and narrow alleys. In the middle of this confusion of old hovels and new buildings, stands the baronial hall. The hall is a superb pile of buildings, but quaint and antiquated, untenanted except by the ghost of a bygone past. Now if you wish to modernise the town, you must prepare a well-thought out plan of reconstruction and secure an honest improvement trust; knocking down the baronial hall will not modernise the town.

ARMY MEDICAL ORGANIZATION.

I had said, in 1929, and I repeat it to-day in 1934, that the medical organisation of the Indian army is out of date, inefficient and unsuitable for Indian requirements, both in peace and war. The station hospital system was only lately introduced, in the Indian army, in imitation of the system which prevails in British Army in England and India. The system may be suited to troops in England where the climatic conditions are uniform and the country is not subject to the periodic visitation of malaria and other epidemics. In such ideal conditions, the sick rate is constant and can be anticipated and provided for with precision. In India, the conditions are different. With the change of seasons and periodic visitations of epidemic disease the sick rate varies and the hospitals are full at one time and empty at other times of the year. But the station hospital system being rigid and inelastic, the sick accommodation can neither be increased nor decreased. This results in a good proportion of the hospital equipment and personal lying idle for a good part of the year. The station hospital system is supposed to train medical units for field service. But on mobilisation the hospital system is discarded and quite a different system is used in the field which bears no resemblance to the station hospital system. In the field a practical knowledge of field sanitation is required. The laying of hospital camps, according to the law of the land and climatic conditions, the disposal of night soil and sullage in slush and mud, the supply of potable water where means of purifying the water are not available, the putting up of economical cooking places where firewood is scanty, the dealing with fly and mosquito pests, are some of the problems which the field units have to face. These things, I maintain, cannot be learned in station hospitals. They have to be learned by bitter experience in the field and in the field they cannot be picked up in a day.

The field medical organisation of the army is no better. During peace time the field medical units are moribund. The equipment is carefully folded up and stored away in stations so far apart as Secunderabad and Alipore. The personnel is distributed for duty in stations as far apart as Bombay and Mandalay and as a matter of fact, field units have no personnel in peace time. It is created by collecting and detailing men from all over India. On mobilisation being ordered, the equipment and personnel are collected and put together before the unit can take the field. This takes time and means delay and expense.

To rectify these defects I suggest that the station hospital system should be abolished and replaced by the field service system. Base hospitals, stationary hospitals and Field ambulances complete with personnel, equipment forms and procedure should

take the place of the present station hospitals and work in peace time as they do in the field.

The advantages which I claim for this change are:—

(1) it is practicable and has all the advantages of the station hospital system without its disadvantages. It may need modification in minor detail; (2) it makes the peace and war time working of the medical units uniform and identical; (3) the field units will take the field at a moment's notice ready equipped with personnel and equipment in a working order as a team; (4) it will do away with the necessity of keeping two sets of equipment, one for peace and another for war; (5) it will lend itself readily to combined administration of British and Indian units whenever found necessary; (6) it will result in considerable saving in the medical budget of the army; (7) it, one stroke it removes defects of peace and war organisation; and the system being collapsible is most suitable to Indian conditions.

CIVIL MEDICAL ADMINISTRATION.

I turn now to the civil side of the medical administration in India. After hearing the defects on the military side, the thought will naturally occur to you that if a military service has not proved a conspicuous success in the army organisation, it cannot be expected to do any better in civil matters for which it was never intended. In the civil you have grievances of the research work, medical relief neglect and discouragement of the independent practitioner, the defective nature of the Medial Council, reciprocity and so on. These matters you have discussed, have formulated your views in resolution not once but several times.

The one defect which stands out most conspicuously in the civil organisation and which is the root cause of your troubles is the fundamental defect in the very structure of the civil machine. This defect is the combination of the civil and military functions of the service. So long as this defect is there the parts of the machine cannot and will not work smoothly. However, in your zeal for reforms you should not lose sight of the fact that there are insuperable difficulties in the way of separating the civil from the military, however desirable it may be. I would remind you that the Government of India, like other Governments in the world, is a conservative Government; it hates change of any kind; the Government firmly believe that what is being done is the best that can be done; it is reluctant to move forward unless it is pushed by the sheer weight of a persistent and accumulated public opinion. The Government machinery is old and antiquated and at the best of times it can move slowly on its rusty hinges. It is an alien Government, therefore it is naturally distrustful of every thing and every body; it is a bureaucratic Government and therefore irresponsive to popular demand. But with all these inherent drawbacks it must be confessed with gratitude, that in this particular instance, namely the separation of the civil and military functions, the Government of India have played their part and exerted themselves as much as they could be expected to do. They have made several attempts to separate the civil and military but unfortunately the forces of reaction have been too much even for them. This defect was so conspicuous and it so hampered the smooth working of the machine, that it could not escape the notice of Administrators who were responsible for its working. Administrator after administrator both civil and military, brought the defect to the notice of the Government and submitted proposals for its removal to relieve the civil department from the incubus of military encroachment. The Government of India, it may be said to their credit and the Secretary of State for India and even the British Medical Association approved these proposals and gave their blessing. Committee after Committee and commission after commission were appointed to give practical effect to these proposals. But every attempt was frustrated. The long-drawn and sad story of these efforts and defeats is told in my address of 1929 in which I have given chapter and verse of these proposals and Government despatches. These need not be repeated here. Suffice it to say that the forces of reaction triumphed, defection overtook the ranks of reformers, the British Medical Association turned tail and surrendered to reactionary of forces.

The control of the recruiting ground, boycott of service, cry of defective Indian

education, arrogant claim of superior qualifications, medical attendance of superior services were some of the clogs which impeded the wheel of progress. But the chief clog which brought the machine of reform most effectually to a stand-still was the military reserve. The reactionary knew that of all the pig heads in the world the military is the most asinine; that his calvareum is unduly thick and once an idea gets inside it, is very difficult to get it out. He exploited the military by putting an idea into his head that I.M.S. reserve is a military necessity. That was enough, after which it was of no use to tell the military that no serves like the Indian army, that no serves where in the world are the civil and military functions of a medical service so combined; that is military reserves have proved a myth and a failure on more than one occasion, that reserves may have been necessary in ancient times when India had no medical practitioners; that India to-day could supply not two hundred but ten thousand medical reserves, but it was of no avail; the military reserves remained and are still there.

From all what has gone before, it would appear that the cause of reform is hopeless and that medical progress is an impossibility. Such, I am glad to assure you, is not the case. The reformer inside the Government of India or the reformer outside has not been idle and has not lost hope. He has mobilised new forces and planned new attack on the stronghold from another direction. The forces of reform are marching with a sure and steady step. Some of the outworks have already been carried and the assault on the main position is being delivered; it is a question of time as to how long the reactionary forces will last out before they finally lay down their arms.

MEDICAL REFORM.

I will describe to you now, that in face of these difficulties, what the reformer has been able to achieve, what has been done, and what remains to be done and the steps which must be taken to gain the final victory.

The first step on the road to reform was taken when health and education were made a transferred subject. This was a most important step. It tacitly admitted that the care of health and education is the people's own concern. If they prove themselves fit in this, they will be considered for fitness for other and more important things. This is an experiment and we are on our trial.

The second step in the same direction is the provincialisation of the transferred subject. This step further assumes that health conditions are different in different parts of India. By provincialising the transfer subjects, each province is left free to work out its own salvation in the best way it can without dictation or direction from outside. Constitutionally speaking, India is in a state of transition. Everything is in a state of flux. The structure is in the making. Its cement is wet and not yet properly set, one cannot say what shape the building will ultimately take.

The Minister of to-day is not the minister of to-morrow. To-day the minister is a raw material in an embryonic state whose spine has not yet ossified. He is undergoing training in the A. B. C. of his portfolio-discipline, a sense of duty and responsibility. To-day, he is counting the coins in his pocket before thinking of schemes of his office. He is not the leader but is led by the heads of his departments. The minister of to-morrow will be a different man; he will be a man of grit, he will have the power behind him and will know how to use it, he will be the master, not the slave of his department. He will know and will insist upon how best to use and where to use the personnel of his department. In the course of evolution, he will ultimately develop into a genuine ministry of health with a professional man at its head.

The third forward step on the road to reform is the establishment of the Indian Medical Council. It has been considered desirable to have a council of our own.

In order to deal with the question of the Indian Medical Council, I desire to place you both sides of the question the Government side as well as the popular side. I present the Government point of view first. In this connection as well as in connection with other controversies our attention is drawn to two undesirable tendencies which are becoming a prominent feature of Indian political life. The first of these tendencies

is that we are getting too much in the habit of ascribing motives to our opponents. This gentlemen, is a Western method of political warfare which we should avoid to imitate. We pride ourselves on being a spiritual people. We should therefore be tolerant and charitable to our opponents whoever they may be. We should be generous enough to allow our opponents the same liberty of conscience which we claim for ourselves. There always is more than one side to a question. If you have a right to one view our opponent has an equal right to hold the opposite view. That being the case, should we not be equally tolerant in criticising the Government measures? Why should we see evil design in every Government action? Cannot there be a popular view and a Government view? According to our critics behind everything which the Government do, there is always hidden, an ulterior motive behind it. In fact if one were to believe everything one hears about the Government doings, one would think that they are a set of wicked men whose one object in life is to hatch schemes of evil designs with no other object but to deceive the public. This attitude of public criticism is, we are told, a western method where at election time we hear they cry "I am an angel, vote for me. My opponent is the incarnation of devil, dont't vote for him." This attitude is not Oriental. If I condemn the habit of unfair criticism in my countrymen I, equally and emphatically, condemn the practice of stifling public criticism by Government officials.

GOVERNMENT'S RESPONSIBILITY.

There are certain classes of officials who cannot tolerate criticism of Government actions. Even the mildest and most harmless criticism acts on them like a red rag. This is specially the case with inexperienced men who are elevated to positions of authority. They show their peevishness in issuing departmental orders prohibiting their subordinates from joining the I.M.A., which is engaged in the legitimate discharge of its duty to the profession. I warn this class of official that he his living in a fool's paradise. The times have changed and it will be to his good if he made his official behaviour conform more to the spirit of imes.

The second tendency to which our attention is being drawn is the habit of impatience. Impatience, gentlemen, is not a virtue but a vice. We are too much in a hurry and want things done soon and at once. Progress to be genuine and true must be slow. It requires patience, persistent and repeated effort. Every step forward is a step in the unknown. It is an experiment. To proceed blindfold and in a hurry is to court failure. In trying new experiments the ground must be first explored, the pros and cons considered, the practical and theoretical bearings of the measure discussed. All this takes time, and we must learn to be patient.

In this connection it is also necessary to emphasise the fact which is often lost sight of, that the Government rightly claim responsibility for medical education in India. It grants the hall-mark of medical degrees. It has, therefore, a right to lay down the standard which it considers necessary and conditions of attaining that standard. We further forget the undoubted fact, that the Government of India are not a free agent in these matters. There is the Secretary of State for India who claims a similar responsibility over and above the Indian Government. He has his own advisors in the British General Medical Council and the Diehard at the India Office. He must consult them and cannot ignore their advice. Your voice might reach the heights of Simla and the walls of its Secretariat but it will not penetrate the thick walls and thicker heads at Whitehall. These are hard facts and practical difficulties to which no honest critic of the Government can shut his eyes.

Gentlemen, this is the Government side of the picture which I have so far placed before you. I have tried to place the Government side of the case as fairly as possible. Now I would like to present the other side of the case which puts a different complexion on the Government version.

INDIAN MEDICAL COUNCIL.

It is often said, that the Government of India cannot do a thing with good grace. I am afraid there is good deal of justification for this view of the Government of India as illustrated by the Indian Medical Council the story of which I am going to narrate. It had been noticed from a long time that

the British General Medical Council had been trying to perpetuate their hold on the medical education of India by imposing their own standard of education and examinations, in disregard of the fact that the conditions of medical practice in this country are quite different to conditions which prevail in England. This was highly resented by the medical profession in India. The Indian indignation culminated in the attempt of the council to foist the appointment of a medical inspector in India at the expense on the Indian tax-payer. This raised such a storm of protest that the Council nominee had to beat a hasty retreat. The next move on the part of the Council was the suggestion that India should have a medical council of its own. This move was to lull the public into the belief that having a council of their own, the educational bodies could solve their educational problems in their own way without interference or dictation from outside. But the hidden motive in this sinister move was that if a subservient council could be set up, it would serve the purpose better than the appointment of an Inspector of Education. Agreeably to this scheme, an Indian Medical Council Bill was passed. At the very start the composition of the Council did not inspire much confidence, out of the 30 members, no less than 22 were officials and nominated by the Government. It was therefore feared that with only 8 elected members no popular measure of reform had a chance of getting through the Council. But with all that it was hoped against hope that members whether nominated or official, were after all honourable and conscientious men, who would not sacrifice the interest of the profession for a seat on the council. The same hope was entertained about the representatives of universities who were also officials. It was further hoped that the Honourable Member in charge of Education and Health being an Indian and patriot was not likely to play into the hands of the British General Medical Council.

The Council was inaugurated by the Honourable member with a great flourish of high sounding phrases that he was going to secure efficiency at home and honour abroad. But the cloven hoof of the British Medical Council was visible at the very first meeting of the Council in the appointment of its secretary who was a nominee of the British Medical Council. The first meeting of the Council was held in March 1934. Members from inside could see how the game was being played better than people from outside the Council. In this meeting a resolution was tabled to the effect that the Secretary of the Council should not be an Inspector of education. The resolution was passed by a large majority of 15 votes to 9 which included officials and nominated members, some of whom made strong speeches in support of the resolution. This move on the part of the non-official members took the wind out of the sails of the British Medical Council. But they had counted without their host the Honourable member in charge. There were two difficulties in his way. First, there were the official and non-official members who had voted for the resolution. Secondly, there was the regulation of the Council Act which required that a motion as a motion or amendment which has been moved or withdrawn with the leave of the Council, shall not be admissible, if it raises substantially the same question, within one year of the date of the meeting at which it was designed or moved.

But the Honourable member is a past master of the art of political game. He got over both these difficulties in his own clever way. A meeting was called in which tails were severely twisted and the Major-Generals and Rai Bahadurs were politely told that honour and conscience may be one thing but voting is something quite different. They were taught the elementary lessons in voting and the art of swallowing one's own words. The second difficulty was got over by simply brushing aside the regulations. A meeting of the Council was called in June 1934 in which the Secretary of the Council was appointed Inspector of medical education in India, thereby the Council reversed its own decision of March 1934. At the same meeting, a resolution was proposed that the council should appoint two sub-committees for considering the question of medical curriculum and a uniform standard of examinations. The idea underlying the resolution was that the sub-committee would draw up a course of instruction which would satisfy the particular needs of Indian medical and health requirements. This however, would not satisfy the authorities of the I.M.C., who are bent upon converting the Indian Council into the branch of the G.M.C. The resolution was turned down and in its place an amendment was passed giving powers to the Executive Committee to form such sub-committees. Whether the sub-committees were formed or not, two printed "Draft-recommendations of the Medical Council of India in regard to professional education for graduates, and Professional examinations" (Adopted by the Executive Committee June 1934) were sent out to all universities in India. These drafts are a verbatim copy of the recommendation of G.M.C. The G.M.C. wanted to have an Inspector of Education of their own and wanted to impose their own standard of studies and examination; they have got both, thanks to the new Indian Medical Council. Such are the achievements of the first Council and such is the parody of a Council which the Honourable member has been able to give to India. After all that haggling and negotiations, this is the net result.

The question naturally arises whether the Honourable member has been hood-winked or has he deliberately bartered away the honour abroad which he was so very jealous to guard—gentlemen politics, is a dirty game.!!

THE COMMUNIQUE OF 1928.

The fourth step on the road to reform was taken in the year 1923 when the Secretary of State in Council under Rule 12 of the Devolution Rules checked the further encroachment in the civil department by the military officers by fixing their number to 268 appointments. The fifth step in the same direction was taken by the Government of India in their communique of 1928. This would have been a large step and a very important step if the communique had been a genuine and an honest document and had given substance of what it promised to give in form. Gentlemen, the communique is an important document and it deserves a careful examination.

The communique is deceptively worded; its secret purpose is artfully concealed beneath profuse official verbiage. At a superficial glance it looks harmless, nay fair and even generous. It is only a very careful study and analysis of its contents which reveal the underlying Machiavedian design and its profound iniquity. It is a long document. I will only give you an outline.

Para 2 lays down that I. M. S. constituted on the same broad lines as at present will be retained primarily to meet the needs of the Indian Army. Please note carefully that the primary purpose of the I. M. S. is the Military duty. Para 3 reads that "on as precise a basis as possible, the number of war reserve officers is 200 of which 134 will be British and 66 Indian Officers." Para 4 is headed Civil Requirements. This would lead one to infer that officers under this head have nothing to do with the military department. It further gives detail of civil requirements, dividing the officers in two categories; (a) officers required for medical attendance on superior services and their families; (b) officers required for civil administration. Then as if, to confound the issue it introduces another category, which it calls residuary officers "the incumbents of which will be permanently retained in civil employment whether for purpose of treatment or of administration and who cannot therefore be treated as part of war reserve." In Para 5 we find that the total number of I.M.S. officers, in all, required for civil employment, is calculated at 302, therefore deducting 200 war reserve mentioned in para 3 we obtain the figure of 102 which represents the number of residuary officers who are not a part of war reserve and therefore whose employment in the civil is purely a civil question and not a military necessity. Before proceeding with the examination of the rest of the communique I wish to draw your attention to a few points which arise out of what has been noted so far, not with a view to expose the iniquity contained therein, so much, as to indicate the line which your demands should take and the direction which the reforms in future will and must take.

LINE OF REFORM

The points are these:

1. As a matter of military necessity the Military ask the Civil Department to oblige them by finding temporary civil employment for their war reserves till such time, that they may be required for military duty.

2. Finding the Civil Department obliging they push another 102 I.M.S. Officers who are not part of war reserve.

3. The excuse, in this case, is not military necessity, but civil requirement. The provision of civil requirement surely is a civil necessity which concerns the civil department only.

As the medical department is a transferred subject these requirements should be met provincially from the provincial cadre.

The civil department could recruit European medical men in the provincial cadre for purpose of attendance on superior personnel.

4. The designers of the communique usurp the function of the provincial medical department, and rob the provincial service of 102 posts, which are theirs by right.

5. They not only rob but dictate the posts which the robbers should occupy, in fact all the posts which carry power and emoluments are usurped without regard to the most important question whether these officers are fit for these posts or not.

The remaining portion of the communique need not detain us long. To provide employment for 302 officers 237 posts are required : the remaining 65 officers will constitute the leave and study leave reserve calculated at the rate of 27½ per cent. But the communique is silent as to where these officers will be kept.

Of the 237 posts 59 will be available under the Government of India and 178 will be provided in the provinces thereby releasing 90 posts out of 268 of the Rule 12 of the Devolution Rules of 1923. The release of 90 posts would have been a boon and a step in the right direction if it had not been nullified by a condition which makes the gift a mockery and a hollow sham.

The communique provides, firstly that the present incumbents of these posts will remain undisturbed until such time that they are gathered to their fathers. It further provides that the next generation of I.M.S. who joined the civil department on the day of the promulgation of the communique will have prospective rights to these posts preserved for them till their generations too die out of natural death. The naivete of this scheme is equalled only by its diabolical ingenuity. The rest of the communique is plain sailing.

Having cheated the provincial services, it proceeds to still more systematically cheat men of the same service, the Indian I.M.S., men. It introduces communal and racial discrimination in an imperial service and destroys that harmony, which is so very necessary for the smooth working of the service. Suffice it to say that the spoils of the civil department have been unfairly and unequally divided, between the Indian and British Officers much to the disgust and discontent of the former.

DISTRIBUTION OF CIVIL POSTS

I will not go into the details of the distribution of civil posts, I have dealt with this subject before and can refer the curious to my address referred to before. It may be noted as a minor detail that the residuary posts are so cunningly arranged that not one of them is reserved for the Indian I.M.S. men. It will so happen that when mobilisation is ordered on a large scale that all the Indian portion of the army reserve will be sent to field service while the British officers will remain enjoing the comforts of residuary posts. It only remains to say in this connection that many official and semi-official explanations have been forthcoming from time to time of this invidious distinction between men of the same service. I would mention only two of them. A high official, who holds a much higher position now than before, told my informant, that a large number of civil posts has been reserved for Europeans in the interest of Indian I. M. S. officers of the future. We are keeping these posts snug and warm for them. If the Europeans give up these posts they will be snapped up at once by the provincial men. The explanation explains nothing but it makes one thing clear that this gentleman's intelligence is no better than his honesty. The other explanation I had, and I have it writing, from the late and lamented Sir Rice Edwards who was a sincere friend of India and an honest man. He told me that, it is really a question of the top dog and the underdog. If you were the top dog, you would do the same. That gentleman is the true and the honest explanation. Our critical survey of the communique has brought out the three future stages of medical reform which you

(Continued on page 65.)

CLINICAL NOTES AND PRACTICAL SUGGESTIONS.

Essential Hypertension.

A vast amount of research has been conducted and is still being continued with the object of solving the problem of Hyperpiesis.

Many theories have been formulated relative to the origin of Hyperpiesis but its cause is still a matter of keen controversy.

Formerly some renal lesion was frequently referred to as the important factor causing the onset of hypertension, but of later years this view has been greatly modified, so much so, that we now frequently have renal lesions associated with hypertension being described as secondary symptoms resulting from continued high blood pressure.

In recent years the endocrine glands have come into prominence as having an important influence on the production of arterial hypertension, and this view has received much support by the discovery that certain glands produce "pressor" substances, but even now this disease constitutes a most perplexing subject. Since a detailed discussion of the full facts relating to hypertension necessitates a very lengthy article we must confine our attention to a few of the important points. In the first instance we must recognise that there are several types of hypertension. The hypertension of glomerulo nephritis, malignant renal arteriosclerosis and the hypertension associated with the toxæmias of pregnancy have been recognised for a number of years. More recently it has been discovered that there are several other pathological conditions in which arterial hypertension will be found as a secondary symptom.

These conditions are, the adrenal gangliomata, pluriglandular symptoms—of which the pituitary may be found as the responsible agent—and denervation of the carotid sinus ; these sinus nerves having a definite influence on the circulatory centres of the medulla.

However we are still confronted with a type of hyperpiesis which is probably the most commonly occuring form and concerning the aetiology of which no really important evidence is forthcoming.

This type has been called Essential Hypertension. Several theories have been advanced regarding the origin of essential hypertension. Some adopt the view that it might be a definite disease due to a single causative factor, others—that it might be a symptom of one or more diseases of which we are at present incognisant. Some abnormality of the adrenal gland has also been suggested as the cause of this disease, but even though over-secretion of adrenalin will produce an increase in blood pressure the evidence we have regarding essential hypertension compels one to look to some other factor as the responsible agent, and at the present moment a large amount of research is being directed towards finding some other humoral agent possessing a a pressor action in the hypertensive.

The statement that renal lesions are not responsible for the onset of hyperpiesis in most cases, may bring forth a certain amount of criticism in support of which it will probably be quoted that albumin is generally found in the urine when hyperpiesis is present. However, close observation has shown that in the early stages of essential hypertension and the hypertensive states which more recently have been found not of renal origin, renal lesions are entirely absent, but due to continued high blood pressure renal symptoms develop at a later stage and influence the maintenance of this hypertension.

Reflecting on what has been mentioned it is quite apparent that when dealing with hyperpietic cases we are confronted with a disease the actual ætiology of which in most cases in unknown or extremely difficult to correctly diagnose.

In the absence of any reliable evidence regarding the ætiology, the question will arise—what is the appropriate treatment for this condition?

Whatever treatment is instituted it must of necessity be perfectly safe and should in no manner aggravate the condition, also, where possible treatment should be commenced early in order to avoid the pathological changes which arise from continued high blood pressure. The characteristic changes are atheroma of the main arteries and sclerosis of the smaller vessels. With hypertension of long standing we find

hypertrophy of the muscular tissue of the heart and arteries and later this passes to degeneration.

One of the older preparations which has stood the test of time and which experience has shown to be perfectly safe in the treatment of hypertension, still ranks prominent among the preparations used to alleviate this condition, this is an extract of Mistletoe or Viscum Album. This extract has been found highly effective in treating hypertension, its action being rapid and constant in reducing hypertension. It functions chiefly by its antispasmodic action, but it also has a diuretic action upon the kidneys. More recently we have had the introduction of certain hepatic and pancreatic extracts for the treatment of arterial hypertension, and it has been found that a combination of these organic extracts with the vegetable extract of viscum album constitutes one of the most effective means of combating the symptoms of hypertension.

A well balanced and effective combination of these extracts will be found in Hypotensyl, which clinical experience has confirmed as being a most dependable, safe and effective preparation. Hypotensyl will be found to exert a beneficial influence on the various types of hypertension, but emphasis should be borne on the point that the earlier Hypotensyl treatment is introduced so the results obtained are correspondingly better, also, the liability of secondary pathological conditions occuring from continued high blood pressure is likewise minimised.

Under Hypotensyl regime arterial spasms which result in the onset of atheroma and arteriosclerosis, and certain pathological conditions in the heart and kidneys, are largely suppressed. In addition Hypotensyl exerts an antispasmodic action on the nervous system, also a mild diuretic action upon the kidneys.

An important feature of Hypotensyl is that treatment may be prolonged indefinitely without the intervention of any secondary reactions, also tolerance is not exhibited. These are two noteworthy points which greatly enhance the value of Hypotensyl, due to the fact that treatment is frequently protracted, also relapses have to be dealt with; but whenever a patient has obtained benefit from Hypotensyl at the commencement of treatment this same effectiveness will be evident during the treatment of a relapse or after several months continuous treatment.

Hypotensyl invariably gives a patient relief from the symptoms associated with high blood pressure, thus the feeling of lassitude and the recurring headaches are removed, the patient experiencing a return of the former feeling of well being and mental alertness. Other symptoms which are beneficially influenced by Hypotensyl are dyspnœa and cardiac pains which symptoms are frequently pronounced in hyperpiesis of long standing. Thus, in view of our limited knowledge concerning the ætiology of hyperpiesis and the beneficial influence Hypotensyl exerts on the different types of hyperpiesis, we must regard this preparation as one of the most rational means of treating this condition, Hypotensyl treatment being perfectly safe and effective.

Sarcoptol in Dermatology.

A number of medicaments have been put forward from time to time for the treatment of various diseases of the skin but most of them have proved of little or no value and in some cases have even proved harmful. This is because these preparations, which are composed of pyrogenic products, sulphurs and phenols, have the disadvantage of high concentrations in order to ensure certainty of action. These frequently cause marked irritation of the skin and thus defeat the very object for which they are meant. There existed for a long time a need for an agent which besides being effective, simple to use and free from odour, does not exercise any injurious effect on the skin and does not produce any toxic by-effects. Moreover it must not soil the linen. This gap in dermatological therapeutics has been undoubtedly filled up by Sarcoptol, the concentrated colloidal preparation of Sulphur with analgesic and antiseptic effects.

Sarcoptol is a non-irritating colloidal preparation for use in dermatology with a constant molecular content of sulphur. It is a liquid of neutral reaction and it does

not possess any odour. Its energetic action is not merely a sulphur effect, but it depends on the molecular complex as a whole. Even when used in the concentrated form it does not irritate the skin. It combines in it complete absence of the irritation of the skin with a strong parasiticidal action and analgesic effects. The nature of the prepartion is such that it entails a gentle percutaneous absorption. Its soothing action on the itching skin is experienced soon after application. On account of its marked soothing and decongestive properties it can be even employed for delicate and sensitive skins. Hence it is an excellent anti-pruritic and it favours epidermisation rapidly.

Due to all these effective pharmacological actions Sarcoptol has become a therapeutic agent of the first order in the treatment of various dermatoses. Clinical experience has clearly indicated that it is of great value in the treatment of idiopathic, infectious and parasitic skin affections. Its most important field of application is Scabies, where it acts as a specific. Its proper use will free the patient from this troublesome skin ailment in the shortest possible time. If correctly applied it will cure scabies by one application only. In this tormenting skin affection it allays itching immediately and speedily cures the condition. Unlike the greasy preparations of Sulphur it is clean and pleasant to use.

Sarcoptol has been employed with remarkable success in Seborrhoea, Ptyriasis and Alopecia. It has likewise proved of excellent value in Ringworm, Acne rosacea and vulgaris and Pediculosis. Suitably diluted and made into a lotion Sarcoptol is particularly useful in Acne on account of its non-irritating character and decongestive properties. The condition is generally cured in a remarkably short time without leaving any black marks. Ringworm readily responds to applications of Sarcoptol. Persistent use of this remedy in concentrated form brings about rapid disappearance of this most troublesome and recurring affection. Unlike Chrysarobin ointments it does not affect the kidneys nor does it irritate the delicate skins. Moreover it does not soil the linen and it is very clean and easy of application. Successful results have also been obtained from the use of Sarcoptol in Pediculosis wherein the destruction of the body lice and their nits takes place immediately due to its antiseptic action. Its beneficial action in Seborrhoea and Ptyriasis is really satisfactory on account of the healing action. We are soon able to remove the scabs and the crusts and the conditions generally disappear within a remarkably short period. Due to its antiparasiticidal action Alopecia due to Tinea yields to treatment with Sarcoptol very easily. The hair-roots in the bald patches are stimulated and the hairs begin to grow if the treatment is continued energetically.

Sarcoptol can therefore be used in a number of skin diseases. Its most important indication is Scabies. Physicians who had the occasion to employ it testify to its rapid parasiticidal action, its complete freedom from injurious or irritant effects and the entire absence of any undesirable action on the skin, kidneys and the intestines. Besides its beneficial action in the numerous chronic skin diseases it has the merit of being very convenient and clean. Its amazingly rapid action in allaying itching is an important feature in its favour. This latter property is of great service in allaying itching caused by a variety of conditions. Due to all these beneficial influences together with the advantages that it possesses it is no wonder that Sarcoptol is given preference over sulphur ointments in all cases where sulphur is indicated. The actions of Sarcoptol may thus be summed up:

1. Parasiticidal
2. Analgesic
3. Antiseptic
4. Antipruritic
5. Keratoplastic
6. Diffusible.

An illustrative case:

Sometime last month a young Hindu lady came to seek my advice for some skin disease on her scalp. Just in the middle of the scalp where she had parted the hair there were some regular ovoid patches covered with brownish red scales. They were quite superficial with slightly raised margins. What alarmed her most was that she had lost some of the hair in that region. On the patches there were some tiny papules which used to ooze out some serum. The scratching sensation disturbed her very much. Diagnosing this condition as Seborrheic Dermatitis I ... Sarcoptol ... one part of ... to four of water. She was asked to rub this in the...

affected part three or four times daily. Next morning she came to me telling me that the scratching sensation was very much less and to my surprise I found the patches had already begun to heal. The crust formation had ceased and the inflammation and the secretion had very much decreased. After four days of this application the patches had cleared up completely and the patient was very much satisfied. I advised her to rub the lotion at least twice daily until the hairs in that region begin to grow.

Thyroid therapy.

It has been the experience of many that most of the synthetic thyroid products do not fully correspond in action to the whole gland, apart from the by-effects, such as nervous excitation and cardiac disturbances which they cause. Attempts were therefore made to produce a fully active substance containing all the properties of the whole gland and to present it in a form of maximum purity. Further, it must be easy of administration in accurate dosages, and free from harmful by-effects. We have at last succeeded in producing a particularly active and harmless substance by a process of extensive fractioning, and have named it Thyratoxine. It has completely superseded the therapeutic effects of various Thyroid extracts that are available to the profession.

Thyratoxine has proved itself superior to other similar products, as borne out by the usual tests, weight reduction, creatin excretion and so forth. It is biologically standardised, each tablet containing 0·03 gm of the pure substance. In addition to the biological standardisation there is Iodine determination of this product which shows that it is definite and constant in composition. It is absolutely free from toxic amines and lipoids found in the fresh gland. By the introduction of Thyratoxine there is a definite advance in therapy and accuracy of Thyroid administration and now we are able to judge what exactly the patient gets in a particular time. In Thyratoxine therefore the clinician gets the full value of the entire activity of the pure gland.

Thyratoxine is a product capable of evoking an exceptional degree of physiological activity. It possesses the characteristic action of the Thyroid gland on oral administration. It represents the entire activity of the gland and it can replace the whole gland substance for all therapeutic purposes. The utility of this preparation is evident in all those states in which thyroid hypofunction calls for the application of the thyroid gland. Its outstanding action is the marked stimulation of metabolism. Due to this metabolic activity Thyratoxine plays an important role in combating infection and in accelerating the growth effective of the tissue. Regular use of Thyratoxine tablets is an effective means of instituting bodily vigour. It facilitates ossification of bones and promotes development of the teeth. This Thyroid product is useful in correcting those common symptoms of thyroid hypofunction characterised by lack of muscular tone, poor circulation, pallor, constipation and the like.

One of the first conditions in which Thyratoxine can be used with benefit is simple Goitre. Thyratoxine administration in small doses at the start has proved effective in a great number of these cases. The metabolic rate gradually rises and the gland soon resumes its normal activity. The treatment should be continued in appropriate dosages even after the desired results are obtained. Thyratoxine may be given in these cases for prolonged periods without ill-effects. In doubtful cases a few tablets of Thyratoxine can be safely given for short periods in order to assist diagnosis. Most brilliant results are obtained in this condition by the suitable application and maintenance of the treatment by Thyratoxine.

The next indication where Thyratoxine can be applied is Cretinism, where it replaces or supplements the lacking secretion of the Thyroid. If given in early stages this preparation produces remarkable results. There is definite and perceptible change in the stunted growth, low and broad forehead and flat nose. The stolid expression and the muddy skin gives place to bright appearance and clear complexion. The mental condition improves and active growth soon commences. Patients suffering from Cretinism tolerate this Thyratoxine

treatment remarkably well. The earlier this treatment is commenced, the better the results.

Myxœdema is another chronic disease where Thyratoxine can be employed with advantage. The dry skin, the bloated appearance, obesity, nervous disorders, tetany and mental disturbances—all these rapidly improve under Thyratoxine regime. Languor, extreme sensitiveness, mental dullness etc. which are the characteristics of this disease yield rapidly and completely to the regular use of this Thyroid preparation. Administration in small doses at first, which are later gradually increased is most effective in these cases. The treatment must be continued indefinitely and in some cases the patients must be told that the treatment will have to be carried on throughout life.

Another condition in which Thyratoxine can be beneficially applied is delayed or arrested development, either physical or mental. This condition is frequently associated with a varying degree of hypofunction of the Thyroid gland. Under this medication the organism steadily grows and the remarkable improvement soon becomes evident in the mental condition. Such cases notably improve in every respect if this treatment is carried on with small doses at the commencement, say 1/10 gr. thrice daily gradually increased to about 20 grs per day.

Obesity in most of the cases is due to exogenous and endogenous, or endocrine factors. The key gland in most of the cases is the Thyroid. It controls basal metabolism and also exerts a regulating influence on the elimination of surplus water from the tissues. In treatment therefore it is better to take into consideration both exogenous and endogenous factors. For the first one, regulation of food intake with proper exercise is all that is necessary. In most of the cases the endogenous factor means that there is hypofunction of the Thyroid Gland. The most suitable therapy for this purpose is the administration of Thyratoxine. It stimulates the pathologically diminished process of basal metabolism and eliminates the excess of fluid combined in the tissues. The dose that is effective in such cases is 2 tablets per day raised to 3 or 4. These can be given uninterruptedly for weeks without causing any injurious by-effects. A very considerable increase in the basal metabolism is frequently observed in all patients. The decrease in weight is often very appreciable. It is important to bear in mind that too sudden and too great reduction in weight should be avoided as it may lead to serious consequences. This can be done by following a strict regulation of dosages according to individual cases. If this treatment is given in proper and continued dosages, a steady stimulation of the process of metabolism is obtained. We are thus able to eliminate morbid deposits of fat and to reduce the body-weight in most of the obese patients.

Certain toxaemias of pregnancy such as albuminuria, hyperemesis etc, are amenable to Thyratoxine line of treatment. These toxaemias are usually due to auto-intoxication, which is easily counteracted by this treatment.

Some cases of nephrosis respond well to Thyratoxine treatment. In so far as nephrosis and disturbed protein metaboliam are dependent on hypothyroidism this therapy is usually effective in correcting the defect. Where other endocrine factors are deficient this line of treatment is not of much use.

In certain cases of fractures where the healing process is somewhat retarded Thyratoxine is of great use in bringing about rapid healing. In these cases the hypofunctioning of the Thyroid is responsible for retardation and the administration of Thyratoxine provides the organism with the necessary secretion and this promotes rapid formation of the callus. This medication combined with calcium and phosphorus has proved effective in the majority of cases.

Chronic deafness which is due to hypofunction of the Thyroid can be beneficially treated with Thyratoxine. When definite diagnosis of Thyroid hypofunction as an etiological factor has been made this medication should at once be exhibited. It has been found extremely effective in ameliorating the condition.

Several skin affections such as chronic eczema, psoriasis have been treated with marked success by this method of Thyroid medication.

Good results have also been obtained with Thyratoxine in some cases of Rheumatoid arthritis.

In view of the fact that there exists some inter-relation between the Thyroid and the ovary and the menstrual function, the administration of Thyratoxine has been found to be advantageous in amenorrhœa and particularly in the delayed onset of menstruation.

This Thyroid preparation should be of special value in the indications mentioned above. It is always well-tolerated and causes no disturbance of the cardiac or renal functions even when given for weeks at a time. Except for a harmless exanthema at times as a symptom of hyper-sensitiveness, no other serious consequences are ever observed under Thyratoxine regime. Tachycardia, if it becomes pronounced, indicates the commencement of the disturbance. At this time the dose should be reduced, but on no account should the medication be discontinued. In view, however, of the peculiarity of the product, it is highly important that Thyratoxine should be prescribed in minimum doses at first and the dose should never be increased until careful examination of the patient over a period of at least a week, has ensured that the full effect of the particular dose employed has suited him well. For therapeutic purposes therefore the use of Thyratoxine in preference to other similar products offers great advantages, of accuracy of dosage, definite effects and freedom from by-effects.

Some interesting clinical reports.

1. A young woman of about 32 was sent to me for treatment of obesity, total disappearance of menstruation and polyuria of unusual intensity from which she suffered for the past three years. For the last one year obesity and polyuria had increased progressively. The patient weighed 206 lbs, when she came to me. Although this obesity was diffuse, it involved certain regions with predilection viz., the gluteal region, the pubes, lower part of the thighs and abdomen.

Menstruation, which had always been irregular and painful had ceased altogether for the last six months. For two months preceding its cessation she had actual menorrhagia. No functional disorders followed this sudden cessation of the menstrual process. She has a child about six years old born at term. Pregnancy and delivery were quite normal. Polyuria had also appeared suddenly for the last one year. Despite all these symptoms her general health was quite satisfactory. Polyuria as well as adiposity had made their appearance almost simultaneously. Polyuria was considered to be due to Diabetes Insipidus and she was subjected to various classical treatments for the same without much avail. When she came to me I gave her injections of Ovaro-Pituitary Co. A. F. D. every other day subcutaneously and prescribed Opocrins of the same, six of which she took every day. All other treatments were discontinued. After twelve injections there was considerable alleviation of the polyuric phenomena. This treatment also effected great improvement in the adiposo-genital syndrome. The reduction in polyuria was accompanied by loss of weight. She passed about 200 ozs of urine every day now and the weight which was 206 lbs was reduced to 190. Menstruation became easy and regular and she had regained her usual energy and activity. The Pituitary extract in the preparation was effective in lessening polyuria and both the Pituitary and the Thyroid regulated the metabolism of water and fats and brought about reduction in weight. The ovarian extract together with the Thyroid had action on the genital apparatus, which was also brought under control. This preparation has a unique combination of extracts whose secretions are interdependent. Hence the regulation of urine, utilization of facts and normal working of the genital apparatus, all of which were effectively restored by it in this case.

This lady continued taking the Opocrins after 12 injections had been administered. She had a fortnight's rest after which she was given another course of 12 injections. Her weight now is 150 lbs. There is no polyuria and menstruation is quite regular She is still continuing the Opocrins.

2. This was a case of a lady of 45 years who was subject to violent attacks of migraine and urticaria in her young age. Before she came to me she presented all

sorts of symptoms, sudden fainting attacks, cardiac syndrome and albuminuria. There was oedema first of the upper extremities and then the lower and lastly of the face. There was headache, dyspnœa and palpitations. The urine was scanty and loaded with albumin. Having made a diagnosis of nephritis with cardiac hypertrophy I kept her mainly on diuretics with Calcium Chloride, Digitalis and Theobromine. This was continued for some days without the least improvement. I considered the prognosis very grave. At this stage one point which she had related to me during the course of her history and which I had missed entirely, struck me as very important; her menstruation had never reappeared after her last delivery which was about nine years back. I thought that perhaps ovaries might be at fault and the marked oedema and scanty urine were suggestive of thyroid insufficiency as well. I thought therefore that Opotherapy with Ovaro-thyroid might be of some benefit to her. She was given one injection of the same A. F. D. preparation every other day and she was taking six Opocrins of Ovaro-thyroid daily. Some days after this regime the improvement in her condition began to be perceptible. Two months later her kidney functions were normal and she passed urine freely. Oedema disappeared and she no longer felt any dyspnœa. The urine was clear and was not albuminous. Menstruation had returned and the hair which was scanty in certain places as the axilla, pubic region and eyebrows began to grow again. Her general health at this time was very satisfactory. After 12 injections were completed she was given a fortnight's complete rest when nothing by way of medication was given, not even the Opocrins. After this rest Opocrins were continued but the dosage was raised to 8 per day. No injections were administered after this. Six months later the patient's health was excellent. There was no oedema and no signs of cardiac hypertrophy. The heart sounds are normal and the menstruation, which was absent for nearly 9 years has reappeared and has been regular ever since. The Opocrins are still continued. She is having a week's rest after every fortnight of the medication. The Opocrins have never produced any by-effects such as headache, nervousness or tachycardia.

This case leads us to believe that there are in reality oedemas of Thyroid origin, because under the influence of Ovaro-Thyroid treatment the complaints of this patient vanished rapidly with dissolution of Oedema. The heart as well as the kidneys regained their functional integrity which showed that no organic trouble was present. The Oedema as also other symptoms were mostly of hypothyroid origin and they yielded beautifully to this endocrine line of treatment.

Clinical reports.

1. An old man aged about 60 consulted me for general lassitude, fatigue, loss of energy, physical and mental. In his youth he was a man of a strong and vigorous constitution. I found that his energies were evidently flagging and he was losing his remarkable muscular power. His chief complaint was that he was losing his ability to concentrate and that his memory had become rather dull. The patient was found aged much beyond his years. His carriage was less erect, his eyes were sunken and his face looked pale and sallow. The muscles had lost their tone and there was considerable abdominal slackness. The cardio-vascular system, however, did not show signs of much wear and tear and it was really very good for a man of that age. There were very little arterio-sclerotic changes in the blood-vessels. The pulse was slow, of regular rhythm and fair force and volume and the sounds at the apex were distinct and unmodified. The blood-pressure was 130 systolic and 70 diastolic. This most exhaustive physical examination did not show any cause of his sudden break down and I therefore advised him injections of Hypercytol and prescribed Fer-Ma-Pho internally. Injections were given every other day intramuscularly. Although slight improvement was visible at the end of the course of twelve injections, he was not quite as active as before. I therefore discontinued the injections and kept him only on Fer-Ma-Pho. He was given 15 minims twice a day half an hour before food. He took this regularly and after he had finished two bottles the effect was really striking. He held himself again with that old erectness, the abdominal fullness disappeared and the muscles regained their old tone. His mental vigour and quickness returned and he was able to

concentrate. He could go through his usual activities without much fatigue. I have advised him to take one more bottle of Fer-Ma-Pho which he has been taking. He now says that he is quite himself again and has been keeping remarkably good health.

2. A 30 year old woman came to seek my advise for habitual abortions. She was in the family way at the time she consulted me. She gave me the history of having aborted thrice following about 10 or 12 weeks of pregnancy. On examination I could not detect any signs or symptoms of past or present syphilis. I therefore sent the blood for Wassermann test which was absolutely negative. The pelvis was quite normal, so also was the position of the uterus. I did not know what to do. I thought this to be a case of avitaminosis and I asked her to take nourishing diet and fresh green vegetables. After some time I thought of trying Thyroid Extract as I remembered to have read about it some time back. I gave her one ampoule of Opocrin Thyroid (A.F.D.) daily until I finished 12 and after that I recommended to her the tablets of the same preparation, six of which she took every day.

She used to take these for a fortnight and then stop for a week and again start taking these. This routine she continued for a long time. The third and the fourth month passed off safely after this, and this was the period when abortion usually occurred. Opocrin Thyroid medication was continued and the result was that she reached full-term and the delivery was perfectly normal and without any incident. This lady showed absolutely no signs of myxœdema. At most, barely perceptible signs of hypothyroidism might be present. This case clearly indicates that even the slightest symptoms of thyroid insufficiency may bring about habitual abortions and it is therefore necessary to find out any manifestations of hypothyroidism in pregnancy and treat them with effective Thyroid Extract. Despite normal genital conditions and the absence of syphilitic affection this patient had suffered from repeated abortions and when adequate treatment with a proper Thyroid product was carried out regularly and continually, she could reach full-term without the least trouble.

3. A fitter aged about 30 came to me complaining of epileptic attacks. He gave history of having suffered from cerebro-spinal meningitis about a year back. After this he recovered and was keeping excellent health until he was attacked by these fainting fits with froth round the mouth. For some six months these attacks used to come regularly every week. Bromides and other sedatives had very little effect. Elixir Bromo Valerianate was prescribed. He was taking one table spoonful thrice daily after food. Bowels and diet was regulated and he was advised to take as little salt as possible. In addition to this he was prescribed Opocrin Thyroid, eight of which he took daily. As the heart sometimes responded too actively due perhaps to these Opocrins, the dose was reduced to six per day. The epileptic attacks after one month of this regime, used to trouble him very rarely, while later they disappeared altogether. The dose of the Opocrin Thyroid was then reduced to 4 per day when he began to get slight attacks off and on. The dosage was therefore again raised and he began taking 6 Opocrins daily together with Elixir Bromo Valerianate. Thereafter he never had any fits for a long time. After three months of this combined treatment the patient became quite well and has gained about 12 lbs in weight. He performs his daily duty, which consists of hard manual labour without being disturbed by fits.

It is said that auto-intoxication follows severe attacks of cerebro-spinal meningitis and this may develop so much as to cause epileptic attacks. Thyroid medication is considered to be the most rational remedy to combat this auto-intoxication and the resultant epileptic fits.

(*Continued from page 64*).

have to fight and struggle for First, you have to demand rendition of the 102 so called residuary posts of the communique. Secondly, you should demand that the release of 90 posts should be made a reality and not a sham. Thirdly, that the transfer of the medical department should be made a living fact and not a farcical comedy. When you have struggled through these stages, your goal will be in sight. There will be only 200 military officers left in the civil department. With the effective transfer of medical department they are bound to be absorbed in the provincial cadre. When that much desired and happy event comes to take place, it will be time for the Director-General I.M.S. to receive his conge from the Government of India and bid good-bye to the fair heights of Simla. The present Director General of the I.M.S. is a personal friend of mine and I only hope this change will not come in his time and if it does come, I hope it will be nothing worse than to change his tunic and plumes of I. M. S. into the top hat and frock coat of a ministry of health. Gentlemen, that is your goal.

Independent Medical Profession.

I have devoted a large portion of my address to the official side of the medical profession. In this, please do not for a moment imagine that I have neglected the independent profession. I have done this for two reasons. In the first place I do not make any distinction between the official and non-official medical profession and secondly, because I firmly believe that the medical officialdom rather than the so-called official medical profession is the chief and only barrier which stands in the way of the Independent Medical Profession. Unless that barrier is removed and the path is made clear, you as independent profession cannot make a headway. In my address I have tried to show how the path can be cleared. In the long and weary struggle which I have outlined so far, you as private practitioners have a part to play and a very important part. In the journey which we have undertaken together, I have assumed the arrival of a stage when some at last of the barriers are removed and the medical department is intact and completely provincialised. You have therefore to work provincially. Your work lies in the Provinces. The most important requisite for provincial work is the formation of strong powerful provincial branches of the Indian Medical Association, with live and active branches in all districts and even villages in all provinces. Organise and consolidate medical opinion in your province. Don't permit cleavage in your ranks into official and non-official medical profession. I am aware that the service man fights shy of the Indian Medical Association. He would rather stand aside and let somebody else to do the dirty work for him and he to enjoy the fruit of your labours. But in this, gentlemen, he is not a coward; he is not his own master, he is cowed down by the tyranny of the Czars at Simla.

The tyranny of the Czar is coming to an end at Simla as it has disappeared elsewhere. The time is not far off, when Sir Rice Edwards under-dog will be coming to his own. It will not be long when the top-dog will come wagging his tail, to lick the hands of the under-dog.

The Licentiates.

The other man whom the Czars are trying to divide from you is the licentiate. Don't desert the poor man, he has done the pioneer work of the profession. There are over 25,000 of them all over India who are doing most useful work in urban and rural towns. The uniformity of education, and qualification is only a device to create division in your ranks. The licentiate is a part of you.

Having secured the solidarity of your profession you set to work. The ministers are your own men, the provincial legislature is your own, secure their goodwill and support. Then you have the public opinion and public press, secure their co-operation and support also. Having made sure of your allies and support, convince them that in matters of medical relief and sanitary reform the co-operation and help of the independent practitioner is most essential in order to popularise and extend the State measures of medical relief especially in times of great national disasters, such as floods, earthquakes, famine, epidemics and great wars.

To be able to render assistance to the Government of your province I should advice you to organise medical relief measures, enlist freely for army reserve forces. Your offer of honorary services as

surgeons and physicians in provincial hospitals and dispensaries will be most welcome. You will be most useful as registrars of birth, vaccinators and health officers in rural areas. The Municipal bodies and district boards who generally live from hand to mouth will be only too glad of your voluntary services. Your willing co-operation will help to enlarge the scope of medical relief and result in economy. There is enormous scope for work in maternity, child-welfare nursing, first aid, health inspection of school children, sanitation and so on. To enable you to render professional services efficiently to your country and the State, you demand the recognition of your status. If the registration of qualification, imposes certain obligations on the recipient it confers on him certain privileges also. These privileges, are your due as registered private practitioners, such as the granting of certificates for recruiting, invalidating, of civil servants, of examining medico-legal cases. You should further demand that the undue and unfair competition which is going on at present between the struggling private practitioner and the salaried State medical man should cease by confining the latter to his consulting practice only. This gentleman, is the writing on the wall and this is my vision of the future progress of the medical profession in India.

TRICHINOPOLY DISTRICT MEDICAL CONFERENCE

WELCOME ADDRESS

BY

DR. C. E. R. NORMAN,

F. R. F. P. & S., D. P. H. etc.

CHIEF MEDICAL OFFICER, S.I.RY.

20*th December*, 1934.

As President of the Trichinopoly District Medical Association, it gives me great pleasure to welcome you all to Trichinopoly.

Trichinopoly is the Centre of Tamil Nad, an important pilgrimage centre and the headquarters of the South Indian Railway. We also hope it will become the centre of Medical activities for South India, and will be the nucleus of as many similar but smaller organisations. Medical Associations are springing up throughout India, but up to now no attempt has been made to have a central parent Association, to be a guide and help to the various Practitioners who are members of smaller organisations and perhaps out of touch with conditions which later on may affect the lives and welfare not only of Medical men, but of the social conditions of people amongst whom we work and are expected to serve. Medical Associations are a power in Europe for the betterment not only of Medical Education, National Insurance and Public Health Services, but also of other public activities which are inseparable from advanced social conditions with which medicine is also bound up.

The British Medical Association is a power in the United Kingdom, and it has acquired this power because most Medical men are members of it, and branch Associations look to it for guidance. It has proved its usefulness. When the British National Health Insurance Act was about to be made Law, there was a large split in the Medical profession at Home. Some were for rejecting it entirely and making the scheme unworkable; others for working it in spite of certain principles objectionable both to Medical men and Insured persons. By the wise and timely intervention of the British Medical Association, the Medical profession, as a whole, was able to present an united front to the Government, and was instrumental in improving the lot of the insured person as well as bettering the position of the medical profession under the Act. In this country there is no such Central Association. That need for such Association exists, is shown by the fact that certain Government Medical Services have their own departmental Associations which has resulted in various improvements in their services. This may be all to the good of the particular service concerned. But it is a pity that Medical men in certain positions should be segregated, as it were, from the rest of the medical profession and the improvements effected ought to have been the result not of their own particular activities, but the activities of the whole of the medical profession in India urging their case through the mouth piece of a central powerful Association. It would lessen the tendency to divide medical men into many different compartments with no sympathy or understanding for each other. What I would like to see, is a Central All-India

body composed of members from Branch Associations, and until this is effected I do not believe we, as medical men, will be able to exercise that counsel which I think, we have every right to give and believe to be acceptable. There are very few countries in this world where at some time or other social activities, have not been brought about by legislation, and invariably the medical profession has had to put up a very stiff front to prevent philanthrophy from being exercised at their expense and to better the lot of the people who are being legislated for. This country will be no exception, and I think it behoves us all to consider carefully the future, and while we know there are several medical men in the Legislative Assembly who will safeguard the interest of the medical profession as a whole their hands will be greatly strengthened if they can show that their views are representative of medical opinion in India.

The Trichy District Medical Association owes its origin to the enthusiasm of two medical men, Dr. T. S. S. Rajan and Dr. Nadungadi. I believe my predecessor Dr. Macaulay-Hayes had some hand in it. It started about 20 years ago with half dozen members who actively promoted the welfare of the Association for some years. After a while it languished owing to the absence of a few of its strongest supporters and its activities tailing off, it required the energy of a Col. T. S. Shastry I.M.S. to whip it into activity again. This is usually the history of all organisations which have the active support of a few individuals only, the rest taking their activities as a matter of course. The moral is obvious. Do not miss these meetings. Come and make them a success by your presence and the part you take in the discussions.

Another point which I think we should consider is the necessity of having a rallying point. Like the regimental banner of the Swarajist flag we require some fixed point where we can crystallise our ideas and where we can keep them on record. This means a building containing a hall for assemblies like this, a room for refreshments, a library, a record office and a Clerk's room and a play ground. In addition, there should be a few rooms for guests. It will be of great benefit to the Association to have a place where we can meet irrespective of monthly and annual meetings and develop an atmosphere which will keep the Association above the differences of personalities, politics and religion. A scheme like this however needs more than goodwill, it means a goodly amount of money and unless we can do a modified loaves and fishes miracle, a possibility beyond of our efforts. The Secretary who has presented his Report on the workings of the Association for the year mentions that our financial position is good and that we are not in debt. It would, however, be more helpful if subscriptions by members were paid more punctually and lee-way made up for arrears.

News and Comments.

Change in the Routine: The aims, objects and policy of The Medical Practitioner being quite different from those of the other medical journals we have to give more importance to the topics concerning the life and prosperity of the members of the medical profession and consequently are forced at times to change the routine we usually follow in editing the journal and have to allocate more pages to publish matter relating to subjects concerning the profession. Christmas holidays are usually availed off by the members of the medical profession for meetings and conferences. We have collected news from various conferences which met in different localities and published such matter which is likely to interest the profession. The only association we have at present in India to represent different grades in the medical profession both in private practice and service is the Indian Medical Association. This Association convenes conferences under its auspices every year and discusses problems of vital importance to the growth and prosperity of the profession. We have therefore dealt in more detail the proceedings of this All India gathering. We trust our members will excuse us for our not being able to follow the usual routine.

F. R. C. S. Primary Examination: As announced by us in these columns the F.R.C.S. Primary Examination was held for the first time in India, Madras being the centre. Professor William Wright, Dean and Professor of Anatomy of the London Hospital Medical College and Professor John Mellanby, Professor of Physiology,

University of London, were deputed by the Royal College of Surgeons to conduct the examination. They arrived in Madras accompanied by Mr. Horace Rew, Director of Examinations. The examination was conducted in the Medical College, Lt. Col. Pandalai, Professor of Surgery, Madras Medical College and Major Bhatia, Professor of Physiology, Grant Medical College Bombay, were co-opted as assessors, the former for Anatomy and the latter for Physiology. The examination began on 27th December and closed on the 1st January. It consisted of written and oral tests, first 2 days were alloted for the written examination and the rest of the days the candidates were tested *viva voce*.

It is said the 94 candidates from all parts of India applied for the examination but 61 candidates actually appeared. Three or four withdrew after the first or second written test. Out of 61 candidates who sat 21 were from Madras Presidency and 40 from all other provinces. 13 out of 21 candidates from the Madras Presidency and 8 out of 40 candidates from all other provinces passed. It is reported that the examiners were very fair and the impression of the Madras candidates is that the examination was not as stiff as they expected.

The holding of the F.R.C.S. Primary Examination in India is a momentous event in the history of the Medical Education in this country. This concession of holding this examination outside London was so far allowed by the Royal College of Surgeons to Canada, Australia and Africa. Thanks to Major-General Sprawson, who it is report ed was mainly responsible in getting this concession for India. There cannot be a second opinion that the concession is a boon to the Indian candidates who wish to get their F.R.C.S. qualification. But in the interest of development of medical education in India the holding of examination in India for granting foreign qualifications is likely to work as a set back to progress. The M.S. degree granted by the Indian Universities will not naturally attract as many candidates in future and it is quite possible that the examining bodies in Great Britain, may in the light of the experience of the F.R.C.S. Primary Examination consider the desirability or advisability of hold ing other medical examinations as well. The aim in India should be to bring into existence in India medical education of no less standard than obtaining in Great Britain and other civilized countries and not to permit or encourage the western medical institutions to hold their examinations here. Healthy rivalry will accelerate the progress of science and the checking of such rivalry will retard its progress. All the same we congratulate all the successful candidates on their success and we are delighted to note the phenominal success of the Madras candidates. This examination has also proved that if opportunities are given, medical licentiates can quite favourably compete with their graduate brethern even in medical examinations as they have been doing in the exercise of the medical profession. One of the candidates who appeared from Madras was a licentiate who not being satisfied with the membership of the Royal College of Surgeons, London and fellowship of Ireland aspired to be a fellow of the London Royal College of Surgeons and came out successful. We wish luck in advance to all the candidates in their second ordeal, the Final F.R.C.S. Examination.

F.R.C.S. Examination and After: There had been events during the week when the F.R.C.S. Primary Examination was held in Madras, which will be of interest to the profession. Prof. Wright and Prof. Mellanby visited Lucknow and other important north India cities. In the course of a talk with a representative of the "Hindu" Prof. Wright said:

"Both Prof. Mellanby, and I have been very much impressed by the excellence of the departments in the Medical Colleges we have visited in Lucknow and in Madras. We consider that their departments will bear comparison with similar departments in other parts of the British Empire. At the same time he added, we have also been much impressed by the high standard attained by the teachers and students alike, not only in Madras but in other places which we visited."

The high standard maintained in the other medical institutions in India does compare favourably with that in Madras or Lucknow and we wish the General Medical Council will note the disinterested opinion of these two eminent professors and satisfy their conscience whether their ban on medical institutions in India is justifiable unless it be to wreak vengeance.

There were a few social functions arranged to honour the two professors. For two of these, a tea party and a dinner, the hosts

were reported to be the staff of the Madras Medical College for the former and the old students of the professors for the latter. The independent medical profession would have been most pleased to honour the eminent guests and the guests themselves would have been more happy in a mixed gathering of officials and non-officials. It is very unfortunate that the Government medical officers especially those employed in teaching institutions do not realise that they are part of the whole medical profession and that the medical institutions are meant for the profession as a whole and that therefore they should identify themselves with their non-official brethren in all possible ways especially on occasions of the nature under reference. It is said that those who initiated and organised these functions were Indians, this makes the position more regretable.

Trichinopoly District Medical Association: For the last few years the starting of medical associations in the District Head Quarters has been an important feature in the history of medical profession in the Madras Province. Major-General Sprawson, while he was the Surgeon-General with the Government of Madras was mainly responsible for the impetus which these associations received through the District Medical Officers in the past. There are instances at least in a few districts where medical associations were started but almost all of them languished for want of encouragement. So it has to be said that the profession has to depend upon official help and co-operation for their betterment. The history of the District Medical Association, Trichinopoly as referred to in the Welcome Address of Dr. C. E. R. Norman, the President of the Association, justify our comments. The Presidents of the Trichinopoly District Medical Association have been officials in the person of the District Medical officer. A couple of years ago this honour was transferred to Dr. C. E. R. Norman, Chief Medical Officer, South Indian Railway, also an official and we are glad to note that Dr. Norman had justified the trust and honour imposed on him by the members of the Trichinopoly Medical Association. Dr. Norman is an European, the Head of the Medical Department of a railway company in India. So any statement or observation made by him will be noted with considerable interest by the profession not only in this province but throughout India. We have therefore published in our Abstract column extracts of the Welcome Address delivered by him on 20-12-34 at Trichinopoly on the opening day of the Conference convened by the Trichinopoly District Medical Association in connection with their annual gathering.

We wish all our readers go through Dr. Norman's address carefully and realise for themselves the necessity of the advantages of bringing into existence associations in the localities where they practise and affiliate the same to a central body "to be in touch with conditions which later on may affect the lives and welfare not only of medical members but of the social conditions of people among whom we work and are expected to serve." He referred to the British Medical Association which he said, "a power in the United Kingdom and it has acquired this power because most medical men are members of it and the branch associations look to it for its guidance. It has proved its usefulness." We will go a step further and say that the British Medical Association has been wielding power not only in Great Britain but all through British Empire and in India it has been able to dictate the central government not only about medical services but was even able to force on the Indian Government their will as in the case of the Indian Medical Council Bill. Affairs of the Medical Association in India will not be otherwise if all of them follow the advice of Dr. Norman and affiliate themselves to the Central All India Medical Association which has its headquarters at present in Calcutta. Dr. Norman is not evidently aware of the existence of the Indian Medical Association. We trust he will soon come to know of the Central Association and set an example not only in this province but throughout India by advising the Trichinopoly Medical Association of which he is the head, to affiliate itself to the Indian Medical Association.

Before closing we congratulate the President, the Secretary and the members of the Executive Committee of the Trichinopoly Medical Association on their all round activites and on their having been able to conduct the affairs of the Association well and with good results. But we will be failing

in our duty if we do not point out to the office bearers the serious omission in not including in the programme of the activities of the Association topics concerning matters affecting the life and prosperity of the medical profession. They have had splendid opportunities of improving the lot of the independent medical profession of which they have not availed themselves so far. The fact that the Government medical officers and the Railway medical officers are amongst the members of the Association should not have been ignored. The Association could expect the support of these officials in Government and Railway service with their chiefs in agitating for equal rights and privileges in the exercise of the profession, now denied both by the Government and the Railway authorities to the members of the independent medical profession in the matter of medical certificates and similar privileges. This Association had recently affiliated the District Rural Medical Practitioners' Association. The development of medical relief in rural areas should be one of the concerns of the medical profession in India. Annual gatherings should be taken advantage of for discussing the problems concerning the profession as a whole. We trust the Trichinopoly District Medical Association will make up for these omissions and show a better record of work in future.

Other Medical Conferences: Practitioners belonging to systems of medicine other than Allopathic met in Conference during Christmas holidays. Those belonging to Homeopathic system organised an All India Conference which met in Bombay and this Conference was opened by Sir Govind Pradhan Ex-Finance Member, Bombay Government. In Madras the practitioners of the Ayurvedic system ran three rival conferences. The Licentiates of Indian Medicine who passed out of the Government School of Indian Medicine organised a Conference of their own. Such of the Ayurvedic practitioners who passed out of a local private Ayurvedic College and who call themselves as Ayurvedic Graduates held a Conference of their own. While the practitioners of Ayurveda who style themselves as hereditary Ayurvedic Physicians who got their training from the father to the son arranged a Conference exclusively themselves. Mr. S. Muthia Mudaliar opened the Conference of the Licentiates of Indian Medicine and presided over the Conference organised by the Madras Ayurvedic Sabha. Advantage is taken by all concerned on occasions of the nature of All-India or provincial gatherings to get public and Government sympathy and support for those who organise such gatherings and therefore invariably the organisers of these conferences manage to get these conferences presided over or opened by persons commanding public or Government influence. So, it is but natural that the Homeopaths got an Ex-Finance member of Bombay to open their conference and in Madras the Licentiates of the School of Indian Medicine were able to get the conference opened by an Ex-Minister of the Government of Madras and presided over by the professor of Pathology of the Government Medical College, Vizagapatam, Dr. T. S. Tirumurthi. The Homeopaths urged the need of the recognition of their system by the Government while the Licentiates of the Government School of Indian Medicine whose system has already been recognised by the Local Government pleaded that they should be given status and privilege which the Government allows to the Medical Licentiates of the Allopathic system. The Ayurvedic graduates and the Hereditary Ayurvedic Physicians found fault with the Government for mixing Ayurveda with Allopathy in the curriculam of studies at the Government School of Indian Medicine which institution they opined was at present letting loose on the public practitioners of a hybrid origin. All the prevailing indigenous systems of Medicine in India including the alien system of Homeopathy like the prevailing religions in this country have their own votaries. None of them could be discarded as quackery. The Licentiates of Indian system of Medicine are perfectly justified in claiming recognition from Government on equality with their brethren in the Allopathic system as the School of Indian Medicine where they are trained is a Government institution. The agitation conducted by practitioners of different systems of medicine other than the Ayurvedic will we hope open the eyes of the Government especially the Madras Government and force them to consider seriously the advice given by us in these columns on several occasions that it should not be the concern of any Government

patronise any particular system of medicine as the public having faith in other systems and from whom the Government is collecting taxes have a right to demand patronage and recognition for other systems in which they have faith. The policy of the Government should be in public interest to see that only those who are recognised as practitioners are allowed to practise medicine and all of them possess the required qualifications. No Government could afford to start institutions in all existing indigenous or foreign system of medicine much less can provide employments for them. Development of any particular system of medicine should be entirely entrusted to the votaries of that system. Vested interests might not allow the Government in this country to have as broad an outlook as this matter deserves but time will come when due to financial and other difficulties the Government will be forced to carry out our suggestion. In the meanwhile may we warn the Allopathic practitioners whose system has been now styled as Scientific System to keep abrest with the agitation conducted by practitioners of other systems lest they should suffer more than they do at present.

Medical Licentiates in U.P. Public Health Department: As announced in our September issue the Public Health Branch of All India Medical Licentiates' Association held a Conference in Lucknow on 30th and 31st October under the Presidentship of Rai Bahadur Dr. K. L. Chaudhri Director Designate of the U. P. Public Health Department. The Conference was very well attended both by delegates and distinguished visitors. Dr. Mit Singh the President of the Branch Association read the Welcome Address. He dealt with some of the long standing grievances of the L.P.H. class viz the absence of the provision of old age pension or Provident Fund, non-conferment of Gazetted status on L.P.H. officers, inadequate annual increment of pay to the new entrants and the limited percentage of promotion of L.P.H. officers to Provincial grade. Dr. I. N. Saxena the Secretary presented the annual report. He emphasised the need of having only one class of Public Health Officers and suggested that Licentiates in Public Health should be permitted to appear for D. P. H. Diploma.

The Welcome Address of the President of the Association was more or less a memorial regarding the grievances of the Medical Licentiates in U. P. Public Health service and consequently the President of the Conference who is the Director Designate restricted his speech in answering the points raised in the memorial. Though the language in which the reply was couched was very sympathetic the effect was rather disappointing. The Licentiates cannot but feel that their position was perhaps destined to be where it is at present. The only remedy whether it be in Public Health Service or Medical Service seems to be to put an end to compartmentalism as suggested by Dr. Saxena in his annual report. The radical reform which should be aimed at to put an end to all sorts of invidious distinctions in the medical profession whether it be in service or private practice, is to bring into existence in this country an uniform standard of medical education which would permit those possessing this standard to go from the lowest to the highest rung of the ladder of progress. All the same till such time persistant agitation should continue. We are in entire sympathy with the legitimate grievances of this hard working members of the U. P. Public Health subordinate service who bear the brunt of responsible work in preventing human illness without commensurate recompense from the Government. Financial stringecy cannot be an excuse for bare necessities of life and we trust Dr. Chaudri will try to be as sympathetic in his action towards these unfortunate subordinates as he was in his expression while replying to the address.

New Year Honours: We congratulate Dr. K. Koman Nayar, Assistant Superintendent and Second Surgeon, Government Ophthalmic Hospital, Madras and Dr. T. D. Rajoo, Assistant Medical Officer, King Edward Memorial Hospital, Secnnderabad on the honours conferred upon them on the new year day. Dr. Koman Nayar gets the Rao Bahadur and Dr. Rajoo the Rao Sahib title.

Dr. Koman Nayar entered the Madras Provincial Medical Service as an Assistant Surgeon in 1911. He was on the staff of the Government Ophthalmic Hospital as Assistant Surgeon till 1926 when he was promoted to the grade of Civil Surgeon.

and appointed as the Assistant Superintendent in the same hospital.

Dr. Rajoo an old student of the Royapuram (now Stanley) Medical School was appointed as a Sub-Assistant Surgeon on the staff of the K. E.M. Hospital, Secunderabad in 1919 and was promoted to Selection grade in 1931. He has had a brilliant record of work from the beginning of his career and is recognised as a Surgeon of merit. Consequently he was promoted to the Assistant Surgeon Grade in 1933 and is now the Assistant Medical Officer in the same hospital where he was first entertained as Sub-Assistant Surgeon.

We wish these two lucky doctors long life of usefulness.

OBITUARY.

DR. T. KRISHNA MENON.

We regret to record the death from heart failure of Dr. T. Krishna Menon, M.B.C.M., M.R.C.S., L.R.C.P., at the early age of forty-nine on 11-1-35 morning at his residence in Poonamalle High Road, Madras. Till 3 A.M. on 11-1-35 Dr. Menon was in best of health. About half an hour before his passing away he complained of an uncomfortable feeling in the chest attendant with sensation for vomiting. Lt. Col. Mahadevan an intimate friend of Dr. Menon and Dr. Sundaram Hon. Asst Surgeon working under Dr.Menon were sent for immediately and Dr. Menon suggested that he would like to have an injection of Omnopon and before the syringe could be got ready Dr. Menon passed away peacefully.

After graduating from the Madras Medical College in 1910, Dr. Krishna Menon worked as Special Assistant to Col. Donovan, I.M.S., in Kala Azar research. He proceeded to England the same year for higher studies and passed the M.R.C.S., and L.R.C.P. from Charing Cross Hospital. After post-graduate work in Brompton Hospital and Mt. Vernon Hospital London for diseases of the chest, he returned to Madras in 1912 and set up private practice. He served on the Hospital Ship "Madras" and saw active service in the Great War. He was in Military duty from November 1914 to 1921 and again from 1923 to 1929 in the Indian Army Medical Corps. In 1924 he was appointed Honorary Surgeon, Royapettah Hospital and later Honorary Physician. In 1926 his services were transferred to the General Hospital. He served as also Honorary Lecturer in Diseases of the Blood and Heart in the Medical College till the time of his death. He was actively connected with the South Indian Medical Union in various capacities and was elected last year to the Indian Medical Council, Delhi. He was awarded the Kaiser-i-Hind Silver Medal for Public services in 1931. Dr. Menon was a tower of strength to the independent medical profession and always held views of his own. The loss the independent medical profession has sustained on account of Dr. Menon's death is irreparable. We have been associating with him in several spheres of our activities for serving the profession and we will be missing him everywhere with deep regret.

May the soul of Dr. Krishna Menon rest in peace and may God give Mrs. Menon and her children enough strength to bear the irreparable loss.

(We regret that due to our inability to publish this issue in time we had to publish this sad event in the December issue though it took place in January. - Ed.)

Correspondence Reports, Etc.

The Trichinopoly District Medical Association.

The fifth annual gathering of the above Association was held on 20th and 21st December 1934 with Dr. C.E.R. Norman in the chair. The Secretary presented the Annual Report which showed general progress all round during the year under review. The election of office bearers for the year 1935 was then proceeded with. On the suggestion of Dr. T. S. S. Rajan the retiring office bearers were re-elected as a mark of appreciation of their past services. Dr. Norman delivered the Welcome Address extracts of which appear in the Abstracts columns elsewhere. Dr. Rajan opened the Conference and in his speech dealt with health problems with special reference to the Indian social customs. and food factors and advocated the necessity of compulsory military training. The activities of the Conference lasted for two days. Medicine, Surgery, Obstetrics and Ophthalmology engaged the attention of those who attended the Conference. Dr. T. Krishna Menon was the President of the Medical, Lt. Col. T. S. Shastry for Surgical, Dr. N. C. Appayya for Obsterical and Dr. E. V. Sreenivasachari for Ophthalmological

and there were very lively discussions on all the papers read before the Conference.

XIth All India Medical Conference, Delhi.

The Conference of the members of the medical profession from all parts of India called under the auspices of the Indian Medical Association met in Delhi on 26th December. Dr. M. A. Ansari, Chairman of the Reception Committee welcomed the delegates and Col. Bola Nath C. I. E. Retired Member of the Indian Medical Service, the President of the Indian Medical Association for the year 1935, presided. The programme of the Conference consisted in the reading of papers of scientific importance under the chairmanship of Lt. Col. W. C. Paton, Civil Surgeon, Delhi and discussion of topics concerning the life and prosperity of the medical profession. The Medical Exhibition held in conjunction with the activities of the Conference was opened by Hon'ble Sir Fazl-i-Hussain, Member in charge of Health, Education and Lands, Government of India. The Reception Committee arranged an "At Home" to the guests and a trip round about in Delhi to places of importance interesting the medical profession. Messrs The Bengal Chemical and Pharmaceutical Works and Messrs the Havero Trading Company entertained the delegates the former with a garden party and the latter with Cinema films to demonstrate "Stored Solar Energy."

Resolutions passed at the XI-All India Medical Conference.

DELHI SESSION.

1. This Conference places on record its deep sense of loss at the untimely demise of Drs. M. L. Mitra, P. Nandi, Ranganathan, B. C. Chatterjee. P. C. Bhattacharya, B. Ram Singh and Dr. Bhajekhar and conveys its heartfelt sympathy and condolence to the members of the bereaved families.

2. This Conference condemns the Indian Medical Council Act 1933 and calls upon the Members of the Indian Legislative Assembly to take early steps, so as to provide therein amongst other things a more suitable arrangement for reciprocity, a large number of elected members on it and the inclusion of Licentiates in its purview.

3. This Conference strongly resents the appointment of a non-Indian as the Secretary of the Medical Council of India.

4. This Conference disapproves of the appointment of the Secretary of the Medical Council of India as an Inspector of examinations and of the Courses of Instruction, and it condemns the action of the members of the council, particularly the elected, which ultimately made such an appointment possible in June 1934, thereby reversing the decision of the Council in this connection arrived at its meeting held in March 1934.

5. This Conference is of opinion that the recommendations of the Drugs Enquiry Committee be given effect to, and a Bill for that purpose be placed before the legislature at an early date.

6. This Conference recommends to the Government of India the inclusion in pharmacopoeae in use in State hospitals and dispensaries of such drugs of indigenous origin whose value has been scientifically established in the treatment of disease prevalent in India.

7. This Conference strongly recommends to the Government of India, the Provincial Governments, and Local authorities not to curtail financial grants necessary for scientific medical research and for medical relief in the country.

8. This Conference strongly urges the necessity of amending the Provincial Medical Council Acts so as to ensure a majority of elected members in their constitutions and invites the Indian Medical Association to take necessary action in this respect through its Provincial Branches.

9. This Conference is of opinion that the demand by the various Governments or bodies under State Control for countersignature on certificates issued by registered medical practitioners is uncalled for and inequitable, and urges its abolition immediately.

10. Bearing in mind such necessary requirements of medical practitioners as conveyance, medical books, surgical instruments, and such other appurtenances as are necessary to an adequate discharge of their duties towards their patients this Conference is strongly of opinion that the Central Board of Revenue should issue directions permitting legitimate deductions from income-tax assessments on charges borne by medical practitioners for purposes such as those stated above.

11. Resolved that this Conference endorses resolution No. 4 of the U.P. Medical Conference held in Meerut in October last and is of opinion that the recent amendments to the U. P. Poisons Act and the subsequent drafts contained in U. P. Gazette, dated 8th September 1934, Part I, page 919, are derogatory and detrimental to the interests of medical practitioners possessing registrable qualifications.

12. This Conference, after a careful perusal of the contents of the Joint Parliamentary Committee's Report (November 1934) places the following on record:—

(a) This Conference is of opinion that the continued appointment of members of the Indian Medical Service to the civil side, as contemplated by para 299 of the Report (part 1—Volume 1) is entirely unjustified and uncalled for.

(b) This Conference concurs with the view expressed in the Report (para 299 lines 26 to 30)

of the services Sub-Committee of the First Round Table Conference that there should in future be no Civil Branch of the Indian Medical Service, that the Civil Medical Service should be recruited through the Public Services Commission.

(c) This Conference expresses the opinion that the present method of recruiting officers for the Indian Medical Services by selection is undesirable and unsatisfactory, and reiterates the resolutions passed at the previous meetings of the Conference that the system should stop and that an open competitive examination to be held in India as adopted.

(d) This Conference is of opinion that all I.M.S. Officers employed in the Civil Medical Department, must be wholly under the control of the Minister-in-Charge of the portfolio.

(e) This Conference is of opinion that the [illegible] of appeal sought to be given by the Report to the Privy Council (Para 364, lines 9 to 14 on page 215, volume 1—part 1) from the considered decisions of the Indian Medical Council as approved by His Excellency the Governor-General-in-Council in India is a direct infraction of the provisions of the Indian Medical Council Act of 1933; and as such a right conflicts with the autonomy professedly enjoyed by the Indian Medical Council, this Conference strongly condemns this recommendation of the Joint Parliamentary Committee, depriving as it does the Indian Medical Council of the right of reciprocity with other countries as to the mutual recognition of the respective medical degrees and diplomas conferred by the said Act.

(f) This Conference dissents strongly from the proposal in para 365 of the Report (Vol. 1 part 1) entitling members of the Indian Medical Service, the Royal Army Medical Corps, the Royal Air Force Medical Service to practise in India merely by virtue of the Commission they hold; thus infringing upon the rights of recirpocity granted to the Council as per sections 13, 14 and 17 of the Indian Medical Council Act of 1933.

13. Resolved that this Conference offers its grateful thanks to our President, Col. Bhola Nath, to the Principal and authorities of the Hindu College and St. Stephens College for allowing us the use of their premises for the holding of the Conference and also Lala Raghubhir Singh for placing his Guest House at our disposal.

14. Resolved that this Conference offers its grateful thanks to the Chairman and Members of the Delhi Municipality, the Delhi Health Department and the Boy Scouts Association for giving us all the facilities for holding the All-India Medical Exhibition.

APPEAL TO THE MEMBERS OF THE MEDICAL PROFESSION

Our appeal requesting such of our readers who have been receiving complimentary copies of The Medical Practitioner has not been in vain. There was response though we have to admit it was not to our expectation. It is just possible that many of you missed to read the appeal published on page 49 of the last issue. May we therefore request those who did not read that appeal to refer to it. As mentioned in our previous appeal The Medical Practitioner is the only non-sectarian medical journal which has been doing propaganda and service to the profession as a whole and the Medical Practitioner has been serving all sections in the profession in service and private practice including the subsidised rural practitioners and fighting fearlessly for the redress of their grievances. Though the journal is published in the capital city of Madras Province, we have been attempting to make it an organ to serve the profession throughout India. We confess we might not have been able to gather news from other provinces to the extent we have been able to do in Madras. The fault is not of ours. If our readers were kind enough to supply us materials to the extent we have been able to gather in Madras we would have been able to serve the other provinces as effectively as we have been doing in Madras. We take this opportunity to appeal to our readers from other provinces to utilise our service by supplying us materials for such service and make us realise our ideal that The Medical Practitioner is an All-India organ.

Please respond to our appeal and supply us with necessary sinews by enlisting yourself as subscribers. The subscription is only Rs. 2 a year an amount which scarcely meets the cost of the journal yet it may help to move the wheels of the machine of service and propaganda to the profession.

V. RAMA KAMATH.

List of Postings of Sub-Asst. Surgeons for the month of December, 1934.

No.	Names of Sub-Asst. Surgeons.	From.	To
1	Dr. T. B. Panchapakesa Pillay	L. F. Dy., Rampachodavaram	c/o, D.S.P., E. Godavari.
		Leave	
2	,, Mrs. L. Anandan	Govt. Hd. Qrs. Hl., Vellore	Govt. Hl., Hospet.
3	,, Venkataraman Orr		L. F. Dy., Tiruvettipuram
		Leave	
4	,, A. V. Suryanarayana	Govt. Dy., Sompeta	Govt. Dy., Sompeta.
5	,, B. Jagga Rao		Govt. Hd.Qrs. Hl., Berhampore.
6	,, A. Ramanuja Acharya	Leave	Govt. Hd. Qrs. Hl., Anantapur.
7	,, A. M. Ethirajulu Naidu	L. F. Dy., Vetapalam	L. F. Hl., Sattanapalli.
8	,, C. Lakshmana Rao	L. F. Hl., Sattanapalli	L. F. Dy., Tanakal.
9	,, K. V. Krishnan Nair	Koraput Agency	L. F. Dy., Palakodu.
10	,, P. S. Ramaswami	Festival Duty, Sriraugam	Govt. Hd. Qrs. Hl., Madura.
	,, E. Balakrishnan Nair	L. F. Dy., Batlagundu	Pol. Hl., Malappuram.
	,, M. Kunhikrishnan Nair	Munl.Hl., Bodinayakanur	Pol. Hl., Malappuram.
	,, Miss. S. Cherian	Leave	W. & C. Dy., Conjeevaram.
	,, C. Manika Mudaliar	L. F. Dy., Poonamalle	Govt. Hd. Qrs. Hl., Chingleput.
	,, Mrs. S. J. Souri, M.B. B.S.,	Leave	Munro's Hl., Gooty.
	,, Miss. L. Borges	Munro's Hl., Gooty	Govt. Hl., Hindupur.
	,, Miss. L. P. Stephens	Govt. Hl., Hindupur	W. & C. Hl., Vannarpet.
	,, Miss. Pushpam Aaron	W. C. Hl., Vannarpet	Govt. Hl., Cochin.
	,, L. A. Subramaniam	L. F. Dy., Gingee	Munl. Hl., Bodinayakanur.
	,, M. Varantharumperumal	Festival Duty, Srirangam	Govt. Hl., Dindigul.
	,, C. R. Narayana Ayyar	Govt. Hl., Dindigul	Govt. Hl., Cochin.
	,, Miss. T. K. Narayanaswami	Govt. Hl., Parlakimedi	Govt. Hd.Qrs. Hl., Berhampore.
	,, C. S. Venkatasubramaniam	Leave	Govt. Hl., Wandiwash.
24	,, P. P. Narayanan Nair	Leave	R.M.D. Hd. Qrs. Hl., Tanjore.
25	,, Y. V. Basaviah Naidu	Leave	Govt. Hd. Qrs. Hl., Nellore.
26	,, A. M. Kandaswami	L. F. Dy., Vonipenta	Agency Duty, Koraput.
27	,, Mrs. A. George	Leave	W. & C. Hl., Tuni.
28	,, K. Achuthan Nair	Leave	Govt. Hd. Qrs. Hl., Calicut.
29	,, Abdul Jabbar Sahib	Govt. Hd. Qrs. Hl., Berhampere	Govt. Dy., Minicoy Island.
30	,, M. Mohammad Khan Sahib	Govt. Dy., Minicoy Island	Govt. Hd. Qrs. Hl., Calicut.
31	,, S. M. Natesa Mudaliar	Leave	Stanley Medl. School, Madras.
32	,, J. Suryaprakasa Rao	Stanley Medl. School	Pol. Hl. St. Thomas Mount.
33	,, P. Kunhiraman Nambiyar	Leave	L. F. Hl., Hosur.
34	,, G. T. Barnes	L. F. Hl., Hosur	c/o Dr. Santra, Propaganda Officer.
		Leave	L. F. Dy., Vidyapuram.
35	,, P. P. Narayanan Nayar	L. F. Dy., Vidyapuram	Agency Duty, Koraput.
36	,, T. R. Subramania Ayyar	Koraput Agency	Govt. Hd. Qrs. Hl., Coimbatore
37	,, O. Govindan Nayar	Govt. Hl., Chicacole	L. F. Dy., Shergada.
38	,, K. Krishnamurthy	Leave	R.M.D. Hd. Qrs. Hl., Tanjore.
39	,, K. Govindankutti Nayar	Govt. Hd. Qrs. Hl., Cuddapah	L. F. Dy., Kosigi.
40	,, N. V. Ramanayya	L. F. Dy., Kosigi	Govt. Hd. Qrs. Hl., Cuddapah.
	,, M. V. Suryaprakasa Rao	L. F. Dy., Nandikotkur	Agency Duty, Koraput.
	,, K. Suryaprakasa Rao	L. F. Dy., Sattiavedu	L. F. Dy., Sidhout.
	,, M. Adinarayanaswami	L. F. Dy., Sidhout	Govt. Hd.Qrs. Hl., Berhampore
	,, G. Suryanarayana		