The Medical Practitioner

vol-7 NO.4,5,6,7.

January, February, March- 1936
April.

THE

Medical Practitioner

Annual Subscription { Inland Rs. 2. / Foreign Rs. 3. }

Single Copy As. 4.

VOL. VII.] JANUARY 1936. [NO. 4

THE FIRST ALL-INDIA OBSTETRIC AND GYNAECOLOGICAL CONGRESS

WELCOME ADDRESS

By

DR. LAKSHMANASWAMI MUDALIAR

Dr. A Lakshmanaswami Mudaliar, Chairman of the Reception Committee, welcoming the delegates and visitors to the Congress said :

It is with feelings of profound thankfulness and sincere pleasure that I rise to extend to you all a most cordial welcome on behalf of the Reception Committee, to this, the first All-India Obstetric and Gynaecological Congress. We are happy to welcome to our City such a large and distinguished gathering of Obstetricians and Gynaecologists from different parts of India. We extend our fraternal greetings to the President and members of the Bombay Obstetric and Gynaecological Society, to representative delegates from Calcutta, Nagpur, Delhi and other parts of Northern India and to the distinguished members of our profession from the Indian States of Hyderabad, Mysore, Travancore, Cochin and Pudukottah. To that noble band of workers, for whose services to the women and children of our land we connot feel too grateful to the medical missionaries we desire to extend a particularly warm welcome. To the delegates who have so kindly responded to our invitation and come from different parts of Southern India and who form the real bulwark of the profession—I refer to the medical practitioners in the rural areas and in remote corners of the Presidency—we are genuinely pleased to accord a welcome, for, they more than any one else, have to face occasionally obstetric problems of such difficulty and magnitude that will perhaps make the stoutest of us quail. We are convinced that this gathering would not have served its full purpose, its deliberations would not have the far-reaching effects that we desire them to have, if the general practitioners on whom the brunt of obstetric work in the mofussil parts necessarily falls, were not here to exchange views and to discuss the many problems of Obstetric and Gynaecological interest from their point of view. And lastly, may I, on behalf of the Reception Committee and on behalf of the delegates from British India, welcome most warmly the delegates from French India and Portuguese India, whose presence here today is a happy augury of the unity of the medical profession in Greater India and a symbol of the keen interest that the profession takes in the welfare of the women and children of the subcontinent.

GENESIS OF THE IDEA

Your Excellency, for some time past, some of us have been dreaming of this day, when we can foregather on a common platform: the Obstetricians and Gynaecologists from different parts of this country. It was not till June last that the happy idea could materialise and its fruition is due entirely to the whole-hearted support extended by the members of the Obstetric and Gynaecological Societies of Bombay and

Southern India. We desire to express our deep sense of gratitude to the members of the Bombay Society in particular, who have been most kind and considerate to us and have given us their fullest co-operation and encouragement in all our undertakings. We desire also to express our grateful thankfulness to Sir Frank Connor and to the present Surgeon-General, Colonel C. Newcomb, whose unfailing sympathy and support helped us in no small measure to organise this gathering. To Your Excellency's Government, we are particularly grateful for the facilities given to those employed in mofussil hospitals to attend this Congress by extending to them the privilege of special casual leave.

It is perhaps not inappropriate that the first Congress of this kind should be held in the City of Madras. Madras may not stand comparison in many respects with the Gateway of India or with the City of Palaces -- the second largest city in the British Empire. But Madras is proud and justly so, of the place it occupies in the Obstetric world of to-day and it is in no spirit of narrow provincialism that I venture to maintain that no other city in India could have claimed this honour with greater confidence and dignity. Madras claims the honour of having the oldest maternity institution in British India, nay, in the far East—for, the Government Hospital for women and children next door, was founded in 1844 and will be celebrating its centenary before the decade is over. Madras claims the honour of having instituted the first training school for midwives in India and for long the only training school of its kind in the whole of this country. Madras is happy to realise that it was the first city which extended through its University and Medical College, the portals of the profession to the women of the country. It is here that the first post-graduate school in Obstetrics and Gynæcology was established and to-day the Madras University is the only University which has established a Diploma through its affiliated hospitals in this speciality. It is, therefore, with pardonable pride that we welcome you to our historic city, but this very fact makes us all the more anxious about our future and the part Madras will play in the years to come. It is our hope and constant prayer that the people of this Presidency and the Government of the day, will feel a title of the pride we feel in our famous institutions and that they will do all they can to maintain its level of efficiency and extend its usefulness to the greatest possible extent.

Fellow-delegates, I am happy to announce to you that the idea of holding such a Congress has been widely welcomed by distinguished Obstetricians all over the British Empire and when a little later, I call upon the Secretary of the Congress to read to you some of the messages that have been received, you will yourself realise how much the idea of holding this Congress has been appreciated and what high hopes are entertained about its future and the part it will play in ameliorating the condition of the women and children of India. How far these hopes will be realised and to what extent our dreams would materialise, it is not for me to prophesy at present. We are encouraged in our task by the kindly sentiments expressed and the good wishes extended to us in such generous terms by the leading obstetricians of the day.

It is our hope that this Congress will enable us to know each other better and to appreciate the work that is being carried on in other parts of the Indian Empire. We hope that this assembly will act as a stimulus to every one of us, not only to keep ourselves abreast of the times, but to take a genuine interest in tackling the many problems that await solution in a tropical country like ours. We feel sure that gatherings, such as these will foster the spirit of research and encourage some of us to increased activity in this direction, where a very fertile and virgin field awaits exploration. It is our hope that through such conferences there will be a dissemination of correct and up-to-date ideas of the subject and that the discussions here would tend to focus our minds on the larger problems that await solution. It would be fitting and proper that a gathering, such as this would be in a better position to offer its considered opinion on the difficult, yet most important, questions of under-graduate and post-graduate training and what is equally important, on the proper training of midwives. We hope further that it will be possible from time to time to place our experiences before the authorities of the land and to acquaint them with our view-point as to the measures

needed for the care of the mothers and infants of this country. And lastly, we hope that this great gathering will serve as a stimulus for the spread of our ideals and that each one of us will be enabled to carry with him the torch of knowledge to his own place and there spread the virus of enthusiasm to the medical profession and the general public.

POST-GRADUATE STUDY

Your Excellency, it is hardly necessary for me to speak at length on the subject of obstetric aid to the people of this country or to dilate on the heavy mortality incident to child-birth or the great amount of morbidity and sickness that follows child-birth. Some of us who have had the sad privilege of attending on Indian mothers for the best part of our professional life, realise only too well, how much has been done in the past and only a little better, how much yet remains to be done. Two problems of transcendental importance which face us to-day are—the affording of facilities for post-graduate study and the encouragement of research in Obstetrics and Gynaecology. In no part of medical science is there greater need for post-graduate study than in the field of Obstetrics. Every one of us will easily realise that the time when one is in a position to understand and appreciate the practical side of Obstetrics, is when one has finished his student's career and becomes an apprentice in a maternity institution. And when it is further realised that midwifery has to be practised as an emergency in many cases and in the remotest parts of the country, the need for adequate training will be more easily appreciated. May I take this opportunity of appealing to Your Excellency's Government, to provincial Governments in other places, and to those in charge of large maternity institutions, to keep open the doors of the institutions for post-graduate training, and subject to the facilities available, to impose no restrictions of any kind, territorial, provincial or otherwise. Every post-graduate adequately trained, is an asset to the nation and an instrument of relief to the mothers of this country.

ENCOURAGEMENT OF RESEARCH.

Another great need of the hour is the encouragement of research. There are problems facing the Obstetrician in India which are peculiar to this country and which must be tackled and solved in this country. The deficiency diseases in relation to pregnancy, diseases like osteomalacia which are so widely prevalent in some parts of India, but which fortunately are rare in Southern India, the varying severity of the toxæmias of pregnancy in different parts of the country, the several tropical diseases and their effects on pregnancy—these and many other such problems are being tackled, but there is greater need for organised research to be undertaken. May we not hope that an appeal from this Congress and through Your Excellency to the generous public will not fail to evoke a sympathetic response? May we not also hope that various administrations in British India and Indian India will co-operate in a spirit of healthy rivalry to organise and support all such laudable enterprise?

Your Excellency, I must apologise for having spoken at some length. To-day is a red letter day in the annals of the obstetric history of this country and it is our hope and prayer that this Congress which is opened under your august auspices will grow from strength to strength and as years roll by, the tender seedling planted by Your Excellency to-day will grow to be a mighty tree spreading its sheltering branches throughout the length and breadth of India, such that under its shady bowers may gather together time and again the cream of the medical profession practising the twin specialities of Obstetrics and Gynaecology, such that its mighty breeze may waft to remotest corners of our land and bring comfort and solace to the rich and poor alike among the mothers of India. And may the Giver of all good, help us in this noble cause, guide us along the path of wisdom and lead us to the promised land!

Your Excellency, on behalf of the Reception Committee and this Congress may I now request you to be graciously pleased to declare this Congress and the Exhibition open.

Governor's Speech.

H. E. Lord Erskine, in declaring the Congress and Exhibition open, said:—

I must at the outset confess that it was not without some feelings of apprehension that I accepted your Committee's kind invitation to inaugurate this Congress to-day.

The position of a layman who is called upon to address a gathering of experts on their own particular subject is not an easy one. I feel that there is very little I can add to your Chairman's eloquent survey of the general aspects of this Congress, and absolutely nothing that I can contribute towards your scientific discussions. My function, then, is to be brief and to say what I have to say not so much to you men of science and medicine gathered here, but rather through you to the public of India at large.

I would, however, first like to tell you how very much impressed I am by the striking demonstration of enthusiasm for the cause of the mothers and children of India that is afforded by the large and widely representative assemblage that I see here before me. It must have cost a great deal of trouble and energy to organise this Congress and no little trouble to many of you to come long distances to attend it, and I would like to offer my most cordial congratulations and welcome to all who are participating. Your keenness augurs well for the advancement of your subject, and the holding of this Congress is assuredly a legitimate source of pride and inspiration to us all.

It would be an impertinence for me to labour the importance of this subject to you who are gathered in this hall, but I am not so sure that its importance and its magnitude are sufficiently realised by the general public. Here in Madras as your Chairman has said, we were among the first to tackle those problems. We claim to be second to none in both the study and the practice of this branch of medical science, and we are proud of the fact that doctors come from all over India to attend the post graduate courses at our Maternity Hospital. Yet in spite of all this, we have to admit that the mortality rate amongst mothers in Madras is four to five times as high as the mortality rate in Great Britain. Surely no stronger evidence is required of the work that is yet to be done both in the field of practical training in research and also in the development of a public sanitary consciousness: and when I say that no fewer than 4,000 maternity cases have been dealt with during the past year in our Madras hospital alone, there can, I think be no more striking proof of the extreme urgency of this work.

MATERNAL MORTALITY.

The question of maternal mortality is one that is now occupying a prominent place in the mind of most civilised countries. Many important advances have been made of late years both in obstetrical treatment and in the appliances used in that treatment, such as those which are in view in your Exhibition to-day. Here in India we may claim that our Governments have not been slow to recognise their duty towards the advancement of this science, while our professional men have been eager to take advantage of the latest discoveries and improvements. But we have a vast country and an immense population to deal with, and in a tropical land there are many and varied problems not met with elsewhere. What is wanted is a wider propagation of the knowledge already to hand, and a more intensive research into the peculiar problems connected with tropical diseases. Surely, ladies and gentlemen, there is no cause more truly deserving of popular interest, practical assistance and financial support. To save the mothers of India from suffering, disease and death and to rear up healthier, happier children—this is a task than which none could be dearer to the heart of any nation. Let the people of India see to it that nothing is wanting to the advancement of that cause which they can achieve by their endeavour and their charity.

For your part, ladies and gentlemen, you have surely chosen the best means towards that end by gathering here for an exchange of experience and mutual discussion of your problems. I feel sure that this Congress will of itself result in a big step forward in scientific knowledge. I understand that, though it is the first of its kind to be held, it will by no means be the last, and that it is intended to extened the organisation of Provincial Societies, which is already functioning so well here and in Bombay, on a permanent footing and throughout India. It is a fine purpose that you have before you and I am confident that the time is not far distant when that purpose will be triumphantly fulfilled. I wish this Congress all possible success and have very great pleasure in declaring it and its allied Exhibition open.

PRESIDENTIAL ADDRESS

BY

MISS IDA S. SCUDDER

Miss Ida S. Scudder, the President, then delivered her address. She said:

It is with especial pleasure that I have the honour of giving you all a welcome to this, the first Obstetrical and Gynaecological Congress of All-India. The impressions and inspirations which result from such meetings are always far-reaching.

In July 1935 I had the singular privilege of attending the meeting of the Medical Association of the United States of America and Canada held in Atlantic City, U. S. A. There, one had the pleasure of seeing and meeting some of the outstanding Medical and Surgical men and women of the two countries, as well as representatives of Great Britain, Europe and the East. All left the conference inspired with what they had seen and heard, and with almost a sense of awe as they realised the advance that was being made. There is much to be learned from those who are making great discoveries, and doing intensive research work in Medicine and these Congresses are a great factor in promoting world-wide enthusiasm and co-operation and in passing on to others the many new facts and methods learned.

Here in Madras a great forward step has been taken, and to-day we meet as the first All-India Obstetric and Gynaecology Congress whose influence should be felt not only in India but throughout the world, for in India we find certain operations and diseases peculiar to this land.

For the past three years, a group of members of the medical profession in Madras have been contemplating the possibilities of holding such an All-India Congress. It was felt, however, that it was necessary first to organize provincial associations, and later with their co-operation to arrange for similar Congresses.

A provincial organisation for South India was established in December 1933 and later Bombay arranged for an Obstetrical section in connection with the All-India Medical Association' Annual Conference and the question of organising an Association in Bombay was raised.

Finally in 1935 the Madras Society approached the Bombay Society with a view to call an All-India Obstetrical and Gynaecological Congress and this present Congress was inaugurated under the joint auspices of the Bombay and Madras Obstetrical and Gynaecological Societies.

The two existing Associations of Madras and Bombay since their organisation, have done good work and it is the hope of this Congress that every province will organise its provincial Association and that we may look forward to a great future of usefulness, when an All-India Obstetrical and Gynaecological Congress may be held yearly, or possibly biennially with all provinces represented.

AIMS OF THE CONGRESS.

What should be some of the aims of this Congress?

As an outcome of this Congress, research should be stimulated, and with this end in view, we should encourage the establishment of an Indian Obstetrical and Gynaecological Journal in order that there may be mutual help and inspiration through the interchange of experience and knowledge.

There is a great need of such a journal to reach all practitioners who are keen on watching the progress of Medical Science in these subjects. The young practitioner, especially in a distant village usually finds that he needs help and that his experience is so limited that he is constantly making mistakes and is greatly perplexed as he is confronted with grave medical problems. These village practitioners are eager to do up-to-date work and we should assist them to keep pace with the medical world by starting an Obstetrical and Gynaecological Journal.

Standards in the villages must be raised. Few young doctors leave their schools and colleges without a desire to give good service to their patients.

The older practitioners need to keep apace with modern methods as surely as the young members of the profession. Therefore, as an Obstetrical and Gynaecological Congress, can we not establish a journal worthy of the cause?

With concentrated effort, India should be able to lead in these subjects, for here in India we have unique opportunities and unlimited material for research along Obstetrical and Gynaecological lines, as well as

unequalled opportunities for alleviating suffering among women.

Secondly, our aim should be to attack the obstetrical problem of the villages which we all (and especially those of us who work in the mofussil) realise is wellnigh insurmountable.

WORK IN THE VILLAGES.

The uneducated *dai* steeped in superstition and ignorance, frequently and unwittingly brings untold suffering and even death to her patient. Many efforts have been made in the past to solve this question, but it is so vast that we have often faltered because of its magnitude. We must consider what we can, as a Congress do, in attacking this problem. Our help and stimulation is needed, and our standards should be raised. Could this not be done through a Central Organisation whereby a frequent and careful supervision of all Obstetrical and Gynaecological work could be carried on? If all the ignorant dais could be replaced by well-educated and trained midwives and nurses, the future problem would be simplified.

One of our greatest needs in India to day is co-operation (a) between all medical workers; (b) between District Boards and local bodies and (c) between the medical workers and the villager himself.

All District and local bodies should be encouraged to co-operate with the central hospitals in this vast work and encouraged to supply ambulances to bring patients from the villages to headquarter hospitals where a highly efficient staff of doctors, nurses and midwives should always be found.

We must have the co-operation of the public in replacing ignorance and superstition by well educated medical workers. Baroda has set us an example by having a circulating library in her villages. Could we not follow this excellent example, especially along medical lines? Educate the villager, with moving pictures, lectures, circulating libraries, etc.

The outlook is so vast as to make it intensely inspiring and fascinating. Instead of our young practitioners flocking to and over-crowding our cities, if we could help them to catch a vision of service to our great village population, and be determined to go out and rise the standard of Medicine in the surrounding country, it would be immensely worth while. This leads us to our second phase of the country problem.

The problems that face practitioners and trained midwives in the villages, are great, whether they work privately, or in small outpost dispensaries. They meet more difficult Obstetrical and Gynaecological problems than those met with in large city hospitals. The demand upon their knowledge and skill is great. Trained in large centres where the equipment is adequate and even lavish, the practitioner in a village is often face to face with very limited supplies—a poor assortment of instruments; and inadequate sterilization and hospital equipment and they become discouraged, then lapse into slipshod methods which lead to very faulty technique—with all its disastrous results.

Would it be possible for the Congress to organise in such a way, that through our Central Base these practitioners, nurses and midwives would be carefully supervised and be given an opportunity at stated intervals to study (perhaps for a month each year) in some large central hospital and be expected to undergo post-graduate courses at the expiration of a certain number of years. In this way our standards would be raised. Village practitioners should not confine themselves to the medical problems alone, but to general uplift of the villages.

Let us, as a newly organized Congress, allow no opportunity pass, but let us press forward, so that in the future this Obstetrical and Gynaecological Congress of India may be one of the most outstanding in the world. This can be done if we all work together.

Your Excellency, I trust that in the future you may look back upon this occasion as one of the great advance steps made in India during this decade. May to-day be epoch-making. I desire to exted my congratulations to and appreciation of the splendid work that has been done by Dr. Lakshmanaswami Mudaliar, Dr. Lazarus, Dr. Smith, Dr. Prabhu and others of the Madras Congress, to whom we are especially indebted for this meeting. In looking over our programme, we are delighted to find names of those who have done outstanding work in India and whom we have often longed to meet face to face to-day we have this opportunity and rejoice in it.

May we be inspired to go forward with greater zeal and enthusiasm than ever before, to do outstanding work along these important lines which will be recognised the world over. We have opportunities for service to womanhood that few have and may we be worthy of this great calling to lead in the future in all matters pertaining to Obstetrics and Gynaecology.

THE ALL INDIA MEDICAL CONFERENCE, XII SESSION, NAGPUR, 1935.

Extracts from the Speech of the Chairman, Reception Committee, Col. K. V. Kukday, C. I. E I. M. S. (Retd.)

On behalf of the Reception Committee of the 12th Session of the All India Medical Conference Col. K. V. Kukday cordially welcomed the delegates and the visitors. He wished to be pardoned for any trouble or inconvenience caused to any of the delegates as Nagpur was a small city, not yet equipped with the amenities of life. All the same he said that the medical profession in the Central Provinces were enthusiastic and keen to invite the conference to one of the most ancient cities in India. To make up for the shortcomings of the members of the Reception Committee, he said, that they were fortunate in having in their midst a guide and adviser in the person of Doctor U. Rama Rau, the President-elect. Doctor U. Rama Rau's experience as a renowned medical practitioner and as the founder of well-known medical journals "The Antiseptic" and "The Health", and in the past his capacity as Commissioner of the Madras Corporation, Member, Madras Legislative Council and of the Council of State, would be a most redeeming feature. He said he did not feel called upon to refer in detail to the various questions which would form the subject of discussion by the Conference, but would make only a few remarks about such of them with which he was familiar. He begged to be excused if the views expressed by him were contrary to the expectation of these who assembled, as there are always two sides for a question and he was accustomed to look more at the other side of the shield which those who could not see eye to eye with him had no opportunities to look at.

The Indian Medical Council claimed the attention of Col. Kukday first. He was in favour of a Central Medical Council placed on a perfect equality with those in other parts of the world including the General Medical Council, Great Britain. He was conscious of the fact that as in the case of constitutional reforms the Indian Medical Council Act did not come to the level of national expectations. But he was convinced that those who represent the profession in the Indian Medical Council were anxious to maintain the highest standard of professional efficiency in India.

Regarding the controversial subject of the relationship between the University graduates and the licentiates, he said, nobody could deny the glorious example in professional as well as in administrative capacity of the licentiates of the type of one who would occupy the chair as the President of the Conference and the late Doctor Daji Ramachandra of Nagpur who Col. Kukday said inspired him to take up Medicine as his profession instead of Law. Col. Kukday also mentioned about numerous capable licentiates with whom he came in contact during his official career. All the same, he said that the fact that the licentiates undergo a shorter course by three years and laterly in some cases by two years than that of the graduates could not be denied. He also brought to the notice of the audience the fact that the licentiates enjoyed equal privileges with the graduates in the provincial Medical Councils. Col. Kukday considered it expedient not to include the medical licentiates within the purview of the Indian Medical Council as it would be a handle to decline reciprocity to the Indian Medical Council. He suggested that there was no need of practitioners who underwent a modified medical course and there should be only one uniform University course in the country. Poor deserving students desirous of entering the medical profession might be given free scholarships. He said he was aware that some provinces like Bombay and Madras had devised means to enable the licentiates to obtain higher qualifications, but the route the licentiates had to take was lengthy and circuitous.

The indigenous system of Medicine was the next subject dealt with by Col. Kukday.

He said that there was a great suspicion in the minds of even the members of the Legislative Councils and local bodies that the Allopaths looked at the indigenous systems with a spirit of jealousy and that the Government were apathetic over this question, and such a suspicion often took practical shape, the local bodies withdrawing or reducing their grants to Allopathic Institutions and establishing in their place Ayurvedic and Unani dispensaries often staffed by persons of doubtful qualifications. He gave credit to ancient sages who without the aid of any instruments of precision were able to observe and treat patients quite successfully. "All the same", he said, "so vast has been the progress of the basic sciences of medicine and the conceptions of diseases based on these, that these old theories would either have to be twisted almost out of shape, or completely abandoned, to fit in with modern researches. I have actually read such artful interpretations being given, just to prove that a particular ancient text, exactly meant, what we find today in Halliburton's Physiology. If Anatomy and Histology, if modern Physiology, and Bacteriology are admitted by both sides, it would perhaps be a vain dispute, to keep on saying that the two systems of medicine are different. There is however, a large stock of indigenous drugs, the utility of which has been proved by years of experience. The therapeutics of these, has not been scientifically worked out, and the virtues of many, are hidden in hallowed prescriptions made up of a couple of dozen drugs, mixed together. There is an emergent need of this work being done as early as possible, and as large funds are necessary for this purpose, Government may be legitimately expected, to render very liberal assistance to this work of practically creating Indian Materia Medica on modern lines. I am not unmindful of the most valuable work being done by Col. Chopra in this direction, but I feel, there ought to be several Chopras working at it, if the work is to be completed in a reasonably short time, and public suspicion completely disarmed."

Regarding the Medical Services he said, "It has been repeatedly demanded, that the Civil and Military Medical services should be completely separated. To be as brusque in language, just for the sake of emphasis, without in the slightest degree meaning to be discourteous, one may safely say this is an impossible proposition. Rather may it be said, that the Civil Medical Service should be completely abolished, that there should be only one service in the country, and that it should be considered primarily military. Though we are at present denied our legitimate share of responsibility in the defence of our country, we must always consider the Army as ours, and look to its interests just as much as to those of the civil population. It is essential, that Medical service for the Army, should be a thoroughly efficient one. It is also absolutely necessary that there should be a sufficient Medical reserve, which would be ready at all times for military purposes; and the most economical way of maintaining this reserve, is to keep it employed for civil purposes in peace times. I should rather express our view by saying that we want only one Medical service in the country both for our civil and military requirements. You may call it the Indian Medical Service if you wish to keep up an historical appellation, or a National Medical service, if you are anxious to make the name more attractive, to the hot-blooded nationalist. Such a service should be recruited in India by an open competition and every member of it however employed, should have the fullest military obligation imposed on him. Laterly the members of the Indian Medical Service, have been divided into two classes the Indian and the British; and certain privileges and some reservations have been attached to each of these sections. This has to some extent unquestionably complicated the situation. Personally during my service of thirty years or more, both in the civil and military departments I hardly recollect having had an occasion, to be reminded of my nationality, either in the case of a European brother officer or that of his family. I almost feel certain, this is also the experience of most of my Indian colleagues in the service."

Hospital Administration was another subject dealt with by Col. Kukday. There being present large members of high qualifications, including efficient specialists in different branches of Medicine, willing to offer their services in an honorary capacity, the Government should avail themselves of the services of the honoraries of a large

scale. He desired a system of certification of the poor through reliable authorities should be devised in the mutual interests of public finance and hospital going poor.

The last subject which attracted the attention of Col. Kukday was about the training of nurses. He said that it was admitted by all that the success of treatment depends upon largely on the proper nursing of the patients. It must be the duty of the profession to encourage educated young ladies to take to nursing profession. He was for training the nurses in the vernacular they knew. Before closing he thanked the Government and the University authorities, the Missionary Institutions, who gladly helped the Reception Committee in providing accommodation to the delegates and the visitors. He made special mention of the Postal authorities, who did their best in giving all facilities in postal service to the Conference. The whole medical profession of the Central Provinces including the C. P. and Berar Medical Association were highly commended by Col. Kukday for their valuable services and co-operation to make the Conference a success.

Extract from Doctor U. Rama Rau's Presidential Address.

Doctor U. Rama Rau thanked those who were responsible for his election to the Presidential chair, and said, "when I first read Dr. Ray's telegram congratulating me on my election I was really taken aback and could not believe my own eyes, for this honour was undreamt of unexpected and undeserved. The grandeur of your reception and the warmth of your affection to me indicate the oneness of thought, the sincerity of purpose and the loftiness of aim on your part in abolishing the caste system and attempting at unity and solidarity of the Profession. This is indeed a happy augury, and the year of 1935 will ever be remembered as an eventful year in the history of the medical profession in India, when the foundation for the unification of the profession may be said to have been well and truly laid in this sacred city of Nagpur. I am sure you will not accuse me of immodesty when I say that I was and am always imbued with the idea of service—service to my professional brethren and service to my countrymen in my own humble way, during my career of 35 years both in the practice of the healing art and in public life and was ever a faithful follower of the doctrine inculcated in the Bhagavath Gita, "Do your duty, without looking to the fruits there of". If, today, it has pleased the Almighty, in the fulness of time, to bestow this reward on me—the highest reward in the gift of the Medical Profession in India—then, I think, I have served in the right spirit. In undertaking this onerous task, I am conscious of my limitations. I know my frail frame and advanced age are real impediments. But, still, with the help and guidance of Providence and with your kind co-operation and support, I hope to be able to discharge my duties to the best of my ability and in the best interests of the Profession."

The Indian Medical Council was the first subject discussed by the President in his address. He said that the history of the Indian Medical Council was a struggle between the British Medical Council and the Indian Universities, culminating in the signal success of the former and the abject surrender of the latter. The present Indian Medical Council Bill, said Doctor Rama Rau, "was not what the nation wanted", and added that the Council required radical reform and nothing but the repeal of the act and re enactment of the same on democratic lines would satisfy India. He very much doubted whether the present Legislative Assembly might be able to help the profession in this matter and hoped for better times, and till then he urged on his brethren in the Legislative Assembly to introduce an amending bill early this year providing for (1) the deletion of the word 'higher' appearing in the preamble as 'higher qualifications' (2) the election of one member from each province from among the Licentiates and (3) to include the qualification of those Licentiates who have undergone a course of 5 years training in any recognised institution, as is now being given in the Stanley Medical School in Madras, in the schedule of Registerable qualifications. He opined that the maintenance of the register and disciplinary control may be left to the Provincial Medical Councils as at present. He wondered how the inclusion of the licentiates in the Indian Medical Council could affect the prestige of the British Medical Council, when it was known that the latter council was open to classes of medical men including Apothe-

caries. He said that the qualifications of the licentiates "was not a whit behind those of the Licentiates of the Royal College of Physicians and Surgeons". He concluded this subject by saying that the aim of the profession should be "to establish a uniform standard of qualifications in Medicine for all Provinces such that persons attaining thereto should be acceptable as medical practitioners throughout India."

Regarding medical education he said it was most unsatisfactory and required a thorough overhauling. The state of affairs of the University medical education was in his opinion tolerable, but the plight of the education of the licentiates was beyond description. It was not possible for the Licentiates to obtain higher medical qualifications in this country unless they were prepared to go through University course from the very beginning. The concession allowed to the L. M. Ps. in the Madras Province for appearing for the M.B.B.S. degree was in his opinion a "sop". The obstacles thrown in the way of the Licentiates to enable them to appear for the M B.B S. degree were formidable as they were required to pass the Intermediate examination in Arts of the Madras University or any other recognised University or the Cambridge Senior with credit in three subjects. He suggested that the University syndicate would have acted wisely if they ruled that the Licentiates desirous of studying for the M.B.B.S. degree should sit for the English paper alone in the Intermediate examination exempting them from the rest of the subjects. His view was to start a statutory body like the Royal College of Physicians and Surgeons in the capital of each Province, the course being for five years and the curriculam, standard, instructions, and examinations being the same as for the University medical degrees. He put a scheme for the starting of a College of Physicians and Surgeons before the Madras Government in 1932. But the then Minister was unable to consider the same on financial grounds. He exhorted the audience to take keen interest in the elections for the Legislatures under the new constitution, and canvass votes for such of candidates who promised to remove the existing anomalies in the medical profession.

Medical Research was the next theme discussed by the President. He deplored that research was not encouraged in India to the extent of its impotence, and for the little research that was done the Government associated only the members of the Indian Medical Service "with fat salaries, high altitude, quiet solitude, cool and breezy climate, and very little result." He said that the best place for conducting research was Calcutta, Bombay or Madras, and not Kausali, Dehradun or Coonoor. He regretted that there was no facilities whatsoever for research and post graduate study in any of the University centres, and the Government was entirely responsible for not encouraging research in this country.

The fourth subject discussed by the President was about the Indian Medical Service in India. He said that as early as 1879, the Government of India attempted to separate the Military services from the Civil, but till 1907 nothing tanjible was done and the Military always had the upper hand. From 1911 the number of the Indians entering the Indian Medical Service was materially increasing. The army department then proposed to have the Royal Army Corps for purely military purposes making the Indian Medical Service purely a Civil service. This attempt on their part proved futile, and the Public Service Commission which was appointed shortly after, recommended the absorbtion of I. M. S. into the R.A.M.C. and the formation of a separate Civil Medical cadre for each province with special provision for the treatment of Europeans by doctors of their own nationality. This recommendation of the Royal Commission was brushed aside by the Government of India and the Secretary of State. In the meanwhile vested interests in England were busy agitating over the question of recruitment to the Indian Medical Service so as to prevent the rapid Indianization of the medical services aimed at by the ministers in the provinces. Concessions after concessions were offered to the Indian Medical Service, two most important among them being (1) abolition of the system of recruitment on the basis of a competitive examination (2) the fixation of a definite ratio of two Europeans to one Indian, recruited for the Indian Medical Service. Doctor Rama Rau said that in 1930 Mr. Jayakar moved a resolution in the Legislative Assembly which as amended by Sir D'Arcy Lindsay urged the Government to revive the competitive examination for the Indian Medical Service holding it annually and simultaneously in India and in England making it obligatory for the entrants to the examination in India to hold a medical qualification registerable in India. Though this amended resolution was unanimously accepted, the Government, said Doctor Rama Rau, did not so far care to give effect to the same. He was of opinion that even the new constitution was helpless to remove the domination of the Indian Medical Service.

Regarding the All-India Women Medical Service Doctor Rama Rau opposed the present policy of the Government of having only 50% of Indian women in the service. He was of opinion that so long as the Government contributed nearly four lakhs of rupees for this service from public revenues the recruitment for this service should be made by the Public Service Commission. Doctor Rama Rau did not relish the idea of a condition forced on this Service that such of them who were given study leave for proceeding to England should resign the service and pay back Rs. 10,000 if they married within four years after returning from England.

Regarding Provincial Medical Services Doctor Rama Rau was of opinion that there should not be water-tight compartments and that the medical officer in the lowest rung of the ladder should have opportunities to reach the topmost. He was for competitive examinations for recruitment to service, the licentiates being permitted to compete with the graduates, a few posts of Assistant-Surgeons being reserved for direct recruitment and a few for the promotion of Sub-assistant-surgeons to the Assistant-Surgeon grade.

The Independent Medical Profession was the next subject dealt with by the President. He said that the profession was overcrowded and unemployment was staring them in their faces and the qualified practitioner had to struggle against the unfair and unwholesome competition with their brethren in service in addition to that of Hakim and the Vaidyan. He gave wholesome advice to junior practitioners and impressed them that hard work and integrity should be their watch-words. He wound up his advice by saying that putting up with the whims, fancies, and idiosyncrasies of the patients would pay them in the long run.

The President had his say regarding Honorary Medical Service and confined his remarks to the existing conditions in the province of Madras. He criticised the G. O. recently passed by the Madras Government on this subject and said that it was unfair to compel the Honoraries to work in hospitals between 7 to 10 A.M., when they had to attend to their private patients. The compulsory attendance, he opined, was likely to make the scheme unpopular. He deplored the existing mentality of those in service and also in power in not placing the Government hospitals and dispensaries under the direct charge of the honoraries.

Rural Medical Practitioners of Madras did not escape the notice of Doctor Rama Rau. He said they were "quasi independent medical men who now flourished in the Madras Presidency." He claimed authorship of the Rural Medical Relief Scheme and said that he advocated for it in the columns of his journal The Antiseptic in 1925 and later discussed the scheme with the then Minister the late Raja of Panagal whom Doctor Rama Rau considered as an "out and out Nationalist so far as the medical department was concerned', and that the Raja of Panagal took the clue and launched the scheme soon after. Under the scheme the Rural Medical Practitioner was given an annual subsidy of Rs. 600 and Rs. 400 for medicines, and the practitioner in return had to treat the necessitous poor free and receive money from the rich. Unfortunately, said Doctor Rama Rau, the Rural Medical Practitioners were placed under the control of Local Boards and in course of time they got themselves mixed up with local politics and were obliged to take sides in the Local Board elections with the result that they had to become victims of persecution by one party or the other. Yet, said Doctor Rama Rau, the practitioners "are made of sterner stuff. They formed themselves into an Association, held annual conferences, waited on deputations to the Minister and the Surgeon-General, got their grievances redressed and thus firmly secured their positions. They are better off now". He then quoted the Rural Medical Scheme introduced in Canada in 1930, where the practitioner got an annual subsidy to the value of Rs. 4,500. Doctor Rama Rau wished

that a scheme similar to that of Canada be extended to other parts of India modified if necessary according to the provincial needs.

The subject matter of Medical Service was concluded by the President with a reference to the scheme of Medical Inspection of schools. As with other schemes he concentrated his remarks on this scheme only concerning the Madras Province, and said that Madras Government tried the scheme haphazardly for a few years and gave up the same as a measure of retrenchment. He advocated the necessity of reviving this scheme not only in urban but also in rural areas. This scheme would provide employment for the members of the independent medical profession. He said that money could be saved for this scheme if the Government extended the Honorary Medical Relief Scheme, and expanded the Rural Medical Relief Scheme, both of which would bring a large saving to the Government. In his opinion the I. M. S. and other medical officers and subordinates in Government employ should be prohibited from private practice except as consultants in the case of specialists and then only he opined the acute unemployment problem among medical men could be satisfactorily solved.

Doctor Rama Rau then dealt in his address about the Indigenous Systems of Medicine, and said that the Aryans of Ancient India exhibited their skill and genius in all the departments of medicine and in spite of the vissicitudes of foreign conquest, records still existed in plenty to demonstrate that the Hindus of old possessed a good knowledge of human frame, and also the diseases. He desired that the Ayurvedic system, the Unani system, and also the Siddha system, largely in vogue in Southern India, should be placed on scientific basis. He then traced the history of the Government Indian Medical School at Madras and said that instructions were imparted in this institution in all the three systems of medicine, Ayurvedic, Unani and Siddha. He concluded this subject by saying that the blending of the Allopathic and Indigenous system of medicine would be most suitable for the conditions prevailing in India.

The next subject dealt with by the President was about Drugs and Medicines. He quoted statistics to prove that the value of drugs and medicines imported in India excluding chemicals and narcotics, increased from 73 lakhs in 1909 to 202.12 lakhs in 1929, while the value of raw drugs exported from India increased from 15.5 lakhs to 41.6 lakhs during the same period. On the basis of average struck out from the above figures the trade balance at the end of 1934 was put down by him at 200 lakhs. Thus India was the looser by Rupees two crores annually. He suggested the necessity of the Government of India establishing chemical Laboratories herbariums in important centres in this country, and making India independent of Europe and America in drugs to save her millions. Doctor Rama Rau said that patriotic spirit was not wanting in this country and men of means and scientific aptitude had established chemical laboratories and it was possible now to get tinctures, sera, vaccines etc., at a comparatively less cost. He put a strong plea to establish bio-chemical laboratories as suggested in the Chopra Committee report, to test the purity of drugs now dumped in this country by foreign firms. He pressed for the need of special taxes on secret remedies and pointed out that the Government of India on account of vested interests did not carry out the suggestions of the Taxation Enquiry Committee, who suggested a tax of 4 annas in the rupee in the case of indigenous secret remedies whose formula were not known, and an increase to 50% in the tariff rate of imported patent medicines. He exhorted the medical men to refuse prescribing secret patent medicines, and dissuade people from using patent medicines imported from foreign countries. He concluded his remarks on this subject by referring to the Government medical stores in all the provinces in charge of the military department which were charging local bodies 20% more than they charged the Government and pressed the profession to agitate so that the civil Government got their supplies at the cheapest rates from the open markets. He also mentioned about the necessity of compiling an Indian pharmacopoeia to suit Indian conditions.

The need for introduction of a course in Dentistry in medical schools and colleges and social service for imparting knowledge on public health to the masses and the necessity of the co-operation of the members of the profession with the Government, in the matter of Preventive Medicine, were other subjects briefly dealt with by the President in his address. He also made special mention of the need of starting National Health Insurance scheme on the model obtaining in England.

Before closing his address Doctor Rama Rau advised the members of the independent medical profession to take keen interest in politics so as to make it possible for a medical man becoming a Minister of Medicine and Public Health, which he said would be the greatest blessing to the people. In the opinion of Doctor Rama Rau there was no dearth of able and eloquent politicians among the members of the Medical Profession and he vehemently pleaded that medical men with a long purse should successfully fight out elections not only in the provincial and all-India Councils, but also in local bodies. Doctor Rama Rau finished his address by making a special reference to the Indian Medical Association. He made a strong appeal to the Conference that every member of the medical profession in India should be a member of the Indian Medical Association, and suggested the desirability of incorporating the All Medical Licentiates Association to the Indian Medical Association. He pointed out the example of the British Medical Association and said that the whole profession high or low, official or non-official, should come under a single banner.

THE FIRST ALL-INDIA OBSTETRIC AND GYNAECOLOGICAL CONGRESS, MADRAS, 1936.

Reading of Papers and Discussions.

Reading of papers on impartant subjects in Obstetrics and Gynaecologly, followed by discussions, was the main feature of the Congress, as it ought to be. The papers were read at such a speed that it was not possible to follow the readers. The discussions were very interesting, in which prominent obstetricians and Gynaecologists took part. We have jotted below the main points of the discussions for the benefit of our readers and are obliged to Doctor A. L. Mudaliar, Chairman Reception Committee for having permitted us to go through the notes on discussions taken down by the Rapporteur concerned for the subjects. We could not get at the papers as we were told that majority of them were returned to the authors for necessary correction. The papers as well as the discussions will be published by the Obstetric and Gynaecological Society of South India and will be made available to the members of the profession at a nominal cost.—Ed.

2-1-'36, after-noon session.

(1) Atonic Port-partum Haemorrhage.—Dr. S. M. Trasi.

(2) Manual removal of placenta: A study of cases from Wadia Hospital, Bombay.—Dr. B. N. Purandare.

(3) Placental infarcts.—Dr. T. Bhaskara Menon.

(4) Retained and adherent placenta with an analysis of five years statistics of the Women and Children's Hospital, Madras.—Dr. M. B. Prabhu.

(5) Causes and treatment of retained placenta.—Dr. (Miss.) D. M. Satur.

Rapporteur.—Dr. R. K. Tampan.

Doctor Venkatagiri (Madras) led the discussion. He agreed with Doctor Trasi in the existence of a condition of the uterus which he called flabby uterus which never contracted in spite of massaging, injections, hot saline irrigations, pituitrin injections, and all other measures which usually brought back to the uterus its tone. He said that it was his experience that injection of pituitrin never caused hour-glass contraction and he usually gave it at the 2nd stage of labour. He had no belief in hot irrigations of the uterus, and said that it was sometimes dangerous. He relied on manual removal of the placenta and said that working through the membranes, saline infusions, hydraulic pressure and things of that sort were not of practical importance. Transfusion of blood was scientifically good but it was not used in Madras for various reasons, especially for want of donors. In case of retained and adherent placenta he was not quite sure whether it was the bleeding or the retention that was the cause of shock in patients. He knew of cases where the placenta remained in the uterus till the sixth day of puerperium, with little or no bad effects. He would say that the distanded bladder had little to do as a cause in retained placenta as the distanded bladder must have emptied itself when the child was expelled. In 50% of cases retained placenta could be expressed successfully by Cred's method. It was the height of folly to remove placenta when the woman was bleeding.

Doctor Subodh Mitra (Calcutta): He said that in the hospital where he worked there were 83 cases of placenta-praevia from 1929 to 1933 with 8% mortality. Though it was said that it was criminal to let a patient die of bleeding it was his experience that in a few cases nothing could be done to save the life. Blood transfusion could not be practised in Calcutta due to the difficulty of obtaining donors and also due to the serious condition of the patient where time was every consideration. In retained placenta there were some cases where nothing could be done to save the life of the patient. He did not agree with the lecturer Dr. Prabhu that retention of the retained products produced shock more than the removal of the placenta, but he endorsed the opinion of Dr. Venkatagiri in this respect. He supported his statement by coating a few cases he had to treat. In case of placenta accreta though the modern tendency was to do Hysteractomy he advocated piecemeal removal.

Doctor A. L. Mudaliar (Madras): As a practical obstetrician, he strongly discounted any suggestion of operative interference in cases of retention of placenta, either Hysteractomy or an attempt for putting on forceps for the clamping of the uterus. So he advocated strongly Crede's method and disagreed with Dr. Venkatagiri and said that distanded bladder was undoubtedly an impediment. He described his method of expression of the placenta and of preventing haemorrhage. For checking haemorrhage he suggested the method that was followed by him,— with two fingers on either side just above the symphysis pubis he pulled up the fundus; the uterine arteries could be felt pulsating, and they could be compressed efficiently in all cases of moderate bleading. He advised non-interference when a patient was colapsed and said that in such a case the risk was grave in trying to express the placenta. In cases of abortion where the placenta was retained attended with temperature suggestive of sepsis he would not remove the placenta, but would wait for days together by which time the placenta came off on its own accord.

Doctor (Miss.) **Lazarus** (Madras): At the outset she said that the condition of the patient resembling shock after manual removal, might also be due to air embolism. She therefore suggested that after separating the placenta from the uterine wall, the placenta should not be expelled immediately. It was wiser to draw the hand slightly and after some time massage the uterus for expressing the placenta. She would never interfere with the patient during shock and in many cases there was a chance of the placenta coming out after the patient bore down. She was strongly of opinion that distanded bladder was an impediment for the placenta to get out and at times it brought about hour-glass contraction of the uterus. The best way of controlling uterine haemorrhage was to bring up the uterus and kink it against the symphysis.

Doctor N. A. Purandare (Bombay): He said that pressure on abdominal aorta resulted in pressure on the symphethetic plexus and led to loss of tone in the uterus. Regarding adherent placenta if there were firm adhesions interference was not necessary. Usually slight separation of the placenta caused haemorrhage and then there was no other alternative than to remove the placenta which was to be done by the hand. He advocated saline irrigations in cases of adherent placenta and said that the irrigations separated the villi and helped afterwards the expression of the placenta manually. Hour-glass contraction was in his opinion, due more to faulty manupalation than due to pituitrin injections. He was surprised why there was great objection by the the previous speakers for hot irrigation in checking haemorrhage. He did find it very useful if properly done. He did not agree with Dr. A. L. Mudaliar that haemorrhage could be checked by pressure on uterus at the lower segment as the upper section of the uterus was supplied by ovarian vessels. He said that it was absolutely necessary to remove the placenta manually when there was bleeding. He was for Crede's method for the expression of placenta.

Doctor (Mrs.) **Dadhaboy** (Bombay): She did not venture to remove the retained placenta with the hand when there was no bleeding. She depended upon glycerine injections into the uterus and said that there were cases when placenta came off by itself even after 20 days without any untoward effect. At the same time she said she would remove the placenta taking all precautions when there was hæmorrhage. Shock was not always due to hæmorrhage, but it might

be also due to nervous exhaustion after the patient bore down. Pituitrin was misused and she said that from the first to the third stage of labour it might be safely given in measured doses. In no case could she observe a hour-glass contraction of the uterus on account of pituitrin injection. She was against hysterectomy in cases of placenta praevia. Saline irrigations was in her opinion had disappointing results.

Doctor Gopalachari (Madras): He said that in an analysis of 165 cases of labour treated by him he found anaemia present in every one of them. He mentioned about a case where a woman having retained placenta would not submit herself to any drastic treatment and he gave her an injection of a liver extract and found to his surprise that the placenta came of the next day.

Doctor Chamanlal Mehta (Bombay): He was of opinion that almost all cases of retained placenta and post-partum hæmorrhage were due to anæmia or albuminuria of pregnancy and efficient ante-natal treatment of such cases would lower the death rate.

Doctor James (Madras)—In post-partum haemorrhage he had tried the treatment recommended by the previous speakers, but without avail. He thought the best thing to do was to shapen the fist of the obstetrician in charge of P. P. H. case into the shortest compression possible, push it into the vaginal voult as high as possible, bend the uterus as forward as possible pressing the fist upwards and the uterus downwards when the bleeding would stop marvellously. Regarding retained placenta he was not in favour of expectant treatment especially when the patient was septic. He would treat the retained placenta undergoing putrefactive changes as a foreign product and would remove it without delay.

3-1-'36 Fore-noon Session.

Subject for Debate:—Pelvic Disproportions Doctor N. A. Purandare to lead the discussion.

Pubiotomy in the treatment of pelvic disproportion.—Dr. (Miss.) A. B. Smith.

Review of cases of pelvic disproportion at Cama Hospital, Bombay.—Dr.(Miss) Telang.

Management of labour in contracted pelvis—Dr. E. A. Menon.

Pelvic disproportions—Dr. P. Venkatagiri.

Infected Ceasarian section.—Dr. Ida Scudder.

Lower segment Ceasarean section.—Dr. P. Venkataswami.

RAPPORTEUR.—Dr. R. K. Tampan.

Doctor (Mrs.) **Dadhaboy** (Bombay)—She said that pelvic disproportion was one of the few subjects in operative obstetrics that called for definiteness in diagnosis and treatment. All cases of primiparae with the head high up or just engaging, were delivered in a few hours if there be good contraction of the uterus. In fact these cases took much shorter time than those where the head was engaged four weeks before the expected time of delivery. So the usual teaching that if the head did not engage during the last 3 weeks before confinement such cases should be classified as those of disproportions, had to be discounted. The treatment of cases of suspected pelvic disproportions was beset with uncertainties. Ante-natal diagnosis was of no avail in these cases. Personal factor played a great part. Trial labour was the only efficient method of treating these cases and untoward results in trial labour were not due to the principle of trial labour, but due to the faulty manupulation. Recourse to forceps and induction of prematured labour were considered by her next in importance and usefulness to the trial labour.

Regarding lower segment Caesarean section she said it was tried extensively with good results at the Cama Hospital, Bombay in cases where patients were not septic. She was not for spinal anaesthesia in cases of Caesarean section as there were usually many deaths due to such anaesthesia

Doctor A. L. Mudaliar (Madras)—He said that there were no such thing as contracted pelvis as the pelvis varied from country to country, and from race to race. So pelvic measurements in a case of contracted pelvis, as an antenatal measure was of little or no avail to put the obstetrician on guard to give a final judgment if a particular case required Caesarean section or Pubiotomy or Symphysiotomy till the women was actually in labour. In his opinion in all cases of pelvic disproportion, the ideal to follow was trial labour as it had been his experience that trial labour usually in a large number of cases ended in natural delivery

and there were comparatively a few Caesarean sections. He had given up induction of premature labour altogether and he entirely agreed to the view put forward by Doctor E. A. Menon that premature induction of labour often resulted in the death of the child at a later stage, in spite of all the care.

With regard to lower segment Caesarean section he said that it had very definite, but at the same time a limited place in obstetrics. He would not advocate this method in septic cases nor would he try in cases which were in labour for many hours. The proper indication for this operation was in border line or a measured degree of contracted pelvis, where trial labour had just failed and the judgement and conclusion should be arrived at only after the membranes had ruptured. As regards induction he said that it was limited in the Government Hospital for women and children, Madras, to induction at term. In cases of contracted pelvis it was not desirable that the child should grow, for, ossification increased everyday and the head became harder to mould easily. He had given up the use of quinine for inducing labour. He relied on purgatives and later small doses of pituitrin $\frac{1}{6}$th or $\frac{1}{4}$th c.c. in the first and second stages or $\frac{1}{2}$ c.c. or larger doses in the 3rd stage. Intranasal medication of pituitrin acted as well. Though the lower segment Cesarean section was intensively practised in hospitals especially after the great encouragement given by Delle, he felt that the classical Caesarean section had a very good place. He did not come across terrible disasters that were ascribed to Caesarean section. He had never come across any case where the uterus had ruptured when the woman got into labour, subsequent to a previous Caesarean section. He said that he had in the hospital a case of fourth Caesarean section. He was of opinion that encroachment of general surgeons into the field of obstetrics, was largely responsible for the increase of Caesarean section. Cases were sometimes reported where a busy surgeon forgot to suture the uterus before closing the abdomen.

3-1-'36 After-noon session.

Clinical aspects of Placenta Previa and its management—Dr. Chakravarthi.

Some aspects of accidental haemorrhage with a review of 212 cases from the Government Hospital for Women and Children—Dr. R. K. Tampan.

Functional uterine haemorrhages—A study of five hundred cases—Dr. Dadhaboy.

Positive five year cure cases cancer cervix uteri—Dr. Subodh Mitra.

Implantation of tubes in the uterus for sterility—Col. V. B Green Armytage.

The place of Radium in Gynaecological practice—Dr. A. L. Mudaliar.

RAPPORTEUR—Dr. D. M. Satur.

Lt Col. Sastry (Tinnevelly, Madras):- He led the discussion. He favoured Caesarean section in all cases of central placenta previa. In Cancer cervix he was for vaginal hysterectomy, and not abdominal, after having seen good results of the former at Vienna. In functional uterine haemorrhage he advocated the injection of the patient's own blood intramuscularly.

Doctor N A. Purandare (Bombay):- In placenta previa he advocated external version on the ground that in all such cases the head was high up and was floating, and it was easy to perform external version. He thought that there was no need of doing bypolar version.

Lt. Col. Hingston (Madras):—He said that he learnt from his professer while he was a medical student that the women should be delivered as soon as possible when a diagnosis was made of placenta-previa. But he differed from that view now. From his experience in the Government Maternity Hospital he found that it was always safe to prolong the pregnancy as long as possible. He taught his students that soon after they saw a case of placenta-previa they should put her to bed and give morphia and keep her quiet. It might appear again. The same treatment should be followed. He had no failures by this treatment. His advice was to prolong the inter-uterine life of the child as much as possible. It was only in cases of profuse haemorrhage that one had to deliver the women, in which case if the head presented he used Willet's forseps or injection of pituitrin. If breach presented he brought down the leg.

Functional uterine haemorrhage was due to firbrosis of the uterus and found a large number of these cases doing well after X-ray treatment. Perathyroid and Calcium were worth trial. In severe cases the only treatment to be decided upon was hysterectomy.

Doctor K. S. Sivaramakrishna Iyer (Madras): He referred to the cases or Placenta previa in the Lady Sir Ramaswamy Mudaliar Lying in Hospital, Madras for a period of ten years from 1921 to 1930, during which period 122 cases of Accidental Hæmorrhage and 135 cases of Placenta-previa were treated. In Accidental Hæmorrhage the mortality was 7% and in Placenta-previa 11.87%. 40 children left the Hospital alive in Accidenral Hæmorrhage, and 34 in Placenta previa. He was of opinion that Accidental Hæmorrhage was mainly due to other so-existing complications such as anæmia, malaria, hook-warm, conditions which have to detected and removed during ante-natal period. He suggested that a large number of deaths may also be prevented by spacing pregnancy. What he said about Accidental Hæmorrhage regarding the line of treatment held good in cases of Placenta previa. Though text-books divided cases of Placenta previa into marginal, central, and lateral varities from a clinical point of view, it was a matter of indifference what the variety was as all of them sometimes bled profusely. In adopting a plan of treatment he would suggest one which cost minimum loss of blood and minimum amount of injury to the patient. The general condition of patients should be a guide to decide whether a case was mild, moderate, or severe, and cases had to be decided on individual merits.

Doctor Allen. She said Placenta previa was one of the horrors of her life in India. She narrated a case of central Placenta-previa with a tremendous hydramnios and the vagina was pulled so high up that she could not reach the cervix at all. The patient under reference first passed large amount of liquor amnii and then terrible hæmorrhage followed resulting in death.

Doctor P. Rama Rao (Madras): He gave out his experience as a radiologist. For hæmorrhages, at puberty or at the climacteric, irradiation of the spleen increased the coagulability. There was always endocrine disturbances associated with hæmorrhages of puberty and climacteric so that the course of treatment adopted radiologically was to give exposure to thyroid and pituitrin. He advocated great care for giving deep X-rays to the ovary. In hæmorrhages due to climactric deep X-rays had very good effect on the fibrosed condition of the uterus and over the ovarian secretion. It was his experience that fibrosed uterus and small fibroids had very good results with X-rays and radium. In cancer, the present tendency in the first stage was to have recourse to radium and deep X-ray thearapy and not straight away remove the uterus. He believed that operative procedures resulted in larger number of deaths than by radio-thearapy.

Doctor Subodh Mitra (Calcutta): In functional hæmorrhage he tried in his practice blood injections with good results. Curetting had little or no effect. He had been trying small doses of radium even on young patients and stated that a patient under his care aged 19 who had radium treatment got pregnant after one and half years.

Regarding Cancercervix, when he started the work with radium in 1926 everybody in the continent used radium. But he saw eminent gynaecologists advocating operation in England when he went there in 1931. He was himself doing operation by the vaginal route. He did not prefer the abdominal route in these cases and he said he would be able to give the results of the treatment he had been advocating at the next Congress.

Doctor Chamanlal Mehta (Bombay): He agreed with Col. Hingston that when the cases of Placenta previa were marginal or lateral and head presenting, it was not at all necessary to do a version. The simple method of treating these cases should be to rapture the membranes and stimulate the uterus either with pituitrin or thymophycin and the results were very encouraging. The treatment was also simple that even the general practitioner could adopt it. The membrane could be ruptured with a long probe which could be simplified with a small handle at the end. The indication for Cesarean section was in cases of central Placenta previa in a primipara with a rigid cervix, otherwise he did external aversion and pulled the leg out. But the danger of a version was a high mortality among the infants, which were certainly higher than in cases of those born by the vertex.

Regarding functional hæmorrhages those which came in the later life were in his

opinion certainly due to fibrosis of the uterus, for which radium or X-ray treatment was the best. Preliminary curretting was advisable before the application of radium.

Dr. Hart (Hyderabad): He did not agree with Col Hingston's that expectant method of treatment for Placentia-previa and allowing a case to go to full term. He thought it was desirable in the interest of the patient who was previously bleeding to empty the uterus as early as possible. He was opinion that functional uterine hæmorrhages were due to endocrine causes. X ray treatment was given for women reaching climactric. In younger women small doses of radium was worth trying.

4-1-'36 Fore-noon Session.

Subject for debate ; Displacements of the Uterus.

Treatment of displacements of the uterus Dr. H. M. Lasarus.

Treatment of retro displacements—Dr. Ida Scudder.

Rapporteur: Dr. P. V. Venkataswami.

Discussion on Dr. A. L. Mudaliar's paper on "Radium in Gynæcology" was taken up this day;

Mrs. Dadhaboy (Bombay): She was of opinion that Radium was misused in India. The complications were chiefly fistulae and infection. In the early part of her practice she used to treat functional uterine hæmorrhages with small doses of Radium. In climacteric hæmorrhages she gave 50 mgm for 24 hours intra-uterine. In fibroid cases it was used for such cases which were either surgically unfit for operation or refused operative treatment. In Carcinoma of cervix in young women she always used it.

Dr. Subodh Mitra (Calcutta): Failure and bad results in Radiotherapy was due to ignorance of proper doses on the part of those who used Radium. Radium treatment should be supplemented by intensive course of deep X-ray therapy. He said that it took him lot of time to standardise the skin erythema doses upon Bengalee women and he found that the dose for Bengalee women was a bit more than the average dose in Europe. He now adopted the Germany and Vienna method of treatment for Cancer cervix radiation plus operation. In fibrosis the results of Radium therapy were very satisfactory. In some cases there was recurrence of hæmorrhage and fibroids were found degenerating. In functional hæmorrhages cent per cent results could be attained.

Col. Hingston: He did not agree with Dr. Mudaliar in the use of Radium in cancer uterus during early pregnancy. The proper thing to do was hysterectomy without hesitation. His experience of the use of Radium on a pregnant uterus was that there were untoward effects on the foetus and he knew cases where the wives of Radium workers produced macerated foetuses. Radium said Col. Hingston should be used by experienced Radiologists who need not necessarily be medical men. He demanded if Dr. Mudaliar could assure them that rectum, bladder or other organs would be free from any damage.

Doctor A. L. Mudaliar's Reply: He said he preferred Radium in Chorion Epithelioma considering the social conditions and the psychic effect in a young girl. He advocated curetting as a preliminary measure for diagnastic purpose. Regards Col. Hingston's criticisms he said that a person became an expert after practice. He did fumble in his earlier days but he could say with some authority for the last four years of his practice he had no untoward happenings by the use of Radium if the Radium was properly applied taking all precautions to keep away bladder, rectum and vagina. He would not permit the use of Radium in the hands of non-medical Radiologist, but in deep X-ray therapy he had no objection for a non-medical man. Regarding pregnancy complicating cancer he said that such a condition was rather rare. Within last 15 years he saw only 4 cases. In two of which he did total hysterectomy. In the other two one refused operation and the other went home. Yet, he mentioned that even in advanced cases it was advisable to use Radium. It had a definite place in cases complicating pregnancy. If Radium was used after the 6th month it was advisable to turn the foetus into one of breach, thereby the effects of radiation were transferred on the foetal breech.

DISCUSSION ON DISPLACEMENTS OF UTERUS.

Dr. Purandare:—He agreed with Dr. Lazarus that many a time abdomen was opened for retroposed uterus unjustifiably

He endorsed the view of the President that pessary was really useful. It was desirable that the patient was made to cough soon after the insertion so that the intestines might go behind the retrouterine pouch. The patient with the pessary on, should be frequently seen and the pessary should not be kept too long.

Ventro-suspension operation was often performed by him with success. He was not satisfied with Baldy-Webster method. With regard to Leforte's operation he had it very often, one of his patients was 75 years old. He combined this operation with perineorrhaphy.

Mrs. Dadhaboy: In her opinion only such cases of retro displacement should have treatment who had definite complications What she did in cases of prolapse with a cystocele, was to incise the vaginal wall, separate the vagina and elevate the bladder under the symphasis. Two structures were involved in the prolapse, the pubocervical fascia and transverse cervical fuscia. After elevating the bladder attention should be paid to those two structures. For inversion of uterus the acute cases might be treated with postural method, and the chronic by Spinelli's operation. She gave her experience of two successful cases of the former and a two latter where she said that there was stormy convalescence.

Col. Hingston: He said that though Fixation was considered to be a back number he considered that it was one thing he would always choose. He tried Fixation in all cases of displacements attendent with sterilisation and almost all his patients got pregnant. He said his experience was based on hundreds of cases. He was of opinion that uterus fixation was better then suspension. He gave up the latter method after trial. It was his firm opinion that in case of prolapse with incontinence of urine, fixation was an ideal operation. He concluded by saying that he had done fixation in Madras on thousands of patients and he had no trouble even when such patients came on for labour.

Dr. Ajenkya: She spoke in defence of pessary for diagnostic purpose before an operation for displacement was decided upon. She also advocated its use immediately after puerperium in cases of displacements.

Dr. A. L. Mudaliar: He endorsed what Col. Hingston said about Fixation and exhorted his audience to have an open mind and promised that he would keep before the next Congress his statistics and experience. Till then he requested the Congress to suspend judgment.

Dr. Lazarus' reply: She did not agree with massaging of rectum advocated by the President as the mucous membrance was likely to be damaged and there was fear of coli infection. To those who advocated the use of pessary she said that the splint action of pessary would not develop the muscular tone of the uterus and that the muscular fibres should be allowed to develop. She advocated more exercise of abdominal muscles during the puerperium. Even after she heard Col. Hingston and Dr. Mudaliar she would condemn the fixation operation.

The President brought the discussion to a close by reiterating her advocacy for massaging the rectum. She said that she treated a large number of patients by this method with very good results. Regarding pessary she said she gave up its use sometime ago, but now found it very useful in some cases and combined with exercise it would be very helpful.

4-1-'36 After-noon Session.

Ante-natal care—Dr. Rosenthal.

Organisation and conduct of child welfare scheme—Dr. Veerasinghe Chinnappa.

Infant mortality; its causes and prevention—Mr. M. B. Prabhu.

The value of post-natal care—A plea for post-natal clinics—Dr. A. L Mudaliar.

RAPPORTEUR.—Dr. R. G. Krishnan.

Dr. (Mrs.) E. D. Rosenthal: She said that there could be no doubt that women during pregnancy needed special attention and care. The statistics showed that maternal and infant mortality in India was many times greater than in European countries. This showed the urgent need for ante-natal care. Even in Western countries where the mortality rate was lower then in India, great attention was devoted to ante-natal care. The objects of ante-natal care as formulated by Ruth Young were (1) to make the period of pregnancy natural and healthy for the mother, (2) to keep the pregnant woman under observation, so that abnormal conditions might be detected before they became dangerous, and removed if possible or ap-

propriate precautions taken, (3) to surround the unborn child with the best conditions and so help in the arrival of a strong and healthy baby, and (4) to secure that the time of delivery should be free from danger and as painless and natural as possible.

Proceeding, the speaker said that in Germany and other Western countries ante-natal care was based primarily on education of the public and on providing a really first-class type of midwife. In India ante-natal care was still to be properly developed. Ante-natal clinics should be run by experienced doctors who had the confidence of the public. The doctor must have the help of a health visitor or well-trained midwife. The value of such institutions had been shown in some places in the Mysore State.

Dr. Veerasinghe Chinnappa: After indicating briefly the principles underlying the organisation and conduct of maternity and child welfare work under the direction and supervision of the Department of Public Health in England and Wales and in other countries, the speaker said that following a careful investigation and Inquiry, the Maternity and Child Welfare Act of 1918 was passed in England. The Local Government Act of 1929 strengthened maternity and child welfare services run by the local authorities. The next step taken in England was the emphasis laid by the Government on the need for expansion of such works and the continuation of care after the first year of life.

Proceeding, the speaker said that maternity and child welfare schemes in the Madras Presidency had been from their very inception placed under the administrative control of local bodies, with women medical officers in direct charge. After describing the nature of the duties and the scope of the work undertaken by the staff of the maternity and child welfare organisations in the Presidency, the lecturer said that a beginning had been made as regards a maternal mortality and morbidity survey. Health visitors trained under the auspices of the Madras Red Cross Society were now being increasingly employed by local bodies and voluntary agencies. Allotments made by local bodies for this work had increased year by year since Government created a separate section for maternity and child welfare work in the Public Health Department, and Government grants for furtherance of this work would before long be available for needy local bodies. Twenty one new schemes had been approved by the Director of Public Health during the last two years. A post-graduate course in maternity and child welfare for women medical officers engaged in maternity and child welfare work had been approved by the Government. The course would be opened early next year. A great deal of ignorance as to the value of this ameliorative and educative work yet existed in the minds of the public and she appealed for support of the workers in the field of obstetrics and gynaecology to remove this ignorance.

Dr. M. B. Prabhu: In his paper on "Infantile Mortality" first referred to the causes of mortality found in Madras and elsewhere. The causes were, he said, mainly ante-natal, natal and post-natal and could also be traced to malnutrition. After quoting statistics, the lecturer dwelt at length on the measures to be taken for the prevention of infantile mortality. He said that mere general education would not solve the problem, unless a knowledge of up-to-date maternity and child welfare methods was imparted to the people. Public health measures to put down the incidence of infective diseases must to taken. Breast-feeding should be encouraged. Proper housing schemes should be started and a good water-supply provided. In fact, this problem could not be solved unless the Government, the legislatures, public bodies, welfare organisations, all played their part. A central organisation was necessary to correlate the activities of the various agencies. The specialist and the general practitioner, the State and the public, should all work hand in hand to save child life in their country.

Dr. A. Lakshmanaswami Mudaliar: Dr. Mudaliar spoke on the value of post-natal care and put in a strong plea for the opening of post-natal clinics. He said that in a tropical country, more than anywhere else, women were likely to develop complications or become victims of diseases which cropped up insidiously, during the post-natal period. Often it had been noticed that diseases like anæmia, diarrhœa, and nephritis, developed at this stage. In many cases, manifestations of deficiency disease had been noticed. He wanted therefore that the period of post-natal care should be extended to one year after child birth. Post-natal care implied a periodic examination and following up of maternity cases for at least one year after child birth. Much had been done and was being done to put the expectant mother in the best possible condition, but were they devoting, he asked, proper attention to post natal conditions? He believed that a post-natal clinic should be attached to every infant welfare centre. The case of the infant would be infinitely more easy if the care of the mother also received attention at the hands of the child welfare worker. He believed that one of the important factors in the health of the mother was the spacing of children. It should be the duty of obstetricians to give proper advice to women.

DISCUSSION.

Dr. Chellapathi Rao: He said that to tackle the problem of infantile mortality, they must conduct much propaganda work in the villages. It would not be possible to provide each village with a trained mid-wife but the village mid-wives could be given adequate training. The speaker then outlined a scheme which he had tried in his district.

Dr. U. Krishna Rao: The speaker expected that Dr. Veerasinghe Chinnappa would deal with the practical difficulties in the working of the Child Welfare Scheme and suggest remedies. But Dr. Chinnappa had dealt only with the development of the scheme. Though the Madras Corporation was spending more than three lakhs, there had not been any substantial reduction in the rate of maternal and infant mortality in the city. The speaker wished to have the views of Dr. Chinnappa on the question whether maternity relief should be given to all people freely, whether the Child Welfare Centres should have dispensaries, attached to them and whether the centres should have any connection with the hospitals. Personally, he felt that free relief should be given only to very poor people. There should be close co operation between the Child Welfare Centres and the Hospitals.

Dr. Kamalamma, Superintendent, C.W.C. Madras Corporation, explained the difficulties under which they had to work. The ignorance, poverty, social customs of the people and the insanitary surrounding were, to a large extent, responsible for the high rate of maternal and infantile mortality in the City. They should undertake intensive propaganda work and have more health visitors.

Dr. Chinnappa, replying to the debate, said that from her experience she could say that there had always existed very cordial relationship between the general medical practitioners and the staff of the Child Welfare Centres.

President's Concluding Remarks.

The President, in bringing the Congress to close, said that they had spent three wonderful days and the debates held each day were highly instructive and stimulating. She hoped that the delegates assembled would carry with them pleasant recollections of the days spent in Madras. The President thanked Dr. Lakshmanaswami Mudaliar and the other members of the Reception committee for the very splendid arrangements made for the comfort of the delegates.

Dr. Lakshmanswami Mudaliar proposed a vote of thanks to the President. He was glad that the first Congress had ended in a great success with the hearty co-operation of all the delegates and members of the profession all over India.

A chit had been handed over to him, he said, asking him to state the attitude of the Congress towards Mrs. Sanger's campaign. He would say that the attitude of the Congress was the attitude of a scientific man, to be receptive at first, to be deliberative and to come to a conclusion at the proper moment. But so far as the work of the Congress was concerned, it would be carried on with vigour.

Dr. Dadhaboy (Bombay) thanked the Reception Committee for the very kind hospitality shown to the delegates and wished the Congress a bright future. She hoped that the next Congress, which might meet two years hence, would be held in Bombay when she hoped to reciprocate the kindnesses shown.

Dr. S. Mitra (Calcutta), Dr. Punen Lucose (Trivandrum) and Lt. Col. Sastri (Tinnevelly) spoke appreciatively of the arrangements made by the Reception Committee and expressed their gratefulness to Dr. Lakshmanaswami Mudaliar and others.

The congress then terminated.

Party to Delegates.

On 2—1—'36 the Chairman Reception Committee entertained the delegates at a tea-party held on the Madras Medical College grounds and on 4—1—'36 the delegates dinner was held at the Madras Medical College hall. Over two hundred delegates and guests were present. Dinner over, toasts were proposed and responded to.

Dr. A. Lakshmanaswami Mudaliar, proposing the toast to "The Obstetric and Gynæcological Congress", said that nothing had given him greater pleasure than to meet such a gathering of obstetricians and gynæcologists from all over India. They had reason to be proud of the fact that they had ushered into existence this Congress. The obstetricians had kept themselvss in touch with the latest developments in surgery, radiology and other departments of medicine. They had never in any manner failed to appreciate researches in other branches of medicine.

Years ago when he was assisting his Chief at an operation at the Government Maternity Hospital, a general Surgeon of reputation entered the operation theatre and funilly sneered at them saying that they were doing cess pool surgery without realising himself, the role of the obstetricians and gynæcologists in the medical profession. The general practitioners he said were likely to be jealous of their present activities.

It had given them great encouragement that it was possible to hold this Congress there. It was not for him, and office-bearer, to say that the Congress had been a success. But he would say that the Congress spirit prevailed everywhere and it augured very well for the future of the profession in India.

The speaker then thanked Dr. N. A. Purandare of the Bombay Obstetric and Gynæcological Society for the help he had rendered to make the Congress a success. Personally, he felt it was the proudest day in his life. One of the dreams of his life for many years, ever since his visit to England, was the convening of a Congress of Obstetricians, and he was glad that it had come to pass. They had produced an offspring and it was now under the care of the profession in general. It was their duty to properly nurture the baby.

Dr. (Miss) Ida Scudder, speaking next, said that it was with great pleasure that she was responding to the toast. She always felt that she belonged to India. A little over seventy years ago, she came with her parents to India and from that time, she loved India and felt herself to be an Indian. It was a great privilege to preside over the Congress. It was good that so many young men and women had gathered on a common platform with old people. Obstetrics and Gynaecology formed the biggest part of medicine. Dr. Scudder thanked them and especially Dr. Lakshmanaswami Mudaliar for making the Congress a great success. She hoped that Madras which had given a lead, would continue to do so.

Dr. N. A Purandare said that the inspiration for bringing into existence the Society in Bombay came from Dr. Lakshmanaswami Mudaliar. Another suggestion made by him was the starting of a journal. The speaker hoped that with the co-operation of the obstetricians and gynaecologists of India the object would soon be realised. On behalf of the delegates, the speaker thanked the organisers and wished that this would not be the first and the last Obstetric Congress. He wished the Congress all success in the coming years.

Dr. H. M. Lazarus proposed the toast of 'The guests' and said that they and the practitioners of the other branches of medicine belonged to one fraternity. The obstetricians saw that the child was safely delivered and he looked to the other specialists, and the general practitioners to nurture the baby. In their work they needed the hearty co-operation of the Government and she had great pleasure in coupling the name of Dr. C. Natesa Mudaliar with the toast. As Deputy President of the Legislative Council, he could render much help to their profession. The Corporation of Madras was doing much for the development of a maternity service, and she hoped that soon a well-organised scheme would be put into effect in the mofussil also. The radiologist was of great help to their Branch of Medicine, and she had great pleasure in associating the name of Captain Barnard also with the toast.

Dewan Bahadur Dr. C. Natesa Mudaliar, replying, assured the Congress that the general practitioners were not at all jealous of the obstetricians and gynaecologists. The general practitioners required their help. It was one of his hopes that there would be a World Congress of medical men. As obstetricians they had brought into existence the Obstetric Congress, and the speaker hoped that it would have a long and healthy life. In spite of the efforts of the Madras Corporation, they were not able to reduce the rate of infantile and maternity mortality to any substantial extent in the city. They as politicians wanted to increase the vitality of the nation and to see that the country was prosperous. The speaker was glad that the Congress had been organised in Madras and thanked the organisers on behalf of the guests.

Captain Barnard said that he was glad of the opportunity afforded to him to meet the obsetetricians and gynaecologists.

The gathering then dispersed.

Original Articles

THE ORIGIN AND GROWTH OF THE INDIAN MEDICAL PROFESSION.

BY

DR. D. V. SUBBA REDDI, M.B.B.S,
Medical Collage, Vizagapatam.

From the very early days of the East India Company, medical officers of the company had been employing indigenous assistance in hospitals. These assistants were first trained locally as dressers under the immediate supervision of their superiors. Up to the middle of the 18th century, these were the only native subordinates familiar with Western medicine.

The earliest recorded reference to a medical subordinate concerns a baniya doctor named Atharbhat at Surat factory between 1639 and 1644. There was Nilakanth, an Indian doctor, employed at Hugli factory about 1676. Another Indian doctor Shevandavadam seems to have been employed as early as 1690 at Fort St., David. He was succeeded by his son, Namassivaya who, was in his turn, replaced by his son. A black hospital assistant is mentioned as serving in Bombay hospital in 1701. Dowjee, a native was serving as a surgeon in the Bombay Marine about the year 1750. By 1761 there were 17 black doctors in the Bengal Army under the command of Eyre Coote. "Fort William Consultations" for the year 1763, offers the explanation for the employment of the natives as doctors. "As gentoos would take physic only from a member of their own caste, a gentoo doctor was also to be attached to each battalion in addition to surgeon's mate". The black slave boy Nicholas was a dresser serving under Anderson when the latter was massacred at Patna, in 1763. In 1767 Madras was allowed one native doctor for every battalion of sepoys. Soon after the middle of the 18th century a military subordinate department came into existence. This service seems to have owed its existence to the energy of individual medical officers who trained private soldiers and Eurasians to assist them in their hospital work.

The next stage was reached when a course of regular apprenticeships became a recommendation or a qualification for appointment as a sub-assistant surgeon. Among the sub-assistant surgeons pentioned in 1785 were Francis Lipton, of Madras Hospital, John Pascol of Vellore Hospital, De-Roza of Madras Hospital all natives of India who had served as apprentices under recognised doctors Mr. Jukas, Mr. Gahagan, and Mr. Raine.

In 1802 a scheme was formulated in Bombay for training native doctors to serve in the cruisers of Bombay marine. Bengal constituted, in 1812, a sub-medical department consisting of European and Eurasian boys trained as dressers and apothecaries under the immediate charge of surgeons at the general hospital and garrison hospital, Calcutta. About the same time similar classes were started at Madras also. In 1819 the number of medical pupils at Madras was increased from 30 to 40. The civil population of rural India depended, however, on a different class who received some sort of instruction in Hindu and Unani systems of medicine in the sanscrit colleges in Madras and Calcutta during the early part of the 19th century.

In 1822, the first real medical school in India, the Calcutta Native Medical institution, for training native doctors was established at Calcutta, Twenty students were to be admitted. The preliminary qualifications were that the student must be able to read

and write Persian or Nagari. Instruction was given in Sanscrit or Urudu and the course lasted 3 years. Pharmacy was the one subject that was taught with great care. Similar classes were started at Bombay in 1826 and in Madras in 1827. Madras re-organised the sub-medical department into two branches in 1827. Apothacaries were separated from dressers. New ranks and designations were given.

The first attempt to establish a civil medical department appears to have been made in 1833, "With the hope of rendering a portion of native doctors educated at the medical institution more efficient and for the purpose of affording to all a motive for acquiring a more profound knowledge of medicine and surgery than they now attain, the Right Hon'ble Governor General in Council is pleased to create a higher grade of native medical officers." The foundation of medical collages at Calcutta and Madras soon gave opportunity for forming such a department by educating native students up to a higher level than the one previously existed.

Medical education on a higher scale was initiated by Lord William Bentic who in 1833, appointed a committee for the purpose of improving the constitution and extending the benefit of the native medical institution. This committee submitted in 1834 a report which summarised the defects of the native medical institution. It criticised the want of proper qualifying standard for admission, omission of practical human anatomy in the course of instruction, the shortness of the period of study, and the mode of conducting final examinations. One point of considerable importance on which the committee were divided was whether instruction should be given in an Indian vernacular or in English. The final outcome of this controversy is thus summarised by the author of the History of the I. M. S. "The Anglicists finally prevailed over the Orientalists and it was emphatically laid down that the knowledge of English was a *sine quo non* because that language combines with itself, the circle of all other sciences and incalculable wealth of printed works and illustrations, circumstances which give it obvious advantage over oriental languages in which are only to be found the crudest elements of sciences or the most irrational substitutes for it." As a result of these recommendations medical colleges were brought into existence. Students who could read and write English were subjected to a preliminary selection examination by an education committee. At Calcutta 50 foundation pupils were admitted and were expected to remain at the institution for a period, not less than 4 years and not exceeding 6 years. The pupils were required to learn the principles and practice of medicine in strict accordance with the mode adopted in Europe. The education committee was also charged with the duty of providing suitable buildings for the college, library, anatomical preparations etc. The Superintendent with the aid of his assistant, was expected to instruct pupils in anatomy and surgery, pharmacy and medicine. At Madras a medical school was established in 1835. Two different courses were given, one to the medical apprentices for the apothecary branch and the other to the medical pupils for the native branch of military sub-medical department. The course for each branch lasted two years, anatomy and physiology being taught in the first year, medicine and surgery in the second. Later, the course for apothecaries was increased to 3 years and that qualifying for civil sub-assistant surgeons to 5 years. The name of medical college was given to the Madras institution only in 1850. In the same year, was started a class for native doctors extending over three years. In 1856 the course of instruction given at Madras was recognised by London Royal Colleges. After 1870, a number of vernacular medical schools were started all over the Presidency, Royapuram, Dindigal, Nellore, Tanjore and Vizag being the most famous of these. No private students were admitted.

From such small beginnings sprang the present provincial medical services and its over flow, the independent medical profession. The appointment of natives to commissions was strictly forbidden by the court till 1855, when these coveted posts were thrown open for competition. The list of successful candidates in the first competition was headed by S.C.G. Chuckerburty, one of the students of the Calcutta Medical college, who accompanied Mr. Goodeve to England for further studies. He became a professor of Materia-Medica in 1864 and was a successful teacher of medicine. Though from 1750 onwards, natives of Europe had come out to

India, to take up service with the princes or to settle down as private practitioners, with a view to future service, there does not seem to have been before 1836, any case of an Indian starting his medical career as a practitioner of modern medicine. By 1836 "The Indian Journal of Medical and Physical Sciences" was brought into existence. The rapid strides that medical education and medical profession in India had made during the last one hundred years have been described, on the two occasions of the centenary celebrations of the Medical colleges of Calcutta and of Madras. To day, India can rightly be proud of a small but efficient profession. Sons of India, following the cult of Aesculapius, have won laurels in many other fields also. In Peace as well as in War, they could count amongst them eminent administrators, Provincial heads of Departments, distinguished educationists who have either acted as Vice-Chancellors of Universities or functioned as Dictators of Universities, Legislators, Mayors of great cities of India, Editors of journals and dailies and founders of parties, and patriotic servants of India. In the practice of the great Art and Science of Medicine, most of them have acquired a modicum of worldly wealth; some have left great fortunes; a few are worshipped as household gods. That an Indian medical practitioner should have been selected to preside over the annual session of the Indian Science Congress this year, is the highest testimony to the scientific outlook of the Indian medical profession.

CLINICAL NOTES AND PRACTICAL SUGGESTIONS

Treatment of dyspepsias.

Digestive disorders are the commonest affections met with in general practice. Dyspepsia, to use the term in its widest sense, is the most common amongst them. It is the enormous percentage of carbohydrates in the present day food that is responsible for the increased strain on the stomach, and on account of hurried meals and want of proper mastication the ptylin of saliva has very often very little chance of acting on the food ingested. As a result there is more or less acute indigestion characterised by symptoms such as fullness and pain after food. This is because the gastric secretions are not able to convert into a digestible form the large amount of carbohydrates taken in. If not properly treated this condition may become chronic, or even a more serious condition such as gastritis or peptic ulcer may supervene.

In the treatment of these conditions Papyta is the medication of choise. It consists of papain with pancreas and bile extracts. Papyta is available in the form of tablets which are absolutely tasteless and odourless. Besides its certain digestive action on the proteins it has an excellent amylolytic effect. There is full evidence to show that Papyta is fully active in the stomach despite markedly acid or alkaline solutions. The best time to administer Papyta is during meals so that it effectively acts on amylaceous as well as protein type of food. Paptya promotes the flow of bile, intestinal and pancreatic juice. It aids digestion and favourably influences most cases of dyspepsias and constipation. It is a physiological stimulus to the secretions of the stomach, liver and the pancreas and when administered during meals it stimulates both appetite and digestion. The glands of the digestive tract are stimulated to activity and especially the secretion of the mucous membrane which results in marked reduction of acidity. In extreme cases the contents of the stomach even become alkaline. Besides the disinfectant and anti-fermentative action Papyata has a mild laxative effect.

From the above it clearly follows that Papyta represents the ideal remedy for all types of dyspepsias. Chronic constipation is also benefitted by this medication, as regular and prolonged administration of Papyta leads to regulation of intestinal function. Intestinal fermentation responds favourably to Papyta. In enfeebled digestion of tuberculous, anæmic and nervous patients Papyta yields highly favourable results. When there is general inactivity of the peptic processes Papyta is really a valuable remedy.

In mild form of gastric disturbances the administration of two tablets of Papyta thrice a day during meals usually gives very good relief. This remedy coupled with care and discretion in diet is frequently useful in averting more serious smptoms, and very often it clears up the condition remarkably well. Hence Papyta has become a very favourite prescription with many of the physicians.

Some of the cases of dyspepsias are due to impaired functions of the pancreas rather than to any defective working of the stomach. It is then very difficult to diagnose the exact trouble, but the presence of fats in the fæces and decreased sugar tolerance may reveal the exact nature of the trouble. For such patients Papyta treatment will prove strikingly successful. The pancreatic extract contained in Papyta is not destroyed by the hydrochloric acid of the gastric juice as it has a particular coating which proves resistant to the juice. The pancreatic extract in these tablets begins to act as soon as they leave the stomach and enter the duodenum. Successful results have been obtained with Papyta in tuberculous, anæmic and nervous patients where it effects complete digestion of food ingested and thus it assists recovery to a remarkable extent.

There are however certain cases in which the gastric symptoms are associated with troubles of the gall-bladder and bile passages. The gastro-duodenal infection may result in catarrhal jaundice and there may be absorption of toxic products into the portal circulation due to incomplete digestion. These infection may travel to the gall-bladder and may cause cholycystitis or subsequently cholelithiasis, both of which may constitute the chief factors in the formation of gall-stones. The symptoms in

such cases point to the stomach and we have therefore to carefully seek out evidence of jaundice or some hepatic or gall-bladder disorders. In all these cases besides Papyta, Boldine should be exhibited. It is essentially a cholagogue and it exerts a softening effect on the gall concretions and helps their dissolution and excretion. It provides an effective drainage of the gall-bladder and ensures gradual and gentle evacuation of bile and is thus able to alleviate all the gastric symptoms associated with these affections.

Dyspepsias are usually accompanied by constipation, which most of the remedies are not able to correct and thus the treatment of dyspepsias becomes incomplete. This is not the case with Papyta which has the unique feature of overcoming constipation together with alleviation of the dyspeptic symptoms. Intestinal stasis leads to intestinal toxæmia and treatment of this must never be neglected when we are dealing with digestive disturbances. Papyta on account of the bile extract contained in it exerts a tonic effect on the intestinal musculature and promotes peristalsis. It cleans and disinfects the intestines and thus overcomes constipation, intestinal fermentation and consequent auto-intoxication. Papyta, unlike other remedies for dyspepsia, does not require any other additional drug to overcome these concomitant affections.

Effective method of recalcification of the organism.

Disorders or derangements of calcium metabolism are not mainly due to simple deficiency of the element, the principal cause being the failure of the organism to assimilate calcium. It has been observed that most of the calcium preparations administered orally are usually rapidly eliminated without much action on the organism. It is therefore highly essential that for complete assimilation and to compensate for the mineral deficiency intensive calcium treatment is necessary and there cannot be slightest doubt as to the superiority of parenteral over oral administration of calcium products. It has been found that injections of calcium intramuscularly produce far better results where oral administration has been quite ineffective. Biocalcium is the preparation of choice for this purpose as it is really designed for scientific calcium therapy. It provides a combination of calcium Gluconate with choline hydrochloride and sodium cacodylate.

Synergy is the keynote of Biocalcium, as it contains calcium gluconate and choline hydrochloride in proportions particularly calculated to provide maximum results without producing any undesirable by effects. Calcium Gluconate is calcium combined with a purely organic acid viz. gluconic acid, and this ensures its complete assimilation. Choline hydrochoride raises the cholesterine content of the blood and this brings about increase in the resisting power of the organism. Sodium Cacodylate is also included for its haemopoietic effects. It is in a form which is rapidly absorbed and perfectly tolerated.

From the above formula it is clear that Biocalcium besides increasing the proportion of calcium in the blood re-establishes and maintains the the glyco-cholesterol equilibrium. It helps to increase the defensive power of the organism and to stimulate the blood-forming tissues. The superiority of this preparation lies mainly in the fact that it is easily assimilated and that it ensures integral utilization of the calcium contents on the part of the organism. The complex organic molecule of Biocalcium is not directly eliminated as such, but undergoes profound breaking up and conversion into colloidal compounds and calcium protein which are easily fixed by the tissue elements. Thus it is found much longer in the organism than any other calcium preparation. On account of progressive assimilation and fixing of the calcium by the tissues, the rapid increase of calciemia, which follows Biocalcium injections, soon disappears. Because of rapid assimilation in this manner in every condition where lime production is hindered, no matter whether it is due to inadequate supply of alimentary calcium or imperfect absorption by the same tract or to abnormal consumption as in pregnancy or lactation or to real pathological processes of demineralisation as in Tuberculosis, Biocalcium supplies the need in every case with remarkable efficacy.

It will be obvious from the above that the field of Biocalcium therapy is very wide. The first and the foremost indication in which Bio Calcium can be used with greatest advantage is Tuberculosis. Whether the latter is pulmonary or surgical, the employment of Biocalcium injections regularly for prolonged periods invariably brings about excellent results. These are attributed to several facts. The progressive and dangerous decalcification of the organism is arrested and compensated and there is rapid stimulation of the physiological process of calcification of the tubercle. Besides these actions it rapidly modifies the gastro-enteric disturbances. In pulmonary tuberculosis it assists regression of lesions, causes disappearance of cough and other toxæmic troubles and brings down pyrexia. In surgical tuberculosis along with other measures of treatment Biocalcium facilitates healing and new bone-formation. For the pre-tuberculous it is an excellent general tonic. It increases the appetite and weight, improves the general condition and raises the resistance of the organism by its recalcifying action and by stimulating the organic defences.

Biocalcium injections are very helpful for anemias in general on account of its ingenious combination. It contains in addition to calcium gluconate and choline hydrochloride, sodium cacodylate. Thus hemopoietic functions are stimulated with simultaneous assimilation of Calcium. This favours regeneration of the blood. The lymphocytes diminish in number and the mononuclears increase rapidly. There is increase in the number of red corpuscles and the hemoglobin percentage.

In debility following recurrent malarial attacks, clinical observations have proved the value of Biocalcium injections. The preparation raises the calcium level of the blood and tends to increase the resistance of the organism. Due to Sodium Cacodylate contained in it Biocalcium is able to prevent further malarial attacks.

In fractures injections of Biocalcium stimulate osteogenesis and firm union and thus help much to lessen the period of healing and convalescence. Biocalcium therapy should be instituted as a routine measure in all cases of ununited, comminuted and compound fractures, as it is a calcium preparation which is easily and rapidly assimilable. It is easily taken up by the blood and readily transformed into substances which will be absorbed by the bones of the organism. Thus, healing of fractures of whatever kind is hastened in a remarkable manner.

The value of Biocalcium in haemorrhages is quite undisputed. Intragluteal injections of this preparation have a very rapid action in any kind of bleeding. It immediately produces the desired effect, as the blood-calcium reaches the highest level half-an-hour after the injection. In menorrhagia, in menopausal haemorrhage, bleeding from the lungs or the stomach and in post-operative haemorrhage the results are more rapid and more certain than can be obtained with any other preparation. The post operative bleeding is controlled by these injections in a very satisfactory manner, specially in operations on the tonsils and adenoids.

Biocalcium injections are usually recommended as a preparatory treatment before surgical operations. It effectively eliminates too much bleeding during the operation by enriching the blood with calcium and increasing its coagulating power, it raises the resistance of the patient, hastens convalescence and prevents all post operative bleedings. It is highly essential therefore to inject a series of Biocalcium ampoules before performing a major surgical operation.

The clinical syndrome of tetany can be completely relieved by the administration of Biocalcium injections. The diminished bloodcalcium in the conditions is soon restored to normal and thus the acute and the distressing symptoms are soon alleviated. If the injections are continued for sometime the blood gets the adequate quantity of calcium which conserves in the organism the normal irritability of the muscles and the nerves.

In Spasmophilia Biocalcium injections are almost specific. While antispasmodic sedatives have their uses in this condition for temporary relief, Biocalcium injected intramuscularly for sometime is very useful as a prophylactic and a specific. It corrects and restores to normal the disturbed calcium metabolism which is usually the cause in this condition. Together with dietetic treatment, which consists mainly of carbohydrates, this therapy has proved successful

in the majority of cases of spasmophilic convulsions in infants.

In different forms of imbalance of the vegetative nervous system Biocalcium establishes the normal humoral equilibrium of calcium with other salts. It brings back the normal balance and maintains it more effectively than any other calcium preparation.

The main reason for the success of Biocalcium treatment is that it can be administered intramuscularly and for a long period without fear of any untoward symptoms. It is quite painless and does not cause any local infiltration. It is possible to exhibit this treatment even in weak and sensitive patients as it is perfectly well tolerated. It is entirely free from any inconveniences and it remains in the organism much longer than any other preparation of calcium.

The superiority of Biocalcium does not lie only on account of these advantages but it mainly lies in the facility with which it is absorbed and in fullest utilization in the calcium contents. It is a carefully, compounded preparation which is readily absorbed and which has a definite therapeutical action. From the evidence before us we are justified in saying that it is an ideal preparation for highly itensive calcium therapy and for cases where calcium and arsenic are indicated.

The following case treated mainly with Biocalcium injections will illustrate to a great extent its efficacy:—

A young Hindu of about 25 years of age came to me complaining of cough, fever and sweating. He told me that he had suffered from chronic bronchitis with apyrexia for about six months. When he came under my care, I found that he has a bad hacking and dry cough with some temperature which was particularly noticeable in the evening. He had profuse sweating at night and abundant expectoration. There was slight haemoptysis off and on. Examination of the patient revealed that his general condition was much run down and there was definite indication that slight anaemic symptoms had commenced. Lungs when examined showed that the breathing at the apex of the left lung was rather harsh and some crepitations were heard over that area. Tactile vocal fremitus was accentuated. I thought I was dealing with a case of Pulmonary Tuberculosis which has just started. I immediately commenced Cod Liver Oil by mouth and Biocalcium parenterally. After ten injections were given, each on alternate day, the fever had disappeared, cough had subsided to a remarkable extent and sweating and expectoration had ceased. At present the appetite is fairly good and there is much improvement in his general condition and in the anaemia. The Pulmonary condition has not, however, undergone any noteable change and the crepitations are still heard over the area. The patients weight has increased by 3 lbs. The injections are still continued and there is reason to believe that if the treatment is continued for some time he will be free from the disease before long. The treatment is perfectly well tolerated despite his weak and run-down condition.

THE Medical Practitioner

VOL. VII.] JANUARY 1936. [NO. 4

KING GEORGE IS DEAD

Long Live King Edward

We mourn with one and all in the British Empire and the whole world over and offer our most respectful condolence to Her Majesty Queen Mary, her son the most illustrious and beloved sovereign His Majesty King Edward, the Emperor, and the rest of the Royal Family and pray Almighty to bless the departed soul of King George with ever lasting bliss. May His Majesty King Edward live long and guide the destinies of his vast Empire on which the sun never sets and bring us all his most devoted and loving subjects, peace, happiness and prosperity is our heartfelt prayer to God, the almighty.

OBSTETRIC AND GYNAECOLOGICAL CONGRESS.

The medical profession in India have to be thankful to Dr. A. L. Mudaliar for having conceived the idea of convening an all-India Congress of Obstetricians and Gynaecologists in Madras. The need for an all-India Society of Obstetricians and Gynaecologists seems to have struck Dr. Mudaliar in 1933 at Bombay where he was invited by the Indian Medical Association to preside over the Obstetric and Gynaecological session of the All-India Medical Conference. Dr. Mudaliar suggested to his fellow Obstetricians and Gynaecologists in Bombay to start a society of their own. Soon after a society was started in Bombay with Dr. Purandare as its President and in Madras a similar society was brought into existence under the leardership of Dr. Mudaliar. It is noteworthy that it did not take much time for Dr. Mudaliar to realise his "life-dream" to organise an all-India Congress of Obstetricians and Gynaecologists. Madras Presidency should be proud that the 1st all India Congress of Obstetricians and Gynaecologists was held in Madras and what more, that it was presided over by a lady doctor Miss. Ida Scudder, a person who though foreign by birth adopted India as her own country and who after qualifying herself as a doctor of medicine, has been devoting her life-long service to those of her own sex at Vellore where she organised not only a well equipped hospital for women and children but also a medical school which is likely to be converted into a College in the near future. The South-India Obstetric and Gynaecological Society invited the Congress to Madras and it met on 2-1-36 and was opened by His Excellency Lord Erskine the Governor of Madras.

Dr. A. L. Mudaliar in his thought provoking address briefly narrated how it was possible for him to realise his "life dream" and suggested ways and means how "the tender seedling planted" by His Excellency the Governor of Madras, would "grow to be a mighty tree spreading its sheltering branches throughout the length and breadth of India". Dr. Mudaliar took advantage of the presence of the Governor of the Province and appealed to him and through him to the public for generous and sympathetic financial help to enable the Obstetricians and Gynaecologists to organise post-graduate study and research for tackling problems of relieving the sufferings of women and children on account of diseases peculiar to this country. His Excellency sagacious as he is offered his "most cordial congratulations and welcome" to the Congress and said that,".....holding of

this Congress is assuredly a legitimate source of pride and inspiration to us all." In his concluding remarks His Excellency added, "there is no cause more truly deserving of popular interest, practical assistance and financial support. To save the mothers of India from suffering, disease and death and to rear up healthier, happier children—this is a task than which none could be dearer to the heart of any nation. Let the people of India see to it that nothing is wanting to the advancement of that cause which they can achieve by their endeavour and their charity".

Under this augury and the august and distinguished auspices of His Excellency, the Governor of Madras, the Congress was held. It was really a grand sight to see that all the available seats in the Government Museum Theatre were fully occupied by members of the medical profession of all grades in service and in private practice having amidst them delegates from different parts of India including the Indian Foreign States and presided over by a well-known and popular lady ripe in age and as much ripe in experience having so nobly dedicated her life for service as an medical missionary. The address delivered by Dr. Ida S. Scudder full of wisdom and practical suggestions should convince all interested in the welfare of this country that none else in India could have been more fitted to occupy the presidential chair. Trained and educated in Medicine in one of the most advanced countries in the world and an enthusiastic medical missionary working in the moffussil in rural surroundings, yet keeping in touch with the ever advancing science, it was possible for Dr. Ida S. Scudder to give out to the congress her views as how best to serve the women and children of India. Propoganda and service was the keynote of the presidential address. Dr. Scudder stressed the need of a journal "to enable the older practitioners to keep pace with modern method as surely as the young members of the profession". It will be worth while for the members of the profession to go through the most inspiring and thoughtful address of the President which would give them an idea how best this country might be served by them not only in the urban but also in rural areas. She exhorted the younger practitioners " to catch a vision of service to our great village population and be determined to go out and raise the standard of medicine in the surrounding country". The advice of the President to the village practitioners that they should not confine themselves to the medical problems alone but to the general uplift of the villages would, we hope, be noted not only by the practitioners but also by the authorities and the public both of whom have been ignoring the importance of the village practitioners towards village re-construction, a problem that should eventually solve the future prosperity and well-being of Indian nation. Dr. Scudder made the Congress to understand that it should make it possible to organise in such a way that through its central base, 'practitioners, nurses and midwives would be carefully supervised and be given opportunity at stated intervals to study in some large central hospital and be expected to undergo post-graduate courses at the expiration of certain number of years'. The ideal of the head and heart of Dr. Scudder could be imagined from the concluding para of her address which runs thus: "May we be inspired to go forward with greater zeal and enthusiasm than ever before, to do outstanding work along these important lines which will be recognised the world over. We have opportunities for service in womanhood that few have and may we be worthy of this great calling to lead in the future in all matters pertaining to Obstetrics and Gynaecology'.

Proceedings concerning the Scientific Session of the Congress were of high order. Prominent Obstetricians and Gynæcologists, Europeans as well as Indians read papers on important subjects. The discussions were very interesting and will certainly benefit the practitioners. The organisers of the Congress arranged for two social gatherings, a tea party and a dinner. These functions brought the delegates in close contact and gave them a splendid opportunity of knowing each other intimately and the after dinner speeches gave an opportunity to outsiders to judge what the Obstetricians and Gynæcologists assembled at the Congress thought of themselves in relation to the profession as a whole. At the earlier stage of the after dinner speeches an impression of superiority complex prevailed as between the specialists in obstetrics and gynæcology and the general physicians. Later a Lady specialist remedied the situation and prevented the complications of the complex which would have otherwise given rise to obsessions. Unfortunately these days, young practitioners in service who had special opportunities for qualifying themselves for higher qualifications, have given rise to a feeling that specialists are a separate department amongst the practitioners of medicine and are higher in status than the general practitioners. In other civilised countries especially in Austria where a specialist has a natural growth, the practitioner practising a special branch of medicine taking to it after many years of his life as a general practitioner and after working in special institutions in various capacities, was recognised as a specialist. In India specialisation is having a unnatural growth especially in Government service for obvious reasons and having deleterious effects on the profession and more on the public. It is the duty of all those in the profession who can afford to be above the pale of competition to impress on the younger generation that the most noble and sacred art of healing cannot be styled as anything else than medical science and the institutions for teaching this art cannot be called by any other more suitable names than the medical schools and medical colleges and those practising the healing art have to be called medical practitioners. Any other prefix in the above names such as surgical or obstetric etc., cannot be substituted. It is good that all those practising the healing art realise that a surgeon is a cutting physician, and so also others in other special field of medicine who have to function to the dictates of the Physician. Specialists exist and have to exist to do special functions for the purpose of co-ordination in the healing art and they have no place if they were not and are not recognised physicians first. The great sage Manu brought into existence special sections in human society in India for doing particular functions for the common good of society and unfortunately as materialistic civilisation advanced the noble purpose of Manu was forgotten and these sections identified themselves as different castes one claiming superiority over the other. The effect of such cleavage has been most disasterous in this country and India could not grow and prosper as one Nation in spite of a splendid record of her ancient civilisation. We warn the specialist that any cleavage in the noble profession will be most disasterous for the scientific development of medicine.

ALL-INDIA MEDICAL CONFERENCE.

The XII All-India Medical Conference for the year 1935 was held at Nagpur on 26th December '35, under the auspices of the Indian Medical Association. From the very inception of the Indian Medical Association which was brought into existence by one of the all-India Conferences, we have been taking keen intesest about the affairs and activities of the Indian Medical Association and did not fail to send our representative, himself a member of the Association to attend the all-India conferences till the year 1932 and were therefore able to publish in the columns of The Medical Practitioner, the proceedings of the conferences year after year in detail for canvassing the support of the profession in this country for the Indian Medical Association as it has been our conviction that the destinies of the profession and the interests of the public with regard to medical relief, can only be solved by the profession itself with the help of an all-India Organisation as is the case in Great Britain where the British Medical Association has been considered as an authority both by the Government and the people of that country to tackle problems of medical relief. Due to circumstances beyond our control, chief amongst them being the indifferent health of our Dr. Kamath we had to depend upon the courtesy of the organisers of the conferences to supply us the details of the proceedings of the conference since 1932. Though the President of the Conference was kind enough to supply us a copy of his address in advance, we were not fortunate to be favoured with the same courtesy by the General Secretary and the Chairman of the reception committee of the last conference, inspite of our request to them to send us all the details of the conference. It is evident that the organisers did not realise the desirability of giving publicity of the proceedings of the conference in the medical journals and perhaps depended upon lay news papers. The taste of the lay public in medical conferences being limited, the news papers publish only such items of the conference which are likely to interest their readers. So we were very much handicapped. At last the general Secretary of the Indian Medical Association was kind enough to send us copies of the addresses and the resolutions passed by the conference. We expected that the official

journal of the Association would come to our rescue, but are sorely disappointed that the latest journal does not contain any news about the conference. We have published extracts from the addresses of the President and the Chairman, Reception Committee in this issue. The resolutions passed by the conference also find a place in the journal. We have therefore been compelled to reserve our comments on the proceedings of the conference awaiting fuller details which we hope to see in the next issue of the official organ of the Indian Medical Association.

Correspondence Reports Etc.

Late Mr. V. C. Seshachari.

With deep regret we wish to inform our readers about the passing away of Mr. V. C. Seshachari on 15th January, 1936. He was the proprietor of the India Printing Works where The Medical Practitioner is being printed. Mr. Seshachari was one of the leading advocates of the High Court and was a versatile genius. He took keen interest in The Medical Practitioner and helped us a good deal by accommodating himself to any unforeseen inconveniences during the course of the printing of the journal. Though he was ripe in age at the time of his death and was an invalid for over five years his intellect did not fail him till a few hours before his death. We deeply mourn with his son Mr. V. C. Krishnaswami and the rest of his house-hold. May the soul of Seshachari rest in peace.

Apology.

Having to publish in detail the proceedings of the 1st all-India Obstetric and Gynaecological Congress and the available proceedings of the all-India Medical Conference, we regret we could not follow the usual order we have been following in the publication of The Medical Practitioner. We did swerve from the usual routine in the interest of our readers.

Man proposes and God disposes. We did all that was possible for us to publish this issue in time, but the sudden death of the proprietor of the Press where the journal is being printed prevented us from doing so. We hope our readers will kindly overlook our default due to unforeseen circumstances.

The XII All-India Medical Conference, Nagpur 1935.

RESOLUTIONS.

1. (a) Resolved that in Clause 8 of Section 3 of the Lunacy Act [IV of 1912.] the words "in the United Kingdom" be deleted, and the same be replaced by the words "with a Medical Council of any of the Provinces in British India".

(b) Resolved that in Clause 1 of Section 5 of the Lunacy Act [IV of 1912,] the words "one of which certificates shall be from a Medical Officer" be deleted and replaced by the words "from two registered medical practitioners."

2. In the opinion of this Conference the standard of education imparted in all the medical institutions in the country should conform to the minimum standard of qualification laid down by the Indian Medical Council.

3. This Conference is of opinion that a separate cadre should be instituted for teaching appointments in medical schools and colleges.

4. This Conference draws the attention of the Government of India and of the U. P. to the fact that the rules recently framed under the Poisons Act by the Government of U. P. are inconsistent with the Provisions of Section 9 (i) of the Government of India Poisons Act (Act XII of 1919) and requests the Government of India to direct the U. P. Government so that the said rules may be deleted so far as they apply to medical practitioners possessing registrable qualifications.

5. This Conference deprecates the growing abuse of hospital facilities by persons of means, thereby depriving the poorer sections of the public of medical assistance and private medical practitioners of income which would accrue to them from services to those who are well able to pay for treatment; this Conference therefore suggests that steps be taken to prevent the abuse of hospital facilities and charitable dispensaries.

6. This Conference considers it dangerous in the public interest to allow vaccination and food inspection performed by non-medical persons and therefore requests the municipalities and other public bodies to appoint medical men for these purposes.

7. This Conference is of opinion that the medical inspection of school children should be made compulsory.

8. This Conference deprecates the policy of excluding the press from the proceedings of the Indian and certain Provincial Medical Councils and suggests to the Medical Councils concerned to remove this ban.

9. Having regard to the incessant and urgent demand for the improvement of public health, this Conference invites the attention of the Government to the necessity for giving much greater attention than in the past to this subject and providing larger funds with a view to improving existing public health facilities especially hospitals, and expanding the activities of this department particularly in rural areas.

10. This Conference urges the imparting of a knowledge of elementary biology, sanitation, hygiene and nutrition in all schools and colleges as being calculated to stimulate the improvement of public health and increase the physical and economic standards of the people.

11. This Conference calls attention to the great advantages of Indian medical men, both official and non-official joining the Indian Medical Association as adhesion of large numbers enables the Association to speak on their behalf with authority and strength and thereby enabling it to protect, and advance the interests of Indian medical men collectively and individually, and undertake constructive work for the benefit of the country.

12. This Conference is of opinion that the rates of fees paid by various Insurance Companies for the examination of proponents by their medical officers are not commensurate with the time and labour spent in examining such cases and it considers it advisable in the interests of the Insurance Companies that the fees paid for such examination should be adequate.

13. This Conference expresses its disapproval of the attitude of the Government of India with reference to the delay in implementing the recommendations of the Drugs Inquiry Committee and urges upon the Government of India and the Provincial Governments the paramount need of:—

(a) enacting necessary legislation, both Central and Provincial, in the shape of a Pure Drugs Act and a Pharmacy Act in India, and of any subsidiary Provincial Acts for each Province, which may be required under the circumstances.

(b) establishing a College of Pharmacy in every Province for the training of Pharmacists and compounders.

14. This Conference resolves that the Government of India be requested to draw a scheme. (1) for prohibition or in the alternative, regulation of medical practice in India by foreign medical men holding qualifications from countries which have no schemes of reciprocity with India and (2) the prohibition of medical practices by quacks and charlatans, whose ministrations are a menace and a danger to public weal.

15. This Conference requests the C. P. Government to give immediate effect to the C. P. medical Registration act which has already been passed.

16. This Conference urges upon the Government of the Central Provinces the urgent necessity of establishing a medical college in the province teaching up to the minimum standard of qualification required by the Medical Council of India.

17. This Conference recommends that instruction in Conception Control Methods should form part of the Curriculum in Medical Colleges and Schools and that Government should pass laws penalising the use of contraceptive methods except on Medical advice.

18. This Conference welcomes the proposal on the part of the Government of India for instituting sickness insurance and recommends that insurance should be made applicable to all workers, and further that the Indian Medical Association should be consulted in the formulation of the Scheme.

19 This Conference places on record its deep sense of gratefulness to the C. P. and Berar Medical Association for having shouldered the responsibility of organising the XII All-India Medical Conference and making it an unqualified success.

20. This Conference expresses its grateful thanks to the Chairman and the members of the Reception Committee and the volunteers for the excellent arrangements and the hospitality extended to the delegates of the Conference.

An Appeal to the Subsidised Medical Practitioners of the Madras Presidency.

From the Honorary Secretary,
The Madras Provincial Subsidised Medical Practitioner's Association.

This is the tenth year of our association and looking back, one may feel encouraged, if not elated, at our achievements. A handsome compliment has been paid to the manner of our working, and the amount of our success, by Dr U. Rama Rau, in the course of the presidential address delivered by him at the XII All India Medical Conference held at Nagpur in December last. He says "Unfortunately these rural practitioners have been placed under the control of Local Boards.....and had become the victims of persecution by one party or the other. But these men are made of sterner stuff. They formed themselves into an Association, held annual conferences, waited on deputations to the Minister and the Surgeon-General, got their grievances redressed, and thus firmly secured their position. They are better off now." The wearer alone knows where the shoe pinches. I should be excused, if I refute Dr. Rama Rau's statement in one respect. True some of our grievances have been removed but we have not as yet firmly secured our position. There are still many grievances to be redressed and added to this we have lost in fundamentals, quite recently though.

It behoves us therefore to continue our activities. Organised agitation is the only panacea, and no words therefore, can be more encouraging than those spoken by the Hon'ble Dewan Bahadur S. Kumaraswami Reddiar, Minister for Public Health to the Government of Madras, at the time he opened the fifth conference of Licentiates in Indian Medicine at Madras on 29-12-35. He

is reported to have said that, "It need scarcely be said that in modern times nothing could be achieved without organisation, agitation, and collective action. The catalogue of grievances, which you have presented to me would receive the best possible consideration at my hands. Your Association was started only five years back, and there are other Associations started much earlier whose grievances had not been redressed. I am mentioning this not as an excuse, as to why your grievances have not been redressed, but only to state that you need not be discouraged in not having met with success in your efforts to improve your condition, nor get dispirited because you have not achieved your objects. I would ask you to keep up your agitation till you succeed". A Very useful and practical advice indeed and I would appeal to my brethren to take up the cue and give me their whole hearted co-operation. A deputation may be led in March or April 1936.

Viraganur. } S. RAMASUBBU, L. M. & S.,
5-1-1936 }

CONTENTS.

THE Medical Practitioner

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

VOL. VII.] FEBRUARY 1936. [NO. 5

Original Articles

THE ACHLORHYDRIC SYNDROME.

BY

DR. A. SRINIVASAN M. R. C. P. (LOND.) M. R. C. S. (Eng).

The syndrome is not a disease or entity by itself but a functional disorder of the stomach either congenital or acquired. It makes itself evident by certain groups of unmistakable signs and symptoms. I selected the subject as it is a fairly common disorder among our middle-aged women, and is very often unsuspected for a variety of reasons, the most important of them being chronicity, mildness of symptoms and absence of any acute form.

Fractional analysis has come to the forefront after the discovery of invariable absence of HCL in pernicious anemia and its ally subacute combined degeneration. HCL is also absent in toxic and infective conditions such as syphilis, tuberculosis and typhoid fever. Recent researches have incriminated hypoacidity as one of the causes of asthma also. I do not want to go in for the other conditions associated with achlorhydria for want of space ; besides it is not the purpose of this article.

The syndrome can be brought under five major heads :—

GROUP I. GASTRO-INTESTINAL: The symptoms may be referable to the gastro-intestinal tract. A persistent and recurring diarrhoea with considerable loss of weight exhibits itself. The diarrhoea of pernicious anæmia also is due to want of HCL in the stomach and is not the outcome of anæmia. This absence of HCL may be a familial or acquired condition. In familial cases patients complain of abdominal symptoms from their infancy on and off. A number of observers have described cases of several members of the same family suffering from diarrhoea and other concomittant symptoms due to achlorhydria.

The severity of the diarrhoea is variable, from absolute troublesomeness to unnoticeability, so much so that some patients are able to recollect the presence of the symptom only when leading questions are put to them. Rarely it is accompanied by passage of blood and mucus. As a rule the stools are foul smelling and pale. There is a sense of fullness and oppression with epigastric discomfort soon after meals, however light they may be. Anorexia is marked in the morning and improves towards evening. Occasionally there is actual pain not unlike that of appendicular dyspepsia. Hæmatemesis has also been recorded in some cases. Patients are depressed, disinclined to work, neurotic and sleepless which may be due either to abdominal discomfort or diarrhœa or both. Palpitation and breathlessness are distressing at times. On the whole the patient becomes a chronic invalid and hypochondriac. Women patients may have irregular menstruation with or without menorrhagia.

Physical signs are vague and few. The abdominal wall is atonic and inelastic. The abdoman is full and tender all over mostly over the caecum and the descending colon. The liver and spleen are generally palpable

but occasionally the liver may be definitely enlarged. The complexion is pale. The tongue condition will form a separate group by itself.

Fractional gastric analysis shows complete absence of HCL or hypoacidity. Injection of 0.5 mg of histamine gives rise to no response at all in the majority of cases. Pepsin content is about 70 units, average being 250 to 500 units. The gastric juice is increased in viscosity. Mucus is generally present in plenty.

Achlorhydria is some times associated with diabetes and exophthalmic goitre. On such occasions treatment without the administration of HCL is bound to fail. The diarrhœa of Grave's disease is thought to be due to some toxicity. It is not so, as it is evident from the amelioration of the condition after treatment with HCL.

The absence of free acid, increased mucus content and rapid emptying rate surely indicate the pathological state of the stomach. This is consonant with gastritis.

THE PLUMMER VISION SYNDROME: Has this anything to do with achlorhydric syndrome? Except for the dysphagia other conditions like anæmia, atrophy of the mucosa of the tongue, pharynx, oesophagus, yellow complexion, Painful cracks and fissures at the angles of the mouth and nail changes are common to both. Obviously it is difficult to estimate HCL in the stomach but in a few cases wherein they were successful in doing it, the acid was found to be either deficient or completely absent even after injection of histamine. Treatment of this condition is almost the same as that of achlorhydric syndrome. Strictly speaking we ought to include this also under the above syndrome.

GROUP II. SORE TONGUE: This group includes people who complain of sore-tongue, ulceration of the mouth and painful cracks and fissures at the angles of the mouth. This syndrome exists either by itself or associated with gastric symptoms. There is well marked atrophic condition of the tongue-mucosa. In a few cases the tongue shows less marked changes but for the atrophy of the papillæ. The most constant appearance is a glazed tongue which is almost pathonomonic of the syndrome. It is intermittant but occasionally persistent even as long as 10 years.

GROUP III. DERMATOOSIS: Urticaria, dermatitis, herpetiformis, and angio neurotic-oedema are found together or separately in the patient. Kyle and Barber have described cases of acne rosacea with achlorhydria.

The nails are brittle and tend to split longitudinally. Sometimes they are spoon-shaped also Koilonychia. These nail changes are peculiar to the condition. This group proves the necessity for gastric analysis in skin diseases of unknown aetiology.

GROUP IV. SECONDARY ANAEMIA. Patients belonging to this group are recruited from middle aged women. They complain of emaciation, loss of appetite, lassitude, debility and pallor of the skin. The anæmia is marked during and after pregnancy and improves sometimes later. The average of RBC count is 3.9 millions. The usual changes of secondary anæmia are found. Witts has always found microcytosis. The haemoglobin ranges from 40 to 58 per cent. The lowest haemoglobin percentage recorded so far is 25 per cent and lowest RBC count 2.58 millions. The colour-index is below unity. WBC count ranges from 3000 to 5000 per cmm. There is no leuco-cytosis.

There is no evidence of heamolysis, for, the serum-bilirubin has always been low. Very often a diagnosis of tuberculosis or malignant disease is made. A thorough blood examination and fractional test meal give away the diagnosis. Sore-tongue is an additional factor to come to our rescue when in doubt. It is of value to remember that 75% of pthysical patients have achlorhydria.

The moment these patients are put on HCl and iron the improvement is dramatic. It is worth while to remember that large doses of iron are necessary. In doing so, we have to be on the look-out for 'iron encephalopathy'. Extracts of liver and stomach have no influence on this anaemia. As the HCl is to be continued for long periods, it may effect the teeth. The patients may be instructed to take it through a glass-tube.

CONTRIBUTORY FACTORS: The most outstanding factors are nutritional disorders and altered gastric secretion. Protein in-take is practically absent either because these patients are unable to take meat diet or they are unable to obtain on account of its expensiveness. Most of us live on cereals which have a notoriously small amount of iron. Iron will be utilised only when free HCL is present. Septic focus anywhere in the body will aggravate the condition.

There is no danger to life in the majority of cases but occasionally achlorhydria is the precursor of such serious conditions as sub-acute yellow atrophy of the liver, jaundice, hiccough etc.

DIFFERENTIAL DIAGNOSIS

	SIMPLE ACALORHYDRIA.	PERNICIOUS ANÆMIA.
Duration of anaemia.	Indefinite 5 to 10 years or more.	2 years maximum.
Gastro-intestinal symptoms.	Marked and long standing.	Not prominent.
Diet.	Abnormal for years.	Normal.
Tongue-mucosa	Atrophic changes constant.	Clean, atrophic changes less frequent.
Nails.	Changes common.	None.
Neural signs.	Uncommon.	Common.
Belirubinæmia.	Decreased.	Increased.
Gastric Secretion.	Achlorhydria.	Achylia.
RBC.	Not greatly reduced Microcytosis.	Macrocytosis.
Haemoglobin.	Relatively low.	Relatively high.
Colour index,	Below unity.	Above unity.

GROUP V. RHEUMATOID ARTHRITIS: The possibility of a stomach factor is to be borne in mind in the ætiology of every case of Rheumatoid Arthritis. A fair guess of deficient HCL can be made if sore-tongue and anæmia are also present in the patient. The joint condition improves markedly if the patient is put on HCL in addition to other suitable treatments. Probably the improvement is due to the bactericidal property of HCL.

CONCLUSION: The syndrome which presents a definite clinical picture appears to be common among us. The proportion of men to women is 1:3. The condition is familial or acquired. Probably the intestinal fermentation over many years and absence of the normal bactericidal action of HCL produce a pathological state in the body. The peculiar anæmia of this condition afflicts adult women. Iron is necessary in good quantity for its cure. This is utilised by the body only when enough HCL is present in the stomach.

The symptoms may occur either in combination or alone. The improvement by the administration of HCL is not uniform. Some improve sooner than others for no obvious reason. The Bio-chemist is much more helpful than the radiologist and his services ought to be more requisitioned.

PROTEIN DEFICIENCY IN CHILDREN.

BY

DR. T. V. MUTHUSWAMY CHETTIAR,
TIRUPPUR.

In a growing infant the lack of sufficient retention of nitrogen may give rise to protein deficiency. This may be due to either a deficiency in the protein intake or a deficiency in the total calories. This condition is characterised by such symptoms as under-nutrition, failure of growth and œdema. Though often due to a deficiency in the protein intake or a deficiency in the total calories, this condition may also be due to organic disease as Bright's disease.

ETIOLOGY: In a growing infant the protein deficiency in the diet may give rise to a negative nitrogen balance. As the retention of nitrogen is dependant upon the quality and quantity of the food protein, a level of intake which is sufficient with one protein may be insufficient with another type. Most proteins complement one another so that adequate nutrition may be obtained at a lower level of protein intake when two or more sources of protein are present in the diet than when only one source of protein is used. Thus only a comparatively small quantity of milk and eggs are necessary to make cereals and potatoes adequate even at a low protein intake. This indicates that the lower levels

of protein intake are probably adequate only when sufficient calories are taken. As such, protein deficiency often occurs in babies who are fed only on one source of protein i.e. breast milk with a low protein content or any artificial food with a low protein content. This is usually the case when the mother's milk is poor in quality or quantity or when the baby is fed on diluted cow's milk or artificial food for a long time.

Symptoms of protein deficiency are met with in the following conditions:-

(1) When the protein content of breast milk is too low.

(2) When the infant is fed on diluted cow's milk.

(3) When the infant is fed on a condensed milk food, protein contents of which are too low.

(4) When children are fed only on cereals for a long time.

(5) Starvation. In this state the proteins, fat and glycogen from the body stores are burned to supply energy.

(6) As a diet deficient in protein is often deficient in other respects, this condition is also met with in the course of dietary deficiency diseases, as, xerophthalmia, beriberi, scurvy, pellagra, and nutritional anæmia.

(7) As and when the proteins are not absorbed into the system as for example in cases of celiac disease and pancreatic insufficiency.

(8) When there is loss of nitrogen leading on to a reduction of protein as in chronic diarrhœa, diarrhœal diseases and dysentery.

(9) Factors affecting appetite as infections (acute or chronic) cardiac disease, nervous factors etc., contribute to the development of œdema.

Whatever may be the condition giving rise to œdema the actual cause for the appearance of œdema is a low serum protein in the blood.

SYMPTOMS ARE AS HEREUNDER :-(1) Cessation of growth, (2) Weight remains stationary, there being no increase in weight. But when the œdema appears there may be sudden increase in it. This, by itself could raise suspicion. (3) Oedema becomes manifest first in the ankles, and then in the leg and feet. (4) Face and throat appear wasted. There is increasing skin turgor leading on to puffiness about the face, pitting, oedema and ascites. (5) Oedema, when it becomes generalised makes the marked wasting of the subcutaneous fat; (6) In nutritional oedema due to the cause other than protein deficiency, the heart rate is apt to be slow; otherwise there is no abnormality in the heart rate. (7) As the result of inadequate intake of proteins and vitamin A, the resistance to infection is lowered. Due to this, in infants, death results from infections. (8) Sometimes, there is loss of hair and desquamation. (9) The length of time necessary to produce protein deficiency due to dietetic causes varies with the age of the child and diet. In older children it takes three or four months to develop. In infants it is less. In premature infants it may only be a few weeks. (10) Basal metabolic rate is lowered. (11) A moderate degree of secondary anæmia results. (12) The addition of salt to the diet increases the oedema. A low salt diet or a salt-free diet deters the development of the oedema. Diagnosis is made by (1) a history of oedema following under nutrition or a dietary deficiency. (2) Determination of serum protein concentration. If it is below 5% and if serum albumin is below 2.5% diagnosis is certain. (3) Determine co existing other dietary deficiency diseases. (4) Find out any cause other than a dietary difficiency which is likely to bring about this condition.

PROGNOSIS:—If the condition is by itself due to a protein deficiency, the prognosis is good as it can be easily and early corrected. Added co-existing infections make the prognosis grave.

TREATMENT:—Carbohydrate foods cause adequate nitrogen retention when whole boiled milk whole lactic acid milk etc., are given in adequate calories. So correct diet whole boiled milk with 8% carbohydrate or whole lactic acid milk or half-skimmed or half evaporated milk with 8% to 10% carbohydrates are suitable.

As this condition is frequently associated with vitamins deficiency add orange juice, cod or halibut liver oil, yeast etc., to diet. If there is no evidence of a vitamin deficiency stop giving these.

As patients are very reluctant to take a salt free diet and as with salt only they can take adequate diet, add salt to diet in very small quantities. To older children give vegetable dishes, liver extracts, eggs and chopped meat.

In anæmia give iron and liver preparations. In serious cases, give blood transfusions and glucose intravenous.

Co-existing infections and diseases as celiac disease, Bright's disease etc., to be treated accordingly.

Abstracts

Crossed Eyes: Their Cure Without Operation.

HARRY VANDERBILT WURDEMANN, M. D., Sc. D., F. A. C. S.
Seattle, Wash.

In the yearly part of 1929 the author gave an address on a similar subject which, perhaps from its intriguing title, gave rise to much comment and correspondence and in a manner called the attention of the general profession and parents of strabismic children to the advisability or early attention and prevention of this optical and cosmetic defect.

While the main facts in that essay and in this are matters of common knowledge with ophthalmologists, there yet remains with the family doctors and the public the idea that squint in small children may be neglected until school age. Hence one can hardly walk along the street without noticing a number of people whose eyes are not straight!

I desire here to amplify with some modern modifications my experience in dealing with strabismus cases during the past 45 years, with the hope that the auditors and readers of this paper may personally give wider publicity to the early care of strabismic cases.

Hence I will briefly go into the physiologic factors entering into binocular vision and the causation of strabismus.

The visal act is of threefold nature: muscular, consisting of accommodation and ocular rotations, which are coordinated movements in biseeing eyes; physiologic, mechanical in the formation of the retinal images; physio-chemical in excitation of the retinal elements, and physioelectrical in the nerve excitations; then mental, with the brain views blended into one image and received, perceived and evaluated by the sensorium in their relations to the outer world.

All animals are born mentally blind and the human infant is no exception. Some, as the felidae, marsupials, and the rodentia, do not open their eyelids for days and weeks after birth. The ego of the animal must learn what the physical images cast upon the retina mean before sight really exists. The function of binocular vision in the human and the apes is achieved later, for, it takes time to synchronize the twelve muscles which move the eyeballs and their cerebral centres to work as a trained team.

We now refer briefly to the physiologic development of binocular vision:

While a newborn baby sees light and movement immediately, the new world is all a blur to him and the knowledge that he can see is not appreciated until mental vision is developed which is after three months of age; that is, the child does not recognize objects or individuals, events, mother, until that age. Both eyes are not used together until about this age, when coordination of accommodation and convergence occurs with correlation of the mental images to the outside world. The fond mother imagines her baby recognizes her face but what baby sees is just a blur, movements of large objects, and perhaps colors. All this means that babies under three months do not have straight eyes and they don't clearly perceive objects until this age, and that if the faculty of seeing with both eyes at once is not then developed, they squint and ultimately lose the sight of the crooked eye.

Any obstruction to vision, inequality of accommodation or action of the recti, interferes with the coordination of action of the two eyeballs and affects the mental perception so that fusion or binocular images is not produced. There being no general to coordinate the brigades, anarchy occurs and the strongest prevails, the other eye turning in, out, up, or down, producing strabismus, which is generally inwards. The deviating eye suspends vision from time to time, suspensopsia, and after a while is forgotten by the sensorium, losing more

and more vision ; the condition of amblyopia ex anopsia.

The two important functions in vision are :

1. Accurate vision with each eye, and

2. The ability to see with both eyes together.

The former is acquired early, the latter late, and under adverse conditions; the latest function being usually the earliest lost.

The most frequent cause of deviation is a large error of refraction, in which any cause reducing the bodily resistance, as measles, whooping cough or other illness, affects the subconscious mind of the child, when it finds difficulty in seeing, and cannot make the extra effort for coordination with concomitant movements and parallelism of the globes in all directions. So efforts at fusion, which is a congenital faculty, are abandoned; the better eye wins out and the other usually turns in. Hence the development of squint is usually ascribed by the parents to whooping cough, measles, and so forth. If both eyes have almost the same acuity and refraction, the eyes may alternate in use.

Approximately the prism degrees of convergence are thrice the diopters of accommodation. Therefore, if a child starts out with 5 D. of hyperopia, it has to accommodate this much for distance and with this would go thrice the amount of convergence and then would, if it were not corrected by dissociation, squint 15 degrees. Then, as we have two eyes, and at first the image of each is perceived by the brain, double vision occurs. When one eye is more hyperopic than the other, the image of the non-fixing eye is not only focussed but is at first seen but not perceived, as a smaller and blurred image which is confusing and which nature does not like, and hence pulls the weaker eye further out of the way, making a secondary deviation of greater degree. Thus the image seen by the poorer eye is subordinated by the sensorium so that ultimately double images are not produced. Hence the failure to develop binocular vision in later life. The primary deviation is always in both eyes, and both eyes squint, so that when operation is needed it is usually necessary to operate on both eyes. Of course, there are other causes of squint, but this statement takes care of the usual cases.

Every oculist is constantly told by parents or patients that their family physician had advised waiting for glasses and operation until the child had reached school age, or even till he was fourteen or fifteen years of age ; that be might "grow out of it." Yes, I have seen a few, but very few, who squinted in youth and had straight eyes in adult life without any treatment. I am convinced that these were not real strabismus cases but were probably ones of partial paralysis of the externi, whose centers and nerves are most vulnerable to toxemias of disease.

Cross-eyed and wall-eyed people are materially handicapped. Besides being only one eyed, the cosmetic defect has a deleterious effect upon their social and mental development and in later life interferes with their love affair and their business. For what man likes to look into the eyes of a cock-eyed maid or who wants to do business with a man who does not look one squarely in the eyes ? Therefore, squint should be prevented, and if the eyes do not function together they should be straightened, and it can be done in almost all cases.

The first step in treatment is to treat the parents. Tell them what can be done and what can not. Explain that the usual case should have the refraction measured, lenses prescribed, and that glasses should be worn all the time and ocular exercises, etc., should be continued for at least six months ; that all eyes can be straightened and that they must be not only for cosmetic reasons, but in order to preserve the sight. Equalization of the sizes of images in so-called "anisokonia" is corrected by ordinary lenses needing so special training apparatus.

Insist that orthoptic treatment and lenses first be tried before any recourse is had to operation, and even in these it is to be continued until stereoscopic vision is established. It is indeed unfortunate that while orthoptic treatment by various means had been known for many years that it is and was neglected by those oculists who have an idee fixe for operations. McKenzie, in 1856, was the first to use the stereoscope in the treatment of strabismus, followed by Javal in 1863, and von Graefe finally expressed the opinion that "these people were not

worth while"and, "Time and patience beyond all reason were required." It went into disuse, but for the last 20 years has been again recognized. Cantonnet and Filliozat recently expressed the opinion that 70% can be straightened by orthopsis, and I agree. It has been so exploited by so-called optometrists, to its detriment.

The procedure in the average case is as follows: Atropin and glasses at once Then after two years of age, exercises with the Worth-Black amblyoscope, a stereoscope with movable sides, in the doctor's office, and a number of exercising instruments, such as Maddox synoptoscope, the Pugh orthoscope, and the Sheila-Mayon strabismoscope. The colored Kroll's charts for very young children and the Hamblin's charts with the stereoscope for older ones at home will, with corrected refraction, in nine cases out of ten straighten the eyes within a few weeks.

These methods relieve excessive accommodation, get clear images in both eyes by glasses and excite the fusion center to work by the development, first, of double images, and then fusion into the single image of normal vision. By these we develop the sensation of depth and full binocular vision. This can be done usually up to the sixth year, after that but seldom, and practically never after adolescence. Still I have had successful cases in adults.

I have seen radical squints immediately disappear under atropinization at once or soon after wearing correcting lenses, during one visit with the Worth amblyoscope, and shortly after beginning the stereoscopic exercises.

Occlusion of the better eye for two hours morning and afternoon aids the amblyopic eye's vision, but constant occlusion may cause amblyopia and deviation and would be more likely to cause a persistence of the squint. These methods involving occlusion of the better eye are of little avail. An exercise for amblyopia may likewise be given by the test letters, the patient gradually increasing his distance away from the letters as he perceives them better. Operation is unnecessary in the early stages, in fact, seldom under the fifth year of life.

Cases that come to operation in the third to eighth year of life sometimes achieve normal stereoscopic vision but after this age all we can expect is a fairly good cosmetic result with the expectation that later in life a relapse or an overeffect may be the result of all our work. An overcorrection by operation should never be made. Always leave a little of the original deviation ; rather advance or make stronger the so-called weaker muscle and avoid the calumny later in life of being accused of having made your patient "wall-eyed."

Do not allow yourself to operate until sufficient orthoptic treatment has been given.

The treatment of squint be given as early as it is observed. Most cases are straightened by lenses and orthoptic exercises. All cock-eyes can be cosmetically cured. Get them early and get results.

Start the treatment of strabismus as soon as deviation is noted after three months of age; you can safely expect straight eyes with binocular vision without recourse to operation in practically all cases although you cannot "guarantee" a cure in any instance, but wait a few years and you can promise nothing but an approximate cosmetic correction with one poor-seeing eye.

The Eye, Ear, Nose and Throat Monthly
September, 1935.

Notes on Therapeutics, Diagnosis and other Medical Subjects.

Eczema of Children

By

SAMUEL L. BAUER, M.D.,
Cincinnati, Ohio.

Numerous classifications of eczema have been made depending on the characteristics of the lesions, their situation, their duration and the like. None of these classifications can be well applied to early life, since lesions of different types may occur in the same patient.

In general, the situation in infants is oftenest the face or head, which may be completely or partially covered.The favourite regions next to the head are the genitals, folds of the joints, breast, abdomen and back.

Much less often the eczema is universal in distribution.

In older children there is much less tendency to involve the face, the flexures of the joints being the favourite seats.

The disease usually makes its appearance between the tenth week and sixth month of life, though it may come on shortly after birth or not show itself until after the first year.

The disease is fairly common in infancy, the figures showing that from three to seven per cent of infants in the United States suffer from the ailment in mild or severe form. Bivings, in a group of 989 infants under one year of age, found sixty cases of eczema in varying severity showing about six per cent of individuals in the group suffering from the disease.

The etiology of the disease has long been a perplexing problem to the medical profession. The classification of infantile eczema as a manifestation of allergy has done much to simplify this difficult problem. While many of the cases are still baffling, especially those which have become chronic, knowledge of the more common etiological factors makes the study less complicated and has placed treatment on a more rational basis.

Hill believes that approximately two-thirds of all infantile eczemas are allergic in origin.

Balyeat, in a group of 181 eczematous infants, was able to find a positive family history of allergy in 76.6 per cent of the cases. O'Keefe and Packman find only a 28 per cent allergic family history in 212 cases, but Bivings in 157 cases was able to discover a 69 per cent allergic family history. Our own experience in a relatively small group, 40 cases in the allergy clinic at the Children's Hospital, 32 cases, or approximately 80 per cent, give a positive allergic family history: likewise in 78 cases of bronchial asthma we were able to obtain a history of eczema in infancy, approximately 62 per cent, or 48 cases.

The clinical diagnosis of infantile eczema is often very difficult to make and confusion of this condition with seborreahic dermatitis, impetigo, scabies, ichythosis, is often the cause of disappointing results in treatment.

The eczematous infant usually exhibits an eosinophilia in its blood picture. Levi and Dumas believed they found a hypoprotenemia in these children. Faber and Roberts report a high albumin and low globulin with a consequent high albumin globulin ratio in the blood. They likewise report an instability in the cholesterol metabolism, over half of their cases showing 200 mgs.% and others being very low.

A basal metabolic rate of minus 3 to minus 7 is usually found in these infants.

Kammer calls attention to the seasonal occurrence of infantile eczema, stating that most children over three years of age exhibit the eczema mostly during the months from December to April, while younger children show the disease throughout the entire year.

The treatment of infantile eczema must be divided into two parts: First, the local treatment; and secondly, the determination of the underlying cause.

In the local treatment, the use of some type of ointment or lotion to allay itching is of great value. Many different types have been used. Some of the more common are: Tar ointments in varying strengths, resorcinol in combination with zinc oxide, lanolin and calomine either as an ointment or a lotion.

Preventing the young infant from scratching by means of some type of mechanical restraint is of importance and reduces the danger of secondary infection.

The treatment of any secondary infection present is likewise of importance. In this connection Hill warns against secondary infection with monelia albicans and related fungi, having found a positive skin test to monelia albicans in 8 per cent of eczematous children, and in only 2 per cent of normal children.

Schwartz feels that no matter how severe the eczematous eruption is, the eczematous child should not be hospitalized because of his lowered resistance, and the frequency with which he contracts some type of infection present in the institution to which he is sent, no matter what isolation precautions are taken. While it is probably true that the lowered resistance of the eczematous child makes him more prone to contract an infection with which he has been brought in contact, the impracticability of home treatment will often show itself after one has undertaken treatment of a severe eczematous eruption.

In the search for the underlying cause of eczema in the infant and young child, the protein skin tests are of great value. These are done on the young child by the scratch or cutaneous method, as the skin of a patient of this age reacts more readily than does that of the adult. In the infant the positive reaction does not, as a rule, form a wheal, but merely an area of erythema following the application of the antigen. It is inadvisable to use the intracutaneous method of testing in the infant and the young child because false positives are frequently obtained in this age of patient, and because of the ever present danger of a severe local and even focal reaction.

In the young infant, the number of skin tests necessary to cover the diet are few. In the older child this becomes more of a problem. As it is a totally impractical to try to test the older child to his complete diet at one time, we have made an arbitrary list of foods, thirty in number, which will form the basis of a good diet. The child is skin tested to these foods at the first visit, and usually to cotton, linen, wool and silk. As the need arises, the child is tested to other foods and to other proteins as thought indicated, at later visits.

The patient may have any food to which he has been skin tested and found negative, but must not take any food to which he has not been skin tested, or to which he has reacted.

Some of the more common offenders in the foods are milk, eggs, cereals, oranges and tomatoes Milk and eggs are the chief offenders in this, but should not be dropped from the diet arbitrarily until they have been proved by skin test to be the cause of the trouble.

In a series of cases, 109 in number, milk accounted for 75 per cent of the positive reactions obtained.

Vaughn and Ellis have found an interesting point which they term "group sensitivity." It is, namely, that if a child is sensitive to cows' milk and gives a positive skin reaction to it, he will probably be sensitive to goats' milk, or milk from any other source, even though his skin reaction is negative.

In a cases where a patient is sensitive to a food, elimination of that food from the diet is the solution to the problem. Attempts at desensitization by the means of propeptones and the like have not been particularly successful.

Milk substitutes, such as soy bean flour, or the milk, egg and cereal free diet suggested by Cohen and associates, may be used in the diet of an infant where it is necessary to eliminate milk.

It must be borne in mind that a patient may be sensitive to more than one food, or may be sensitive to a food only in combination with another food. Thus a child may not be sensitive to milk or wheat alone, but when given a combination of a wheat cereal and milk may show a definite reaction.

In some cases, even after a careful study of the diet and other likely offenders in the patient's environment, the eczema will continue unchanged. It is of value then to study the bacterial flora of the intestinal tract, the nose and throat, and skin. These may be cultured and the patient's skin tested to the individual organism, and if found positive given an autogenous vaccine composed of those organisms to which he reacts. I suggest this type of treatment only after all other factors have been carefully ruled out, and know that much has been said and written both for and against it. My own experience has been with a series of cases, only ten in number, which we have followed in the allergy clinic at the Children's Hospital for the past year and a half. These children were all above two years of age, which is the age where eczema will often clear up spontaneously. They did not react to any food, clothing, or protein in their environment. They did react, however, to certain bacterial cultures obtained from the nose, throat and stool. They were given an autogenous vaccine for a period of three months. At the present, six of these children are entirely free of eczema and have been so for the past fifteen months. One is improved and three entirely unaffected.

While in many respects our knowledge of the basic nature of this common and distressing disorder remains defective, that a state of allergy exists in most cases seems fairly well established and we seem to have made some progress in the right direction.

The Journal of Medicine 19th September, 1935.

The Psychology of Local Anesthesia.

To operate under local anesthesia is a psychological problem. It cannot be successfully done unless the surgeon has both the anesthetic and the patient under his control. The control of the anesthetic is, of course, a technical matter complicated somewhat, to be sure, by the patient's toleration, idiosyncrasies, reactions, etc., which however, are more or less objective considerations. The control of the patient, on the other hand, is a purely psychological affair, both on the part of the surgeon and on that of the patient.

If a surgeon cannot control his patient under local anesthesia it is no good his trying to operate by this method. It is rarely indeed that a complete elimination of pain can be guaranteed by any form of local anesthesia; at any rate by any that are available to the eye, ear, nose and throat surgeon. The best that can be done, as a rule, is to so obtund the pain, and reduce it to a minimum, as to render the procedure fairly comfortable or bearable to the patient, and to enable the operator to work freely and effectively. Under these circumstances the nervous reaction of the patient becomes an important factor in the situation; and while patients differ considerably in their nervous reactions all are to some degree nervous, and all require some degree of psychological control at the hands of the surgeon.

Much of this control rests with the surgeon's personality; but much of it also lies in the observance of certain general rules. Gentleness, to be sure, should be observed in operating under any kind of anesthesia, general or local. But under local anesthesia it must be extended to a very personal quality of gentleness. Deliberateness and confidence, which may simply exist in the case of general anesthesia, must be positively exhibited in local anesthesia operations, where the patient is susceptible to such impressions. Quietude is another essential. Under general anesthesia this is not so essential, and we rather suspect that surgeons who are in the habit of operating under general anesthesia acquire a habit, as do also the attendants, of talking freely, and otherwise "letting themselves go," so that when they come to operate under local anesthesia they forget the patient's open ears and conscious sensibilities.

The success of local anesthesia depends to a very large extent upon these elements of personal control. The head surgeon will do well to impress upon himself the dictum with which this little preachment began, that to operate under local anesthesia is a psychological problem. He is, of all surgeons, the one who does most operative work with this kind of anesthesia.

The Eye, Ear, Nose and Throat Monthly
September, 1935.

Adrenalin in Glaucoma

From "Therapeutic Notes" May, 1935. "To reduce intra ocular tension in acute glaucoma S. R. Gifford, M. D., of Chicago, advises (Canad. Med. Assn. J., March, 1935) the addition of 4 minims of 1:1000 adrenalin to 1.5 cc. of 4% novocaine solution in the syringe. Quoting from Dr. Gifford's paper: "The value of adrenalin in glaucoma has been brought out chiefly by the work of Hamburger since 1923. While 1:1000 adrenalin by instillation showed no dependable effect on tension, he found that subconjunctival injection of 4 minims of the 1:1000 solution caused a marked fall in tension of most patients It was accompanied by mydriasis, but occured to an equal decree when mydriasis was prevented. A sharp rise of systemic blood pressure followed such injections, and in some cases this caused faintness or even collapse.

"Gradle showed that when 4 minims of ordinary 1:1000 adrenalin are placed on a cotton pledget in the upper fold for four minutes enough absorption occurs to produce an effect similar to that of a sub-conjunctival injection. In my experience such an adrenalin pack does produce almost, if not quite, as marked an effect as injection. A few cases were unaffected by adrenalin, and where one attempt has failed nothing is to be gained by further attempts. The principle indication for adrenalin is in chronic simple glaucoma.

"I agree with Vannas that adrenalin is contra indicated in types of glaucoma accompanied by inflammation. In glaucoma following cataract operation or discision, however, the same objection does not seem to hold, and I have seen a number of such cases in which adrenalin has controlled the tension until normal drainage was re-established without operative interference.

"Even in chronic simple glaucoma there is some danger that an acute rise of tension may occur following adrenalin. Apparently the mydriasis which occurs at first is the cause of this, converting the slight primary rise of tension which is normal into a marked one. I have seen this occur in several cases, and now always precede adrenalin by 3 drops of 0.2 per cent eserin at 10 minute intervals before a treatment and one drop every half hour for the next two hours, or long enough to keep mydriasis from occuring. The danger seems to be over in six to eight hours.

"As an adjunct to miottics in cases almost but not quite controlled by them, certainly adrenalin has shown itself of very great value. The same cannot be said of other proposed therapeutic measures in this type of glaucoma."

The Eye, Ear, Nose and Throat Monthly,
July, 1935.

MADRAS MEDICAL COLLEGE STUDENTS' HOSTEL.

ANNUAL DAY.

24-2-1936

MAJOR MCROBERT'S ADDRESS.

Col. Newcomb, Mr. Principal, Fellow students of medicine,

Having refused the honour of addressing the assembled students on several previous occasions, I consented to do so to-night with a good deal of misgiving as I cannot claim the longstanding intimate knowledge of student life in South India possessed by Col. Newcomb, nor am I a silver-tongued orator like Dr. Lakshmanaswami Mudaliar who addressed you last year.

In approaching me, your representative asked for words of advice to the student body.

Now I have an innate horror of the usual type of platitudinous utterance of the senior official who begins with a reference to the nobility of your chosen profession and then proceeds to urge you to devote your lives to almost gratuitous work in remote mofussil villages far removed from all the amenities of life to which you are accustomed.

But what else can an official say? Ours is a Government college, staffed by civil servants and we are bound almost to silence by government rules and by ordinary decency which prevents the employee from criticizing his employers in public places.

I should have liked to have been able to say "work hard, be conscientious in your studies, for the rewards are for the ablest and the best among you"—but I am afraid that I could not say that with complete honesty, though I hope that someday in the future, a time will come when capability will count more than caste and brains come before birthplace as recommendations for appointments.

I feel however that there are a few points which I may usefully touch upon without encroaching on forbidden ground.

In the first place I would urge you to cultivate friendship with fellow students over as wide a field as possible, not restricting your intimacy to devotees of medicine but mingling and exchanging views with members of all the faculties and also with men and women outside university circles.

One of the great dangers of life in a hostel, is its tendency to seclusion of its occupants from other members of society and the danger is especially great in a hostel of this type restricted to one class of professional student.

Coming as I have recently from a sister university on the other side of the Bay, where all undergraduates live in Hall but where segregation by faculties is not allowed, I am not too keen on the growth of any isolationist movement for medical students, though any hostel even a purely medical one, is better than the ill-lit and badly ventilated lodgings in which some of you have perforce to exist.

With these reservations I join heartily in congratulating the founders and committee of Jaya Mansion hostel on the success of their efforts and on their praiseworthy enterprise, and I earnestly hope that the students of Madras college will continue to press strongly through the proper channels for the provision of wholesome sanitary residential accommodation for every student—man and woman alike.

My next word of advice is with regard to your attitude towards criticism. I would urge you to try to cultivate a sense of humour and of tolerance of criticism.

It is exceedingly painful for a teacher who has made what appears to him at any rate to be an amusing remark or a mild and harmless joke at the expense of an erring member of his class or clinic to have the

same taken as a slight or even as an insult.

On more than one occasion I have been met by a student who asked forgiveness for having incurred the evident displeasure of his teacher, who had completely forgotten the incident beyond recall.

Do not be ready therefore to take offence lightly nor to look for slights where nothing but harmless and entirely friendly comment or criticism is intended.

Another and even more important admonition is—Cultivate your sense of humanity.

Reasons given by students for entering the profession of medicine are numerous and varied. Its much vaunted nobility may call to some, to many it appeals as the most interesting of all the professions, always improving and steadily advancing; but to most it attracts as a safe means of proving a reasonable remunerative mode of living. Whatever may be the motive which brings us into the profession, we early find ourselves in a position greatly to assist and to benefit our fellow human beings and one of the great joys of practice in the tropics, is the large proportion of patients to whom one can give real relief, whom one can literally snatch out of very jaws of death.

There is however the very real danger which we must fight against from our earliest clinical days—the danger of regarding patients as cases and not as fellow human beings in distress.

Those of you who work in my clinic know that the favourite method of approach to treatment is "what would you recommend if this were your own father, would you advice operation if this were your brother", and so on.

I would therefore appeal to you from the earliest stages of your medical studies to regard with special care those poor illiterate people who have sufficient trust in our medical science to offer their bodies for our ministrations and manipulations against their ancient traditions and against the wishes and advice of their relatives and friends, and to help them as much as possible in hospitals where daily so many wander bewildered about the corridors with admission tickets looking almost in vain for some mysterious person designated H A to S-1, R. M. O-2, etc.

I would emphasize also the necessity for the development of a public health outlook. The role of the private practitioner in this country is still mainly confined to treatment of individual patients to the neglect of prevention of spread of disease and I have been greatly shocked both in hospital and outside to find evidence of enteric spreading gradually through household after household without any adequate measures having been taken to apply the simplest rules of hygiene and preventive inoculation to obviate spread of the disease.

With regard to examinations, I should like to say that so far as I have been able to ascertain after careful and painstaking study, the element of luck is almost entirely absent from the final M. B. B. S. examination.

I have been assured by students that they have failed by bad luck but the system which we have adopted of multiple examiners working in pairs, asking simple but important questions only, practically rules out the possibility of failure of a student who knows his subject reasonably well.

The object of the examiner is neither to pass nor to fail. He is an agent of the great Indian public to whom he guarantees that those who leave the portals of the College may reasonably and safely be consulted as having a good grasp of the elementary principles of their profession.

No amount of theoretical knowledge will make up for obvious lack of familiarity with clinical examination of patients; the regular burning of the midnight oil will not make up for lack of experience in the use of the stethoscope or the fingers, and I can assure you that there would be a higher percentage of passes in Medicine at any rate if less time were spent listening to teachers and more devoted to examination of patients.

In conclusion may I quote the lines of my late colleague, Lieut. Col. J. W. Jones, I. M. S. of Rangoon:

If you want to tell the bison from the elephant or cow
The adder from the python or the sambhur from the sow
You don't swot up long descriptions in a scientific book
You pay your entrance at the Zoo and go and have a look.
If you want to learn your life work and to know about disease
You may listen to your lecturers or not, just as you please,
By all means read and learn it up, but take a tip from me,
Go and walk the hospital—it beats the zoo—its free ! !

CLINICAL NOTES AND PRACTICAL SUGGESTIONS.

Treatment of Diabetes.

A substantial majority of cases of diabetes mellitus encountered in general practice are of the mild or the moderate variety and are mostly amenable to regular treatment which does not necessitate any hypodermic or intravenous injections. Diabetes is primarily a disease of carbohydrate metabolism. The immediate cause of the disease in most of the cases is undue strain on the functional capacity of the pancreas due to overfeeding and the consequent excess of weight. Any treatment therefore should aim at reducing the strain upon the pancreatic function to a minimum and in controlling the several phases of diabetic pathology and defective carbohydrate storage. This can be achieved by Pancrepatine which is administered orally.

Pancrepatine contains pancreatic and hepatic extracts which are active in maintaining normal carbohydrate metabolism. It has a vegetable gluten coating which protects the Opocrin from any inactivating effects of gastric digestion and it enters the intestines where it delivers the active pancreatic extracts contained in it. Pancrepatine supplies the necessary internal secretory substances which are elaborated by the organism for regulating the carbohydrate metabolism. Due to active extracts contained in it Pancrepatine retards the abnormal formation sugar from Glycogen and favours the formation and storage of glycogen from sugar in the liver and muscles. This effect consists in reduction of sugar as is evidenced by the sugar level in the urine and the blood. It exercises a potent effect in the organism which prevents rapid breakdown of stored glycogen into blood-sugar. It supplies the special pancreas proteins and amino-acid complexes and this exerts a regenerative effect on the defective pancreatic tissue. Hence it is a valuable therapeutic agent for routine treatment of diabetes.

The value of insulin in the treatment of diabetes mellitus cannot be doubted or belittled and in cases of severe diabetes we have no other alternative but to have recourse to these injections. Insulin, however, shows great imperfections and there is no evidence that its continued administration effects permanent increase in the carbohydrate tolerance or capacity of the organism for utilising the sugar intake. Besides, Insulin is a powerful drug which cannot be given orally. It must be administered hypodermically or intravenously. In overdosage it gives rise to violent symptoms such as convulsions, hypoglycemia, etc. Insulin administration requires constant observation by the physician. It has, however, a definite place in therapy, especially in severe and complicated cases of diabetes. For the treatment of coma, acidosis, diabetic gangrene, insulin injections are absolutely necessary, but for the routine treatment of the mild or moderate type which drags on for years oral administration of Pancrepatine is the only satisfactory method which can be carried out at home without any necessity of medical supervision. Pancrepatine assists utilisation of sugar by the organism. It depresses a relative adrenal hyperfunction, diminishes polyuria, lessens glycosuria and in many causes its entire disappearance. It effects remarkable improvement in the subjective symptoms of diabetes and reestablishes normal carbohydrate metabolism. Under Pancrepatine regime the dietetic restrictions are less rigid and due to the increase in the internal secretion of the pancreas the carbohydrate tolerance is raised more rapidly.

In any form of diabetic therapy the most important fact to be borne in mind is about dietary measures. There is hardly any treatment which can do away with these. Treatment with Pancrepatine has simplified to a great extent these measures and has reduced the rigours and the privations which a diabetic patient had formerly to adhere to. Pancrepatine treatment enables the diabetic to take sufficient calories to meet his needs of nutrition and to increase his tolerance so that he can digest most of the food taken.

In mild cases of Diabetes routine treatment with Pancrepatine with dietetic measures is generally sufficient. If after the tolerance examination we find that the patient is not satisfied there should be a gradual increase in the diet until the patient gets enough. At this time the dosage of Pancrepatine should be increased a little. Usually 8 globules are given daily but there is no harm in increasing the dosage to 12 or even 16. Insulin treatment in these cases is quite unnecessary.

Treatment of moderate and severe form of diabetes should be invariably commenced with Insulin administration, but later Pancrepatine globules can be given Insulin administration should not be stopped too suddenly but should be gradually decreased. Pancrepatine should be given after this. Urine control is necessary during this period.

The large majority of cases of infantile diabetes are of the severe type and must necessarily be treated with Insulin. Some, however, have found Pancrepatine equally satisfactory in such cases as with this form of therapy the Hypoglycemia so easily induced in infants can be avoided without difficulty. Pancrepatine treatment in cases of children needs no regular attendance or vast experience.

In the complications of diabetes, especially surgical, insulin therapy is absolutely essential. In these cases insulin can be successfully combined with Pancrepatine which very often prevents such recurrences in future. This is due to the fact that Pancrepatine is able to restore the damaged pancreas to its normal condition and to repair the affected tissues by means of the extracts contained in it.

The general pathology of diabetes mellitus points out that there are abnormalities in the functions of the liver and disturbances in the secretions of the pancreas, and these are often associated with faulty digestion and defective absorption in the stomach and intestines. When these facts are taken into account, the exhibition of Pancrepatine in these cases is quite rational. It is a potent pancreatic and hepatic product which is prepared in such a way that all the active elements and enzymes, are fully utilised by the organism. It is effectively absorbed when given orally, it lowers blood-sugar, increases glycogen storage and combustion of sugar. Further, it is well-known that in most of the cases of diabetes Mellitus insulin alone is not sufficient to maintain normal metabolism, but a supplementary treatment like Pancrepatine is necessary to establish and to keep up normal metabolism.

Pancrepatine, in short, has been found of greatest therapeutic value because its action consists in helping the regeneration of the patients deficient insular apparatus and in providing those principles which are lacking in the diabetic. It supplies the organism with the deficient pancreatic ferments as well as the enzymes, with the help of which the disordered digestion is regulated. It considerably influences sugar tolerance and tends to increase the tolerance for digestion. Thus it diminishes the sensation for thirst, increases the appetite and prevents troublesome complications and sequelae. By favourably influencing digestion it improves both the physical and psychical aspect of the general condition.

Pancrepatine fully meets the usual needs in the majority of cases of diabetes which the general practitioner comes across. It offers many remarkable advantages on account of which it has gained preference over other similar products. They are :—

1. Pancrepatine is an effective preparation which can be taken orally and which displaces disagreeable injections and does away with constant medical supervision.

2. Even when taken for unlimited periods it causes no harmful secondary effects and it is perfectly assimilated by the system.

3. Pancrepatine need not be dosed individually as the reduction in sugar formation is uniform and fairly regular.

4. It regulates metabolic processes which are usually disturbed in diabetics.

From all this we can conclude that Pancrepatine is a dependable and quite a necessary part of the routine treatment of diabetes mellitus.

A case report :

A Hindu patient of about 50 weighing 147 pounds came to consult me about frequency of micturition at night, great thirst, ravenous appetite and lassitude. He was a well-built man, but he looked distinctly ill. Examination of the urine revealed the presence of sugar and laboratory estimation showed it to be 1.48 per cent. Liver was slightly enlarged but the spleen was not palpable. On auscultation the first sound was found to be a little accentuated. He usually suffered from constipation. Diagnosing this as Diabetes Mellitus he was put on Pancrepatine treatment and his diet was restricted to about 1200 calories per day. He took 2 globules four times daily, before food. The reduction in urine and sugar was not much evident during the first week, nor was there any amelioration in other symptoms. The dosage in the next week was increased to 12 globules per day. In the third week however he felt better and thirst and constipation improved much. He voided less urine and the sugar percentage was reduced to 8. The patient continued taking only Pancrepatine treatment and a week after the sugar percentage was only 2. The patient was very much better after this and his weight was reduced to 130 pounds. After about five weeks the urine was completely free from sugar and subsequent to this he had his usual diet. After exactly two months the patient felt perfectly fit, but was still continuing the treatment, 4 globules per day.

Bacillary Dysentery and its treatment.

In India although amoebic dysentery is widely prevalent, the Bacillary type is by no means uncommon. Before instituting the right line of treatment one should therefore make sure whether one is dealing with the amœbic or the bacillary form of dysentery.

Bacillary desentery is caused by different kinds of bacilli amongst which B. Dysenteraiae Shiga seems to be the most important. These bacilli are usually detected in the stools, intestinal ulcers and lymph nodules of the mesentery and very rarely in the blood or the urine. The next common bacilli which give rise to this form of dysentery are Flexner's bacilli. This bacillus, it is supposed, causes only a mild form of bacillary dysentery because it forms only occasionally some soluble poisons which are of very low toxicity. It is however difficult to distinguish clinically and pathologically these various types of dysenteric manifestations caused by these different bacilli

These bacillli enter the system probably through drinking water We must at the same time not forget the fact that infection due to contact plays an important role. Chronic bacilli carriers are a source of danger to people amongst whom they move.

The pathological anatomy in bacillary dysentery is typical. These bacilli, Shiga's or Flexner's, penetrate into the mucous membrane of the intestines, where they cause a spreading necrosis of the superficial epithelium. There forms on this exposed surface a fibrinous exudate which when removed leaves behind a superficial ulcer. These ulcers soon coalesce with the neighbouring ones. The intestinal wall becomes oedematous and this inflammation may reach right into the serosa.

As regards the clinical picture diarrhoea is the most predominant symptom that comes to our notice. At the outset there might be 6 to 7 motions per day, but later the number increases so rapidly that as many as 60 stools are passed every day. There is severe tenesmus and the stools are often preceded by colicky pains, especially in the region of the sigmoid flexure. The stools mostly consist of sero-mucus fluid streaked with blood and mixed with pieces of necrotic mucosa. These stools have a characteristic odour and in severe gangrenous forms they have quite an unpleasant smell. The abdomen is rigid and tender along the course of the colon. There is complete loss of appetite. The tongue is dry and coated and the patient complains of intense thirst due to serious loss of water. The eyes are sunken and the heart is very weak. As a result the patient feels much debilitated and exhausted. In this type of dysentery temperature is usually present but it seldom rises above 102o. There is nothing unusual in the blood-picture except a slight rise in the number of leucocytes.

Recovery starts, if everything goes well in about ten days' time. The number of stools is lessened and they assume a faeculent character. Under certain circumstances and under inadequate treatment the acute symptoms become chronic and the patient thus suffers for a long time, sometimes for years.

Complications in this type of dysentery are rare. There is what is known as dysenteric arthritis which may attack one or more joints. Another complication is nephritis which is rather uncommon. Perforation due to to these dysenteric ulcers is very rare. This type of dysentery seldom gives rise to liver abscess.

Bacillary dysentery has to be diagnosed from the amoebic variety by the type of stools present. The stools in acute bacillary dysentery are generally a mixture of mucus and blood. The mucus is of whitish or yellowish colour and the blood appears separate and is clear red. In amoebic dysentery the mucus is clear and transparent with admixture of blood. Seen under the microscope the cloudy mucus of bacillary dysentery shows a vast number of leucocytes. These are very few in the clear mucus of amœbic dysentery. The amœbic stools contain Charcot-Leydon crystals, which are

absent in those of bacillary dysentery. Temperature is usually present in the bacillary type but it is always absent in the amoebic one. All these points render differential diagnosis easy.

Treatment should be started as soon as the symptoms become manifest. The patient must be kept as warm as possible, warm abdominal compresses being employed for this purpose. As regards nourishment they should be given only liquid diet. Weak patients should be allowed some strengthening diet from the very commencement. At first an aperient is given to clear out the bowels, castor oil being the drug of choice for this purpose. This should be followed by mild astringents such as Thoroxyl, Cryptargol etc. but these remedies do not in any way affect the cause of the disease. For this purpose we had mainly to depend in former years on anti-dysenteric serum. It was, however, very difficult to treat people with their serum therapy on account of several contra-indications and great risks. Some patients are asthmatic, others easily get serum-sickness while there are many especially children, who refuse any sort of injection treatment. Again to be of maximum benefit to the patient serum treatment must be started within 48 hours of the onset of disease. We rarely get patients coming to us as soon as the disease starts. In recent years treatment with Bacte-Dysenteri-Phage has assumed the foremost place in this type of dysentery. It is a highly potent phage which acts as an excellent specific for all forms of bacillary dysentery. It needs only oral administration This Bacte-dysenteri Phage is a therapeutic agent of high efficacy in the treatment of acute and chronic bacillary dysentery. It has neither any taste nor does it cause any reaction.

Where Bacte Dysenteri Phage is prescribed Thoroxyl, Cryptargol or any other Antiseptic or metallic substance should not be given.

Bacte-Dysenteri-Phage is meant for ingestion only and is specially designed to dissolve and kill the Shiga, Flexner and Hiss bacilli. It is a phage which makes active and convenient medication possible through the mouth. In all cases of bacillary dysentery pronounced improvement in the symptoms is obtained even after the first 24 hours after the administration of this Phage. The painful tenesmus soon disappears, the stools lose their frequency and do not exhibit their diarrhoeic character. Fever is brought down and the severity of the disease is soon checked. Acute bacillary dysentery is usually brought under complete control in 48 hours. Two days' treatment with this Phage is enough to cure bacillary dysentery. It soon checks mucus and blood in the stools, abolishes the presence of gas and putrid fermentations, destroys the bacilli, regulates the transit of the intestinal contents and renders the motions normally consistent.

Bacte-Dysenteri - Phage is a tasteless, odourless liquid. It can be easily given to children and sensitive patients. It leaves no reaction or after-effects as is usually the case with injections of serum. Anaphylaxis is conspicuous by its absence with this Phage therapy. In cases of sub-acute and chronic bacillary dysentery serum treatment is not of much use and it is here that Bacte-Dysenteri Phage gives good results. For economic reasons also Bacte-Dysenteri-Phage is to be preferred to serum injections. It is perfectly harmless, as no evidence of toxicity from this Phage is noted in any of the patients.

Record of a case treated successfully with Bacte-Dysenteri-Phage is given below :—

A Hindu male aged about 35 came to me with fever and dysentery of a week's duration. The stools were very frequent and were mixed with blood and mucus. There was severe tenesmus. and colicky pains in the abdomen. Before he came to me, it appears according to the history he gave me he was probably treated with anti-dysenteric serum. There was absolutely no improvement in the condition of the patient. I started at once Bacte-Dysenteri-Phage treatment. He was having 2 c.c. of this in half a glass of water every four hours. Immediate improvement in the condition of the patient followed after 24 hours of this treatment. The nature of the stools completely changed. Fever subsided, blood and mucus had stopped and the offensive character of the stools disappeared. Well formed stools were passed on the third day of this Phage administration and the convalescence started on the very day.

EAST AND WEST KHANDESH MEDICAL PRACTITIONERS' CONFERENCE, BHUSHAWAL

Presidential Address

By

DR. JIVRAJ N. MEHTA, M.D., (Lond.)
M.R.C.P. (Lond.), F.C.P.S. (Bom.)

8th March, 1936.

Ladies and Gentlemen,

I thank you very sincerely for the honour you have done me asking me to preside over your Fourth Annual Session. I welcomed the opportunity of meeting you all, because while I knew first hand the problems of medical relief in the City like Bombay, I was less intimately in contact with the organisation of medical relief in district towns and rural areas and I was anxious to acquaint myself with it at this Conference.

INSTRUCTION IN MEDICAL SCHOOLS.

2. There are a great many questions which at present engage the attention of the medical profession. One of the most important is Medical Education. In this matter unfortunately we are confused by various system of medicine in this country, viz., Allopathic, Ayurvedic, Unani etc., etc., and even in the particular system which we follow, standards of education vary a great deal. It is essential in the interest of the profession we follow, that a minimum standard of Medical Education should be laid down by a central medical authority like the Medical Council for India, not only for those proceeding for the University degrees but also for the Licentiates. The system of education as imparted in the schools for the latter needs overhauling. It is indeed a happy augury that the Licentiates themselves are anxious to bring this about. Medical Science has grown so rapidly of late that it has become well nigh impossible to receive a thorough training in it, within a period of less than five years after Matriculation. The number of admissions to medical schools needs to be regulated in accordance with the facilities available for laboratory work and clinical instruction, if the practitioners passing out of these institutions are to be efficiently trained.

3. It is indeed a matter of regret that enough laboratory equipment work does not exist in some of the schools, and that in the hospitals attached to some of them, beds are either inadequate or too disproportionately distributed on the medical, surgical or obstetric etc. sides to permit a well balanced practical and clinical instruction to be imparted to the students. Further, the system of appointing teachers in the schools under Government control leaves much to be desired. The interests of service are still allowed to predominate. In several cases teachers are appointed without a postgraduate or special qualification in the subjects they are called upon to teach. Not infrequently one teacher gives instruction in two entirely different subjects. Medical science is such a wide field that you cannot attain proficiency in every branch of it even with a life's study. The practice of one man teaching more than one subject was perhaps excusable when there was a dearth of qualified teachers and specialisation unknown; but now that it has become increasingly possible to secure better qualified and specially trained persons who can efficiently fill teaching posts in all important centres where Government medical schools are situated, it is high time that these antedeluvian method ceased. It is a matter of satisfaction that not only the Bombay Medical Council but also the College of Physicians and Surgeons, Bombay are giving attention to these problems, and the Government of Bombay have felt the necessity of an enquiry into these questions. Let us hope that the enquiry will be thorough and the evils noticed will be radically dealt with as early as possible. I hope the terms of the Committee of Enquiry will be wide enough to cover all aspects of the question of medical education for the Licentiates. I would go even further and ask, is it really wise or necessary to continue the Licentiate course? The demand for admission to the two medical colleges in the Presidency is so great that the scope of the enquiry may be well extended to consider if the existing medical schools could not be converted into medical colleges. This should not be very difficult, so far as the school in Poona is concerned.

POST-GRADUATE MEDICAL EDUCATION.

4. Medical Education as you all know, does not stop with the attainment of a medical degree or qualification. The progress of medical science, particularly on the biochemical side is so rapid and the clinical

opportunities in private practice so restricted, that the development of postgraduate instruction for the benefit of general medical practitioner has become imperative. In Europe and America such instruction is given either in special postgraduate schools or by the opening of special 'Refresher Courses' in medical colleges. With the help of the Honorary staff particularly the junior Honorary staff, in the two teaching hospitals in Bombay, the possibility of instituting such a course may well be considered. Will there be a sufficient response from the general medical practitioners if such a 'Refresher course' is organised? It would mean the payment of a sufficient fee by them to make it worth while for the staff to take up such work. You are in a better position to advise to what extent it would be possible for a practitioner in the moffussil area to leave his practice to attend such a course, say, once every three years; the course being of course organised every year—for about 4 weeks—preferably during the vacation period.

EXTENSION OF MEDICAL RELIEF.

5. Another important question which invites attention is the development of public medical relief in the mofussil areas, particularly rural areas. In large cities like Bombay, Ahmedabad and Poona about 50% of the patients attending hospitals come from outside these cities thus encroaching to that extent on the limited hospital accommodation of those cities. In spite of the increase in the number of beds to the extent of about 1,500 in the City of Bombay during the last 12 years, the demand for admission into hospitals is so great, partly due to the growth of 'hospital habit' in the people and partly due to the influx of patients from the mofussil, that the Bombay hospitals are always overcrowded, and many patients have every day to be refused admission for want of accommodation. Unless, therefore, the district hospitals are improved by the appointment of better qualified and experienced medical officers and by the increase of bed accommodation in them, and unless the Taluka dispensaries are converted into small cottage hospitals, the difficulties of those responsible for hospital administration in large cities are not likely to be minimised. At the present moment about 300 to 400 beds, though already constructed in Government hospitals in Bombay, are lying idle for want of funds. Government find it difficult to provide finances for opening these beds on account of the increased demands of the district and rural medical relief on their resources. In the Legislature, there is unfortunately a rivalry between those members who come from the districts and those who hail from the City of Bombay, with the result that the former who constitute a majority carry the day and the splendid hospital buildings erected eight or ten years ago in the City of Bombay still remain empty for want of funds, even though, as already stated, the Bombay City hospitals provide medical assistance to mofussil patients to the extent of about half the total number of beds available. The problem is no doubt very difficult. I have already urged the necessity of providing more beds in the district hospitals. But even with the development of such hospitals, a fair number of patients from the mofussil would still continue to go to big cities for expert treatment. The question therefore is how medical relief can be conveniently extended both in the Cities and the District areas.

6. It may well be asked, is there not sufficient scope for economy in the present system of hospital administration? Is it necessary for Government to engage highly paid medical officers? Is it not possible to save enough on this head of expenditure and to utilise the savings for opening more beds? In the past owing to the paucity of medical practitioners in the country, it was necessary for Government to employ medical officers for the treatment of the general populace as well as of Government servants. With the rapid growth in the number of medical practitioners, some of them very well qualified and experienced, all over the Presidency, there seems to be no necessity now of employing highly paid medical officers in district hospitals. So far as the treatment of Government employees is concerned, they can now arrange for their own treatment with private medical practitioners as is done in England. It is well worth considering if the district hospitals and dispensaries cannot be handed over to the district municipalities and Local Boards, Government giving them the necessary

grants corresponding to the amount now spent by them on these institutions and exercising control over their management. The Local Boards and Municipalities should, on the other hand, provide the necessary funds for the extension of medical relief in their respective areas. As a large number of highly qualified doctors are now available and as the number of such doctors is increasing every year, they could be appointed as Honorary medical officers in the District hospitals in the same way as at the various County Council hospitals in Britain, a resident medical officer previously trained in the large teaching hospitals, and a Steward or Secretary being employed to carry out the internal administration of the hospitals under the direction of a Hospital Committee of the Municipality or Local Board.

7. To bring about such a reorientation of our medical policy, a number of difficulties will have to be faced; but with will and effort none of them need be insurmountable. Unless some such radical change is introduced in the hospital administration and medical relief in the Presidency, I fail to see how medical relief could advance rapidly throughout the Presidency. I hope the Government of Lord Brabourne would consider the possibility of exploring this method of expanding medical relief. A start may be made in certain areas only, say by stopping the recruitment of new officers in the Provincial and Subordinate medical services. The prospects of the present incumbents will not be affected thereby. In case the district hospitals are handed over to the municipalities or local boards, there is a great likelihood of these hospitals receiving gifts in cash or kind on festive occasions from the local inhabitants. Such help will be material in reducing the cost of the hospital, as seems evident from the experience of the Seth Vadilal Sarabhai General Hospital, Ahmedabad, whose annual reports for the last three years give much information on this point.

8. So far as rural medical relief is concerned, the idea of the Licentiates settling in such areas is far from being fulfilled. From the information I had collected in 1931, I had found that a very large number of Licentiates settled in cities or in towns with a population of over 10,000 inhabitants. To induce the medical practitioners to settle in rural areas, it seems very necessary to give them some subsidy. I take it that the present Surgeon-General with the Government of Bombay Major-General Bradfield who spent several years in Madras, is conversant with the scheme of subsidising rural medical relief in that Presidency, and will consider the possibility of introducing a similar arrangement with the necessary safeguards in this Presidency. This experiment may also be started in certain selected areas. Any how Government would do well to explore this question.

RURAL SANITATION.

9. Any discussion on rural medical relief would not be complete without a reference to rural sanitation. As I am not familiar with this branch of medicine, I prefer to say little except to urge that this has long remained untackled on any appreciable scale. It is indeed a vast problem. It has to deal with the village water supply the disposal of the night soil, and the proper construction of well ventilated houses. The town planning of villages and the construction of such roads in them as would reduce the dust nuisance to the minimum, would need also to be considered. I would refer here only to the question of the disposal of the night soil. Gandhiji, while he has occasionally amused the medical profession with some of his theories regarding the causation and treatment of diseases, has laid us under a deep debt of gratitude by the way in which he has been tackling the problem concerning the disposal of the night soil at Wardha and elsewhere. If his experiments are a success, he will have greatly helped in solving this difficult problem for rural areas.

CHAIRS OF AYURVEDIC AND UNANI SYSTEMS.

10. In all questions affecting rural medical relief the question of the cost of medicines should always be remembered. It should be brought down to the lowest possible limit to make it possible for the poor villagers to pay for the medicines. The advantage of the Ayurvedic and Unani systems lies in that the practitioners in these systems are able to suggest medicines which the very poor can afford. With the position to which Materia Medica is being relegated in our medical curriculum, it has become impossible in the medical colleges to teach students the relevant knowledge about drugs or household remedies which the poor can buy conveniently. A

question has been raised if the instituting of chairs of Ayurvedic and of Unani systems in the medical colleges would help in increasing the use of the household remedies by the rich and poor alike, and further help to reduce the import of foreign drugs. I do not feel myself competent to advise on this question. But it does seem to me that if a Chair on the ancient Indian system of medicine is instituted in the medical colleges, it would undoubtedly be in the best interests of medical education and research, and consequently of medical knowledge. With the help of such a teacher, it would be also possible to prepare pamphlets in easy vernaculars explaining the use of the most common household remedies met with in the Ayurveda for general use, and particularly to the benfit of the poor.

DEVELOPMENT OF THE HOSPITAL REQUIREMENTS INDUSTRIES.

11. The more important thing is to foster the culitivation of medicinal plants on a large and scientific scale in the country to develop the drug industry, as well as the manufacture of surgical instruments and dressings and other hospital requirements including the scientific apparatus. The K. E. M. Hospital and the Seth G. S. Medical College have done quite a lot, I am glad to say, in this connection. For the manufacture of cotton wool and lint in Bombay I had made great efforts as early as 1926-27. We considerably helped the use of vaccines and sera made in India. The result has been that the price of cotton wool is now about half of what it was 10 years ago, of lint about two thirds and of sera and vaccines less then half. We have also encouraged the manufacture of hospital equipment to a large extent and of surgical instruments and scientific apparatus to some extent. A great deal yet needs to be done in these directions.

12. It is however evident that if we encourage the growth of indigenous industries relevant to the requirements of hospitals the cost of medical relief would undoubtedly go down and to that extent more public medical relief would be made available. If the history of the sale of a tube of Salvarsan at hundred rupees, each, is not to repeat itself on the outbreak of another war, which according to some, looms large on the horizon, our efforts for the development of these industries will need to be redoubled. While on this subject, may I not repeat what has been so often said regarding the urgent necessity of giving effect to the recommendations of the Chopra Committee to prevent this country being the dumping ground of all cheap or worthless and even harmful medicines. An effective control is also necessary on the local manufacturers as well Sir Fazli-i-Hussein when opening the exhibition in connection with the Annual Medical Conference held in Delhi in December 1934, made a public announcement about the Government of India having taken up the active consideration of putting the Chopra Committee's recommendation into effect, but although 15 months have passed since, we see no proposals coming forward.

SPREAD OF PULMONARY TUBERCULOSIS.

13. I would like to take this opportunity of warning the public of the great inroads that Pulmonary Tuberculosis is making in the country. I find that Kathiawar, which has an excellent dry climate, is rife with it, due partly to the ignorance of people as to the way consumption spreads from man to man, and partly to their poverty which has much reduced their vitality to withstand the onslaught of the disease. If it is to be prevented from spreading, a great deal of propaganda is necessary to educate the people as to the disposal of the sputum of tubercular patients and other preventive measures for avoiding infection. It is also necessary to have wards for tubercular patients in large teaching hospitals, partly as treatment centres, partly propaganda centres and partly for the proper instruction of medical students. Special tuberculosis hospitals in all large cities and sanatoria on the hill stations have also to be provided. There seems to be a feeling abroad that tubercular hospitals should not be started in Bombay in view of its climate. I regret to say that such remarks are given currency even by medical men. They seem to forget that the provision for the treatment of tubercular patients in large cities is only the first step in the campaign against the eradication of the disease. A city like London with its very bad climate in the winter has several such hospitals. How can tuberculosis be prevented from spreading in cities unless the city patients suffering from the disease are treated in some hospitals and thus isolated from other people? Eradication of pulmonary tuberculosis is, no doubt, a big problem but unless it is tackled vigorously, the country will have to suffer heavily in course of time from the ravages of this white plague.

NUTRITION RESEARCH.

14. The problem of nutrition is also important. We are at the present moment engaged in working out the essentials of an ideal dietary under local conditions at the Seth Gordhandas Sunderdas Medical College, in close colloboration with the Bombay Presidency Baby and Health Week Association and with the help of grants from the Sir Dorab Tata Trust and the Indian Research Fund Association. The problem is however so large and the funds at our disposal so meagre, that it will take some time before this problem is satisfactorily tackled from every point of view. I would appeal to those who have funds to dispose of in charity, to help us in persuing this enquiry.

SICKNESS INSURANCE.

15. It is gratifying to note that Government were considering the question of introducing some form of Sickness Insurance for certain groups of industrial workers. In this connection, I cannot help but register a protest that the members of the medical profession have been entirely ignored in the preliminary enquiry which Government made on the subject. I hope that in all subsequent enquiries the members of the medical profession will be duly consulted. It was with the co-operation offered by the members of the medical profession in Britain that the National Health Insurance Act has become a great success in that country. I may add that the provision of sickness insurance would go a long way in overcoming the difficulties of organising rural medical relief. It would be, therefore a great pity if domestic and farm labour are excluded from the purview of the act at the start.

NURSING AND HEALTH VISITING.

16. Lastly, I would like to say a few words on the necessity of developing the nursing profession in the country. Christian ladies have been the pioneers in this field in India. The Parsis have also begun to appreciate the value of nursing as a vocation. Hindus and Mohamedans are still backward. I would appeal to them to consider the advantages of joining this profession. It is doubly blessed in that they play an important part in the growth of medical relief and in that they are enabled to have a vocation of their own and an economic independence. Besides nursing, the Health Visiting, is also a very useful profession. An excellent school for the Health Visitors' course has been recently started in Bombay. Nursing and Health Visiting afford ample opportunity of humanitarian work and economic independence to those ladies who may think of seeking a profession after passing the Matriculation.

17. Ladies and Gentlemen, there are still several problems on which one is tempted to speak, such as the constitution of the Indian Medical Council, Medical ethics, the organisation of medical research in the country, medical inspection of school children, the development of physical culture, the necessity of developing a hobby for medical men, the institution of a medical defence union etc. etc. but I have already detained you long and I close. I thank you most cordially for the honour you have done me by electing me your President this year.

THE

Medical Practitioner

VOL. VII.] FEBRUARY 1936. [NO. 5

ALL INDIA MEDICAL CONFERENCE.

We just received the February issue of the official organ of the Indian Medical Association and glad to see that the proceedings of the last Conference held at Nagpur, have been more elaborately published than was the case with such proceedings in the past. This is as it should be. Nobody could attempt to give a correct picture of the activities of the Conference more than the official organ of the Indian Medical Association under whose auspices the yearly Conferences are held. The proceedings as published give an idea to an outsider what was attempted and what was done by the Indian Medical Association with the help and co-operation of representatives of the profession from different parts of India. The Editorial comments on the Conference appearing in the official organ of the Indian Medical Association are rather meagre, perhaps on account of the obvious reason that the Editor wished to maintain courteous discipline to all those who have been guiding or expected to guide the destines of the Association including the journal. Being in touch with the activities of the Indian Medical Association from its very inception and being very eager that the Association should gain strength and popularity year after year, we have been publishing in these columns our views as to what the programme of the Conference should be and after the Conference met we commented on what the Conference did. This, our duty we have been able to do to our satisfaction till a few years ago as our Doctor Kamath was one of the guiding spirits of the Association from the very beginning of its life being in the executive committee of the Indian Medical Association. Later due to circumstances beyond his control and mainly due to his indifferent health, Doctor Kamath has not been able to be in touch with the activities to the extent his heart yearned. Just on the eve when the Conference met at Nagpur the President-elect held a meeting of the practitioners in the city of Madras in connection with the starting of a Branch of the Indian Medical Association in Madras for which meeting neither we or Doctor Kamath the oldest member, of the Indian Medical Association was fortunate to get an invitation. We are not perturbed nor disappointed on account of this omission. We mentioned about it lest we or Doctor Kamath should be misunderstood either in this province or outside for not evincing any interest in the affairs of the Indian Medical Association near at hand. In spite of such omissions and commissions our heart will remain always sound towards the affairs of the Indian Medical Association which being a national organisation is bound to advance as such and any body who has a spark of patriotism in him will stick to the Association as firmly if not more firmly than before and be on the alert that this national institution does not dwindle into a conclave of an individual or group of individuals.

From the published report of the proceedings of the Conference, we are convinced that the national outlook of the Indian Medical Association has been spreading firmer and deeper roots in the hearts of the members of the medical profession and that time will not be far when this national medical organisation will be able to command in this country and outside, an influence and response which similar institutions have been commanding in Great Britain and other civilised countries. We have been noticing not without reason that the scienti-

fic section of the conferences so far held were poorly attended. The cause is not far to seek. The medical profession in India is to day not so much wanting in knowledge and skill for treating and preventing human ailments as they are in material and a field to make use of what the profession knows. In other words, the talent in the Indian medical profession is not found wanting. The profession is very much hampered and handicapped for want of opportunities of service. The scientific section of the Conference cannot help them to solve the more important and urgent issue of finding employment for them. We do not mean to suggest employment under Government or anybody else, but employment for oneself under himself for the mutual benefit of the profession and the country. "How can we serve and how can we live?" is in the lips of the member of the profession especially the rank and file of it. India is a continent in itself and the Indian Medical Association cannot afford however much it may be desirable or necessary to hold all India Conferences more than once in a year. Nor has it been possible for these Conferences to hold the session for more days than three. The Conference that met at Nagpur did not sit even two days in full. The Indian Medical Association will do well in future to concentrate its attention on vital topics concerning the life and prosperity of the profession especially the independent section of it and find out all possible ways and means to have in this country a contented medical profession though not a prosperous one as contentment is more consistent with the ideals of the medical profession than prosperity. The two important personages to whom the country looks to for guidance and lead in all-India Conferences, are the Chairman Reception Committee, and the President of the Conferences. Basing on the utterences of these two, the subject committee usually drafts and places before the open conference, resolutions for final approval. Col. Kukday, Chairman of Reception Committee was as brief yet circumspect in his speech as Doctor Rama Rao was elaborate in his address. Both were quite consistent with the avocation they have been following, Col. Kukday as a Military Medical Officer, and Doctor Rama Rao as a member of the independent medical profession and a public man dealing in varied activities.

Col. Kukday restricted his speech to five important subjects—Indian Medical Council, Indigenous system of Medicine, the Services, Hospitals, and the Training of Nurses. Dr. Rama Rao dealt in his address almost all conceivable topics regarding the medical profession in this country not excluding those appearing in the speech of Col. Kukday excepting the subject about Nurses. Dr. Rama Rao perhaps thought that the subject of Nurses was outside the boundary of the Indian Medical Association, though he was quite competant to deal with this subject also most practically.

Indian Medical Council was the very first theme considered by both the Chairman, Reception Committee and the President of the Conference. Each of them saw this question through an angle of vision of his own. Col. Kukday perceived innumerable possibilities of action by the Indian Medical Council to maintain "highest standard of professional efficiency in India" and said that "this our National Medical Council will function as usefully and as independently as any other, in the civilised countries of the world." While Dr. Rama Rao denounced the same Council which he said, "..... will play second fiddle to the General Medical Council, Great Britain, a Council where the large and important body of medical men, the Licentiates.....have no place and a Council whose decision in the matter of reciprocity can be over-ridden by the Governor-General in Council". The manner and the reasons displayed by Col. Kukday in reconciling the medical licentiates to their lot in not being brought within the purview of the Indian Medical Council and the method suggested by Rama Rau for including the Licentiates within the purview, of the Council, are most disappointing and glaringly inconsistent. The former is seen as an author of both a "climax" and an "anticlimax" when he put the licentiates in the role of "our other professional brothers, the so-called licentiates" and pointed out in the person of the President of the Conference, a glorious example of professional merit and administrative capacity and referred to "the magnificient career of another licentiate in the person of the late Dr. Daji Ramachandra of Nagpur whom Col. Kukday acknowledged as his inspiration to take up medicine instead of law. Yet he advised the Licentiates to be satisfied with their lot and live in an atmosphere of inferiority

as Col. Kukday feared that the foreign Medical Councils would use the inclusion of the Licentiates within the purview of "our National Medical Council" for "withholding reciprocity for us". Col. Kukday's statement that the course of studies of the Licentiates compared with that of the graduates, "is shorter by three years and laterly in some cases by two years—than that of the graduates," is incorrect. Nagpur being nearer to Bombay we presume that Col. Kukday must have had his training at the Grant Medical College, Bombay where we are told the graduates underwent a course for only three years in good old days, later for four years and now five years. Licentiates existed as medical men much earlier than the graduates and the difference of course of studies between the two has been from time immemorial only one year. At present no medical school exists in India where the course of training is only for three years. On the other hand in Madras the course has not only been extended to five years but brought to the standard of Membership of the Royal College of Physicians and Surgeon in England. It is a most unfortunate irony that Col. Kukday a staunch admirer of the Licentiates should make a mistake about them in his speech as the Chairman Reception Committee of the all-India Medical Conference. Dr. Rama Rau must have delivered his address after Col. Kukday delivered his and there was an opportunity for Dr. Rama Rau to correct the Chairman Reception Committee though the Presidential address was printed before the Conference met. The omission is regrettable the more when the President made a case in his own way for the inclusion of the Licentiates within the purview of the Indian Medical Council. We find that even the President did confuse the issue of his pleading for the Licentiates. The remedies suggested by Dr. Rama Rau are self condemning if not most inconsistent. He urges on his medical brethren in the Legislative Assembly to introduce an amending bill to provide (1) the deletion of the word 'higher' in the preamble occurring in 'higher qualifications' (2) the election of one number from each province from among the Licentiates and (3) *to include the qualification of those Licentiates who have undergone a course of 5 years training in any recognised institution as is now being given in the Stanley Medical School in Madras, in the schedule of Registerable qualifications.*" (Italics are ours). The inconsistent confusion of Dr. Rama Rau is displayed the more when later in his address he says "I wonder how the inclusion of Licentiates in the Council can at all affect the prestige of the British Medical Council" while the British Medical Council is open to Apothecaries whose qualification Dr. Rama Rau avers is no way superior to those of the Licentiates. Dr. Rama Rau has thus in his confusion unwittingly suggested a barrier for the inclusion of the Licentiates within the purview of the Indian Medical Council Act by suggesting in the amending Bill the inclusion of the Licentiates of 5 years' training. The suggestion made by Dr. Rama Rau for the starting of a College of Physicians and Surgeons in each province with an idea of levelling up the medical profession in this country is not likely to appeal to anybody. No good purpose will be served by this College if the standard of the medical education is to be the same as that imparted at the Universities especially so when the University Medical Institutions and proposed College of Physicians and Surgeons are to be run by the same body, the Government. The Government will be wasting public funds for running two rival institutions for the same purpose. Multiplicity of medical teaching institutions will instead of levelling the profession in the country will perpetuate a much wider cleavage than is now existing. The best course to adopt is to do away with the L. M. P. course which is now considered inferior to that of the University course and have only one medical qualification of uniform standard throughout the country.

Regarding Medical Services, the bold frank and practical suggestions of Col. Kukday would be appreciated more than the faltering and accommodating utterances of Dr. Rama Rau. The ideal put forth by Col. Kukday, is to have one medical service for the country to be called the Indian Medical Service or National Medical Service, recruitment to which to be made in India by open competition. Col. Kukday wishes that this service should be primarily intended for Military Service but during peace they should serve the civil population. Col. Kukday opines that Honorary Medical Officers should be depended upon entirely for service in big and small hosptials and even dispensaries, arrangement being made

with the Honoraries for military duty when needed. The dictum of Dr. Rama Rau, "what cannot be cured must be endured", regarding the I.M.S. is inconsistent with the existing national spirit prevailing the country in which Dr. Rama Rau cannot be said to be wanting, himself being an active congressman. His suggestion to hold competitive examination for recruitment in the Provincial Medical Services, permitting the Indian Medical Licentiates along with the University Graduates, is unpracticable and will not even catch the hearts of those for whom this gesture was meant. Dr. Rama Rau would have done better service to the Licentiates if he as the President of an all-India Conference got the support for a proposal that Sub-Assistant-Surgeons after 10 years service should be made to sit for a competitive examination for selection as Assistant-Surgeons, 25 per cent in the cadre of the Provincial Medical service being set apart to those who are thus selected. Such a course would have been quite consistent with the policy now adopted by the Government of all provinces with regard to the promotion of Sub-Assistant-Surgeons to the Assistant-Surgeon Grade. The picture given by Dr. Rama Rau regarding the Subsidised Rural Medical Relief scheme, seems to be different from realities as could be evidenced in the appeal to the Subsidised Practitioners appearing in the Correspondence columns of The Medical Practitioner, January 1936, by the Secretary, Subsidised Medical Practitioners' Association. The Secretary says amongst other things, "A handsome compliment has been paid to the manner of our working and the amount of success, by Dr. Rama Rau in the course of the Presidential address.....The wearer alone knows where the shoe pinches. I should be excused if I refute Dr. Rama Rau's statement.....True some of the grievances have been removed. There are still many grievances to be redressed and added to this we have lost fundamentals quite recently though." These unfortunate practitioners far from flourishing as expressed by Dr. Rama Rau find it difficult to keep their body alive. Even their soul cannot exist as such, if radical changes are not effected in the Scheme in the near future, as, far from being independent as mentioned by Dr. Rama Rau they are on the border line of slavery.

The Indigenous systems of medicine attracted the attention of both Col. Kukday and Dr. Rama Rau. In this connection reference was made by both about the Madras Government School of Indian Medicine. Dr. Rama Rau states in his address that the duration of the course in the school is 5 academical years though as a matter of fact it extends only for 4 years. Dr. Rama Rau sees "a happy blending of both the Allopathic and Indigenous systems of medicine suited to our soil", in the Government School of Indian Medicine. The question naturally arises regarding the desirability of this "happy blending" of two systems Indigenous and Allopathic as such a blending is in the opinion of the President of the Indian Medical Association is best "suited to our soil". The country and the medical profession of all the existing systems of medicine (in this country) will therefore look to the Indian Medical Association for the solution of this problem both in the interest of public finance and the future existence of the practitioners of the Scientific (Allopathic) system of Medicine. We do not mean to say that the Indigenous systems of medicine are less scientific, but we only quoted a new name for the Allopathic System proposed first by Major-General Sir Megaw (if we remember right) and later introduced by the Government of Madras. An impression is now afloat in our opinion, homicidal to the prosperity of the practitioners belonging to the Scientific system of medicine that the Licentiates of the Madras Government School of Indian Medicine, are superior to the Licentiates of Scientific system as in the school of Indian Medicine there is a mixture of both the Indian and Allopathic medicines. Dr. Rama Rau had said in his address that the Government Indian Medical School at Madras grants a special Diploma called A. I. M. (Associate in Indian Medicine) in addition to L. I. M. (Licentiates in Indian Medicine) and A.L.I.M. (Associate Licentiate in Indian Medicine). The A. I. M. Diploma is specially meant for Allopathic practitioners both Licentiates and Graduates. It is within our knowledge that graduates of the Madras University at least a few of them have qualified themselves as A. I. Ms. or F. I. Ms. (F. I. M. indicating Fellow of the Indian Medicine stood for A. I. M. a few years ago). When the Government, at least in one province runs its own school of Indian Medicine and forces

the public to recognise the Diploma granted by that institution, it is but natural that those who are decorated with these Diplomas will claim and are claiming superiority over the Diplomas and Degrees granted by Government Schools and Colleges of Scientific Medicine. The provincial governments though they are made to appear more democratic and hence responsible to the people that are governed are on their trial and will be so even after the introduction of the new constitution. During this transitional stage of democracy it has been the bitter experience of the people in this country that the so called popular ministers have been governing and are likely to govern at least during the transitional stage minding their own self interests with little or no regard to their responsible duties to the country. The Government Indian Medical School in Madras is the work of an ambitious and powerful Minister, the late Raja of Panagal. It has to be said that he started this school as a gesture to demonstrate his patriotism with the purpose of strengthening his position as a leader of a communal political party. Consequently he had to play on the credulity of the masses in this province and the Indian Medical School was an achievement towards this end. If the late Raja of Panagal had Scientific faith in the votaries of the systems taught in the Government School of Indian Medicine in Madras, he would not have chosen to die in the hands of the Allopathic practitioners. It must be within the knowledge of the public that the Ministers that succeeded the late Raja Sahib and who in public platforms and on the floor of the Madras Legislative Councils talked about the Government School of Indian Medicine most eulogistically have been treated by the practitioners of the Allopathic system for serious ailments at least. It is therefore essential not so much in the interests of the practitioners of Scientific system but in the interest of public safety whether this "happy blending" of two systems should continue. This question should be approached boldly and seriously and with as much expediency and a decision arrived at by the public and the medical profession, if Indigenous systems of medicine cannot find a place and with less danger to the public safety in the existing of medical schools and colleges teaching Scientific system of medicine. We have been sufficiently long in our comments on the activities of the all-India Medical Conference and choose to close abruptly as the other subjects treated in the address of the Chairman Reception Committee and the President of the Conferences are of secondary importance to the principal subjects dealt with by us in these columns.

MEDICAL AND PUBLIC HEALTH BUDGET.

This is the season for the discussion of Government Budget Estimates for the next official year both at the provincial and also the central seats of the Government. We have been attempting these few years to be able to compare and contrast the Budget Estimates of all the provinces at least in main features regarding the Medical and Public Health expenditure, but so far have not been successful in our attempts, and had to be satisfied with the Budget Estimate of the Madras Presidency only. For want of well organised and healthy parties in the Legislative bodies excepting now at the Legislative Assembly, the opposition either here or elsewhere has not been able to have an efficient control over the Government. The Medical and Public Health departments being of technical nature than other Departments of the Government, they usually escape criticisms on the floor of the Legislative Councils to the extent they deserve. Public Health and Education should naturally demand more attention from all concerned as all other departments exist for the health and welfare of the public and not for themselves as such. We wish the popular representatives of the public in the Legislative Councils note the glaring disproportion in expenditure between the Medical and Public Health Departments in this country as compared with those in other civilised countries where the death rate is far below the average obtaining here. This is due to the fact that the Government in those countries spend larger amounts of public funds in preventing diseases than for treating diseases. In all countries almost all the institutions for Medical Relief are entirely under the control of the people who finance them and the medical officers are honoraries. So it has been possible in those countries to give medical relief on much larger scale than in India where the Government is in entire charge of medical relief and have not been able to supply even one medical man for every

50,000 of population inspite of their spending nearly a crore of rupees for medical relief in Madras Presidency. No other Department of the Government spends such a huge amount and what return the public get for this one crore of rupees is within the knowledge of every member of the Legislature. This year without going into the details regarding the defects in the Medical Administration, as we have been doing in the past, we wish to point out to the Government and the members of the Madras Legislative Council that the one most serious defect which is mainly responsible for all the other defects in the Medical Department, is the want of effective control over an expenditure of one crore of rupees in this Department which is now under the supervision of one officer, the Surgeon-General assisted by only one Assistant. Usually nothing attracts the eyes of the Government more than finance and we wish to discuss this serious medical problem on financial grounds. We mentioned above that the Government is spending nearly a crore of rupees for medical relief in all its aspects. No other department of the Government spends such an amount including the Judicial Administration. Yet this department is under the supreme control of only one officer, the Surgeon-general helped by a personal assistant whereas, the sister department of Public Health is under the control of a Director assisted by 4 or 5 officers. The Budget Estimate for Supervision in the Public Health Department is nearly 1½ lakhs (being the salary of the officers and establishment etc., in the office of the Director of Public Health) and the Medical Department spends only about a lakh for supervision (being the salary of the establishment in the office of the Surgeon-General) though this Department is entrusted with the largest amount of expenditure i.e. a crore of rupees while the Public Health expenditure is only about 8 lakhs. It is therefore no wonder that all sorts of conceivable defects and irregularities have crept into the Medical Department and that even the walls of medical institutions are at times charged with corrupt practices which cannot but go undetected. The Surgeon-General much less the Director of Public Health can be blamed for this scandalous inconsistency of the amount, spent by the Government for supervision. As mentioned above the Surgeon-General who should control an expenditure of one crore of rupees is helped by one officer of the grade of Civil Surgeon whereas the Director of Public Health gets the assistance of not less than four officers of almost the same grade as that of a Civil-Surgeon though he has a control of expenditure of only 8 lakhs or very near this amount. It looks as if those in power and authority have eyes yet would not see, have ears yet would not hear and those under them have eyes yet cannot see and have ears yet cannot hear. Apart from his legitimate office duties the Surgeon-General with the Government of Madras has not less then twenty other ex-officio departments under his control in addition to the Medical Department which must necessarily interfer with his legitimate duties to such an extent that he has little or no time to look after the affairs of the department for which he is paid. May we appeal to the people's representatives in the Madras Legislative Council to concentrate their attention only on this aspect of the question in the Medical Department and nothing more till it is solved. This is not a party question much less of the individuals and does not require much labour by way of talking on the floor of the Legislative Council. Even elsewhere in other provinces the state of affairs of Medical Administration cannot be better than in this province and this appeal of ours may therefore hold good throughout India.

News and Comments

Major McRobert an Administrator, Teacher, Examiner and a Friend: On 24th February, 1936 Major McRobert Professor of Medicine, Medical College Madras and Physician Madras General Hospital addressed the inmates of the Jaya Mansion Hostel on the second Annual Day Celebration for which the students, the Professors including the Principal and other important staff of the Medical College were invited. Lt. Col. Newcomb the Ag. Surgeon-General with the Government of Madras presided on the occasion. The Jaya Mansion Hostel is a private enterprise of the students of the Madras Medical College started two years ago in a rented building not far off from the General Hospital catering exclusively the medical students belonging to the Medical College. The warden of the hostel is one Mr. Alva a student of the Medical College hailing from the District of South Kanara, and who has been the sole active guiding spirit for the starting of this Hostel with the help and co-operation of other fellow students. The Hostel came into existence actually on 1—9—'34 with 11 students. At present the strength is 80 including 7 associates as against 54 members and two associates during the corresponding period last year. The present building has no accommodation for more and could not cope up with rush of applications received by the warden. The management is entirely under the control of the students who have appointed special committees to be incharge of mess, library, outdoor and indoor games and other social activities pertaining to the Hostel. It is said in the report read by the warden before the assembled guests on 24—2—'36 that Dr. M. R. Gurusamy Mudaliar has been the Honorary Medical Officer looking after the health of the inmates of the Hostel and Dr. A. Lakshmanaswami Mudaliar is the advisor to the Hostel Management. In fine the Hostel seems to be an autonomous popular institution started and maintained very efficiently by the students of the Medras Medical College without any financial aid from any outside agencies including the Government. In fact it looks that the students were forced to depend upon self help as the Government would not start a hostel for them inspite of repeated prayers conveyed to them by the successive Principals year after year. The warden bitterly complains in his report against the authorities for not supplying a long felt urgent need of the students of the Madras Medical College and suggests that the Government may be pleased to consider the urgent necessity of starting a hostel for the college students at least this year when there is a surplus in the provincial budget. It is in this atmosphere of despair that Major McRobert was requested by the inmates of the Hostel to address them on the second Annual day of the Jaya Mansion Hostel. The speech delivered by Major McRobert is published elsewhere in this issue of The Medical Practitioner. From the perusal of this address it is seen that the inmates of the Hostel could not have got a better person to advise them. We are sure that not only the inmates of the Hostel but the whole student population of this province and elsewhere, the entire medical profession throughout India and public should be thankful to Major McRobert for his thought provoking brief yet most cogent address. Major McRobert has rightly taken advantage of a social function arranged by the medical students of the Madras Medical College and inadvertently but rightly dealt in a reserved yet frank manner almost all the subjects in which not only the medical students but students in general are interested in this country. Major McRobert would not have taken more than 15 or 20 minutes at the most to deliver his address but it is most admirable that he dealt in his address all that concerned the medical profession from the student days right up to the exercise of the profession as practitioners in service or in private practice. The wise words that came out of the lips of Major Mc Robert without any rhetoric, climax or anti-climax usually seen in the high flown, and as high pitched oratory on important occasions like the one that took place at Jaya Mansion Hostel on 24—2—36, should service as advice not only to students for whom they were primarily meant but to administrators, teachers, examiners, practitioners not excluding the members of the public interested in building up an harmonious human society. Frank talks however well meaning at times or perhaps many a time give rise to offence. Major McRobert did not see eye to eye with those who invited him to address and as a preamble to his sweat-tongued speech he

criticised the Government policy which counted birth and the place of birth more than 'capability' and 'brains'. He expessed this view with respectful regards to his 'employer'. All those interested in the harmonious growth of human society should agree with the most sensible advice given by Major McRobert to the medical students, warning them against seclusion which he said was 'one of the great dangers of life' especially in a hostel. Apart from any other considerations, the cultivation of friendship by medical students with fellow students of all other faculties, will certainly give them a wider scope of service in after life. We trust that any special hostel accommodation primarily intended for medical students to be started in future by the Government will not be a sectarian one as the other Government hostels are in this city all of whom admit students belonging to all faculties. Major McRobert's advice to the students of the medical college 'to cultivate a sense of humour and of tolerance of criticism' is worth the consideration of not only all students in general but the society as a whole. "Cultivate your sense of humanity. We must fight against from our earliest clinical days – the danger of regarding patients as cases and not as fellow human beings in distress," was another golden motto inculcated by Major McRobert. This motto deserves to be inscribed most prominently not only on the walls of the Jaya Mansion Hotsel but on the walls of all medical institutions public and private not including the residence and consultation rooms of medical practitioners of all denominations. "The favourite method of approach" in vogue in Major McRobert's words in the General Hospital, "What would you recommend if this were your father, would you advise operation if this were your brother, and so on" should be the ideal in all wards especially of the Surgeon specialists not only in Madras General Hospital but all hospitals all over the world. There is now a wild tendency for gastro jejunostomies for any imaginable gastric pain and tonsillectomies for all inflammed throats. Medical students should be guarded against hasty conclusions. So any advice and education in arriving at decisions by the future medical practitioners is most wholesome, "The necessity for the development of a public health outlook" was another piece of advice on which Major McRobert laid special stress. The existence of a department of Public Health has been to a certain extent responsible perhaps for the neglect on the part of the practitioners not considering prevention of diseases as a part of treatment of diseases. Unless the general practitioner takes upon himself 'the role' of a sanatarian and those in Public Health Department do not grudge this 'role', India will continue to be a hot bed of all preventible diseases to which she now pays a very heavy toll The subject dealt last by Major McRobert in his address was about examinations. Medical examinations have been a bug bear to Indian students especially in Madras. Bright students who entered the medical college from Arts colleges have had most unsuccessful careers and there are instances where even bright students of the Medical College have not been faring well with some examiners. Many causes are at work for these misfortunes. This is not the occasion to deal with them. But the examiners especially the younger amongst them who were once the students of the Madras Medical College (a few of them at least had not the good fortune of being bright students) would do well to read what Major McRobert said about examiners. We shall here quote only a few pertinent words of Major McRobert on this subject. "The object of the examiner is neither to pass nor to fail. He is an agent of the great Indian public to whom he guarantees that those who leave the portals of the College may reasonably and safely be consulted as having a good grasp of the elementary principles of their profession". Major McRobert appears to us not only as Professor and Physician but a student who not only reads and studies books but also observes keenly his surroundings.

Profession looks to Surgeon-General: There are at present two important questions, one affecting the Honorary Medical Relief Scheme, the other subsidised Rural Medical Relief Scheme, pending disposal by the Government and the members of the medical profession interested in these schemes rightly look to the Surgeon-General for the solution of these two questions as the Surgeon-General is not only the chief adviser of the Government but is also the person by virtue of his being the President of the Madras Medical Council who should guard the rights, privileges and status

of the medical profession. The spirit and principles underlying the Honorary Medical Relief Scheme and the Subsidised Rural Medical Relief Scheme are identical with one exception and that is, the payment of a subsidery to the members of the latter Scheme as they could not depend upon private practice in rural areas to the extent their brethren can in urban areas. Unfortunately, due to causes beyond the control of the members of the profession belonging to both these schemes, these schemes do not at present function to the extent originally expected of them. It was never the intention of the Subsidised Rural Medical Relief Scheme that it should be a permanent fixture to the Medical Department and that the subsidy paid to the practitioner to encourage him to settle in the village should be during the life time of the practitioner. After the abolition of the Taluk Boards in this presidency and even before, attempts have been made by local bodies to convert some subsidised rural dispensaries into puca L. F. Dispensaries. The Government have ordered that in such cases, the subsidised practitioner of the particular village where the puca L. F. Dispensary is to be started should be preferred to be in charge of the L. F. Dispensary. We also understand that recently Government have passed an order increasing the age limit of the rural practitioners so appointed to 35 years. It is also said that in exceptional cases where the Government is satisfied that a particular practitioner in a particular village was solely responsible for the popularity of the dispensary as it existed at the time when it is to be converted into a puca L. F. Dispensary, the Government was prepared to exempt age restriction altogether. The subsidy was given merely to encourage the practitioner to start life as an independent practitioner in a village and ought to be stopped the moment the practitioner was able to stand on his own legs. The Government ought to have therefore fixed the period during which a subsidy was to be given to a particular practitioner depending upon the conditions prevailing in a particular village. By adopting this procedure the Government and the local bodies would have by this time enlarged the scope and usefulness of the scheme. We have been discussing in these columns and elsewhere regarding the defects of this and Honorary Medical Relief Schemes drawing the attention of the Government, the public and the profession to the defects in both the schemes but our efforts in this direction have not been fruitful to our expectations.

It is reported to us that the West Tanjore District Board had obtained the sanction of the Government to convert a subsidised dispensary into a puca L. F. Dispensary and that the subsidised practitioner of that place had applied to the District Board that he should be appointed as the medical officer of the proposed L.F. Dispensary condoning his over age which seems to be a few months above 35. It is also said that the President District Board considers that the communal rotation rule should be made applicable to this appointment. And that the whole matter is under the consideration of the Government.

The Government ought not to encourage the conversion of subsidised dispensaries as L.F. Dispensaries as such a transformation is against the spirit of the subsidised scheme. It may be contended that some of the rural areas are rapidly growing in importance and that the rural scheme cannot supply the needs of medical relief in such localities. The best thing to do in such cases is to stop the subsidy to the practitioner and equip the place with a puca medical unit, where the existing rural practitioner should be requested to do honorary work at fixed hours to attend to the necessitous poor. A hospital committee may be provided for on democratic lines for the executive administration of the unit. Such an arrangement will serve a double purpose—supplying not only the medical needs of a locality quite satisfactorily but also afford opportunities of educating the members of the lay public to take part in the administration of medical relief without burdening the public finance. The West Tanjore District Board has a splendid opportunity for taking a lead and show to the rest of the local bodies an example of educating the members of the public to administer their wants regarding medical relief. We are told that the rural practitioner of the place where the conversion is contemplated is an enthusiastic young man commanding the confidence of the people. We will advise the practitioner to offer his services free at the proposed L.F. Dispensary at stated periods and lay a true and real foundation to the honorary

medical relief scheme. We are surprised at the attitude of the Government and to a certain extent of the President, District Board, West Tanjore when both of them inspite of existing G.Os., put obstructions in the way of the subsidised rural practitioner who obviously did not realise that his suggestion to convert his subsidised rural dispensary into a puca L.F. Dispensary was cutting at the very root of the scheme to which he belongs. He will show his mettle by agreeing to the suggestion thrown out by us by volunteering his services as an honorary medical officer of the proposed L F. Dispensary. The Government, the District Board and the rural practitioner will all respect themselves without violating any principles, if the existing subsidised rural practitioner is appointed as the Honorary Medical Officer of the proposed L. F. Dispensary. The Subsidised Rural Medical Practitioners naturally look to the Surgeon-General for such an eventuality to take place as he is the only adviser to the Government in this and similar matters.

The other subject referred to by us, is the designation now proposed by the Government to the Licentiates in Honorary Service. Our readers might remember our having commented upon a recent G. O. which contravened a previous G.O. on this subject. A few years ago, a Committee appointed by the Government with the Surgeon-General as the Chairman, proposed to the Government to do away with the ignoble and meaningless designation, the Honorary Sub-Assistant-Surgeon and suggested various suitable designations to the honoraries. These were approved by the Government and a G. O. to that effect was passed. The new G. O. is an amendment to the old one so far it relates to L. M. Ps. and L M. &. Ss. It entails that the practitioners posessing the latter qualifications should be designated as 3rd Grade Licentiate Honorary Medical Officer, 2nd grade Honorary Medical Officer and 1st grade Honorary Medical Officer after 5 years and 10 years service respectively. We remarked in thesse columns after we learnt about this G. O. that such designations were unknown in any part of the world and it was most rediculous to designate medical officers in honorary service with a prefix to indicate their qualifications and that the Government to be consistent with the spirit of their G. O. should add such prefix to all the honorary medical officers. We also said that this amended G. O. cannot be made applicable to the honoraries who were entertained as such before the date of this new order and that the Government was morally and legally bound to designte the honoraries who joined honorary service before the date of the amended G.O. was passed, as per the terms of the old G.O. The Government did confer the designation of Honorary Assistant Surgeon to a medical Licentiate entertained as a Clinical Assistant in one of the city hospitals and it is also said that quite recently a L.M. & S. Clinical Assistant has been promoted as Honorary Assistant Surgeon. About a year ago when two Clinical Assistants were recommended by the respective Superintendents of the hospitals where these Clinical Assistants have been serving as such, it is said that the office of the Surgeon-General felt the necessity of a change in the designation of the medical Licentiates in honorary service. We now learn that a reference has been made by the Government to the Surgeon-General as to how the Licentiates who joined honorary service before the new G. O. was passed could be brought under the purview of the new G. O. The eyes of the profession especially the Licentiates section of it, are now naturally turned towards the Surgeon-General. They expect that the Surgeon-General who is well acquainted with the designations and other details of honorary medical officers' scheme in Great Britain where no prefix is added to the designation of honoraries to indicate their qualifications inspite of the existence in that country of medical qualifications of various grades and standards would rectify the mistake. They rightly feel that the Surgeon-General who is also the head of the independent medical profession being the President of the Madras Medical Council, will be true to the position he occupies by sticking to the proposal that emanated from his office perhaps inadvertently and gracefully advises the Government to withdraw the new G. O. It is reported to us that the Madras Medical Council have passed a resolution at the instance of Dr. V. Rama Kamath that calling honoraries with a prefix indicating their qualifications is against the spirit of Medical Registration Act. This resolution will we trust strengthen the hands of Major-General Sir Connor.

Specialists in Govermment Service: We have received a communication from a prominent member of the medical profession of repute as a Physician who raises an Ethical issue whether specialists in the medical profession can practise in other branches of medicine when they style themselves as specialists in a particular branch and are recognised as such. We are glad this pertinent question comes from a State-paid medical practitioner and not from a private practitioner. We would have been gladder if the State-paid medical practitioner permitted us to publish his communication. To us Specialisation means division of labour for better service, in the interest of those to be served and not at all in the interest of those who wish to serve. The Code of Medical Ethics so far published by the Medical Councils in India is a copy of the Code published by the General Medical Council, Great Britain. After we received the communication under reference we went through the Code as published by the Madras Medical Council and found that there is no particular reference to the for in subject of Specialisation All the same, mention has been made in the body of the Code of Ethics that what was mentioned so the Code are only examples and nothing prevents the Medical Council to bring within the Code such acts of omission and commission by the registered practitioners which in the opinion of the Council is unethical. Ethics is rather a loose term and what constitutes good or bad Ethics depends entirely upon a society, its environment and the prevailing conditions. For example running of chemist shops and public nursing homes is considered unethical in some countries but this is permitted in India so far. Specialists should always be consultants and cannot at any time take the role of a general practitioner. In India, Specialists either in Government service or in private practice were originally self-styled. Many such practitioners exist and will continue to exist for sometime at least. Private practitioners in Allopathic System which is now styled as Scientific System, owe their existence in India entirely to the British Government who introduced this System in the country. The Medical Councils were also brought into existence in India by the British Government on the model of such a Council in Great Britain. Unfortunately the Medical Councils in India are not recognised by the Indian Government to the extent the General Medical Council is recognised by the British Government. So any advice to the profession from the Medical Council is not likely to be heeded and may even be questioned more by the Specialists in the Govt-service than by those in private practice if the Madras Medical Council takes the initiation and calls upon the Specialists not to practise in other branches of medicine than the one in which they are specialists. The safer course would be for the Government to restrict private practice to State-paid specialists calling upon such of them who are permitted private practice to restrict it to the subjects specialised by them. At present a gynæcologist and an obstetrician is found practising as a general practitioner and a physician as a surgeon and *vice versa*. These specialists may perhaps be excused to a certain extent for going out of the sphere of work which only, they are expected to deal. The most incongruous position which should not be tolerated more in the interest of public safety than in the interest of the profession is to permit general practice to medical officers employed as Bacteriologists, Pathologists, Radiologists, Bio-Chemists, and Chemists in the Government Department as Physicians, Surgeons, Obstetricians, and Gynæcologists. The specialist were brought into existence by the Government consistent with the ever advancing medical science so as to give the patients the best benefit of treatment in the matter of diagnosis where bacteriological and laboratory tests are considered essential to confirm or aid physical diagnosis. Medical officers in these special branches should devote their time and attention, only, for the purpose for which they are paid. Their avarice to amass more money as general practitioners will and is telling upon the credulity of masses who cannot assess the usefulness of medical officers employed in different special branches of the Government Department especially so when such specialists are working in the premises of medical institutions where the public avail themselves of treatment either free or paid. The masses are generally carried away with the grandeur of the environment of hospitals where these specialists work in special units and do not and cannot know for what purpose a parti-

cular medical officer working in such a unit could be consulted by them to their best advantage. We trust it will not be difficult for the Surgeon-General who is a recognised Surgeon of international reputation to realise the necessity of restricting private practice of the specialists working under him to the special work these specialists are expected to do. The credit or discredit of private practice in Allopathic system of medicine now enjoyed by the members of the profession goes to those in service. It should be so in special private practice also. We trust the Head of the medical administration in this province will appreciate our comments on this subject and advise his subordinates to value the honour and prestige of the profession more than lucre. In the meanwhile the medical profession has its own duty to perform and we trust the specialists in private practice will note our remarks and co-operate with the Surgeon-General in case he takes a lead in the way suggested by us as the Surgeon-General is the Head of the independent medical profession also, in his capacity as the President of the Medical Council.

Dr. Jivaraj Mehta: We have published in this issue the address delivered by Dr. Mehta at Bhushawal where he presided over the Conference of practitioners belonging to East and West Khandesh, on 8-3-36. Dr. Mehta dealt in his address most important topics concerning the medical profession and medical relief in this country. Instructions in medical schools, post graduate medical education, extension of medical relief, rural sanitation, blending of the indigenous systems of medicine in the scientific system of medicine, the development of the hospital requirement industries control over pulminory tuberculosis, nutritional research, sickness insurance scheme, and last but not of least importance, nursing and health visiting work, were the subjects in which Dr. Mehta interested himself in his address.

Dr. Mehta is a person of eminence holding responsible office as the Dean of K.E.M. Hospital and S.G.S. Medical College Bombay. He is also a recognised patriot. His address deserves the attention of the profession and the Government on both of whom lies the serious responsibility of solving problems concerning the health and welfare of the public. His constructive criticisms regarding the present deplorable condition of Medical Schools, are as just as his suggestions for Post Graduate Medical Education are elusidative. Both these subjects have been discussed by us repeatedly in the columns of The Medical Practitioner and we are glad to note that the views on these subjects expressed by Dr. Mehta are identical with ours. We wish the Government as well as the representatives of the people in the Legislative bodies not only in Bombay but in other provinces to read the words of wisdom and sagacity expressed by Dr. Mehta, in his address. Living as he does in the city of Bombay entrusted with the responsible duties of managing and administrating a national University Medical College and Hospital, Dr. Mehta displayed a wide and comprehensive outlook regarding the extension of Medical Relief. He made as good a case for the better equipment of Head Quarters Moffusil Hospital as for the Metropolitan Medical Institutions where country people usually flock to get expert treatment. He pointed out that the District Hospitals should be improved "by the appointment of better qualified and experienced medical officers and by the increase of bed accommodation in them". He was keen that the Taluk Dispensaries should be "converted into small cottage hospitals". Dr. Mehta was perfectly right in saying that the difficulties of those responsible for hospital administration would be minimised if the moffusil hospitals were equipped with staff and materials as satisfactorily as the city hospitals. Dr. Mehta practical man as he is, did not fill his address with mere head lines followed by pious narrations of grievances of the public and the medical profession without showing ways and methods of carrying out the reforms suggested by him as is usually done by compatriots in his position when they address gatherings of the kind which Dr. Mehta addressed at Bhushawal. We wish our readers and those interested in the extension of medical relief in this country read paras 6, 7, and 8 in his address as the methods and ways suggested by Dr. Mehta are worth their consideration. For want of space we are compelled to supress over temptation to comment further on the address of Dr. Mehta and have to be satisfied to follow the example of Dr. Mehta himself who in his address dealt in detail about most important subjects and

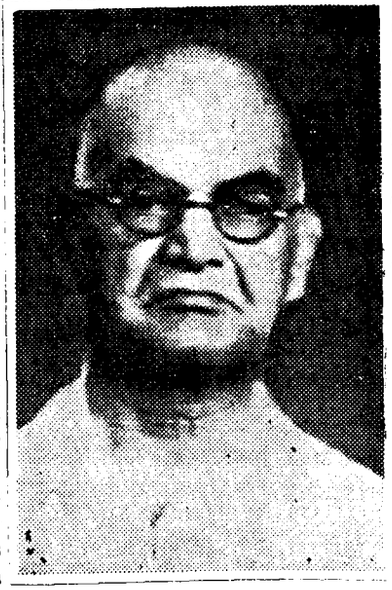
closed his address as abruptly as we are doing now regarding our comments on his address by merely mentioning about other subjects concerning the profession. We therefore once again commend to our readers the thought provoking address of Dr. Mehta. It is worth reading over and over again.

Apology Again: The Medical Practitioner was brought into existence not for private gain or as a commercial organ living on advertisements. Though it has an ownership for legal and moral purposes, the owner has kept this organ at the disposal of the medical profession and devoting it entirely to serve them in all possible ways. Its existence these seven years without being fed entirely by advertisers is a test for its popularity. It has no funds. It has been depending upon humble savings of labour of one individual member of the profession. There were occasions, two of them could even be called *grave crises* when the proprietor was about to stop the publication not for want of funds but his inability to stand the strain of editing. Year before last, the journal lost its Senior Editor who was also the origin founder of the journal. None could be found so far to shoulder this responsibility. Exactly a year ago the Managing Editor who has been in indifferent health for over 4 years had a serious illness. He was just approaching a few eminent members of the profession to colloborate with him for conducting the scientific section of the journal. A few have offered their services but as it is the intention of the management to have an Editorial Board representing all branches of medicine, the formation of the Board had to be postponed. Misfortunes never come single. The Managing Editor is a President of a Co-operative Bank. Recently a fraud of over 10,000 rupees was detected in the Books of the Bank and the President as a complainant has to spend lot of his time in attending Police Court where the clerk of the Bank is undergoing trial for criminal misappropriation. Under advice of the Co-operative Department, the Secretaries do not function and the President had to be at the Bank counter for six hours a day in addition to his attending the Police Court. He has also to attend heavy and responsible correspondence. As we are sure that the hearts of our readers are with us we have been narrating story after story of our troubles and worries hoping to tide over them by the good wishes and prayers of our sympathisers. It is expected that the affairs of the Bank may not require the sole attention of the President after a month. Though we are forced to go to press late on several occasions, we have been attempting that the news communicated by us, is not stale nor over comments belated. With this purpose in view we did at times publish current news though the issue is a month younger. We crave the indulgence of our readers to judge us by the circumstances we are put in and by our purpose and motive and excuse us for any technical errors. We have been forced to hold over publication of a large number of communications which we will publish in future issues giving preference to such of those, the publication of which serves any good purpose to the profession. With this apology we close another story of our troubles.

OBITUARY.

Col. Bhola Nath C.I.E., I.M.S., (Retd.)

We were not much surprised to hear about the sudden death of Col. Bhola Nath on 31—1—36 due to heart failure. We had his acquaintance for the first time when we came in contact with him at the Poona Session of the All-India Medical Conference in 1931. He took a prominent part at the Poona Session and ever since we had been watching his activities in connection with the Indian Medical Association. It was at his instance that the All India Medical Conference was invited to Lahore in 1929 when he was elected as the Chairman of the Reception Committee and in 1934 when the All-India Conference met at Lahore he was elected as the President of the Indian Medical Association and continued as such till December 1935. Ever since he became a member of the Indian Medical Association, he identified himself with its activities sole heartedly. Neither expense nor infermity would deter him from the path he had chosen to serve the Indian Medical Profession through its accredited agency the Indian Medical Association. When he came to Madras last December our Dr.Kamath had a very long interview with him. Something common between these two prolonged the interview beyond the usual limits and Dr. Kamath gathered all about theCol. as Dr. Kamath had even then grave misgivings if Col. Bhola Nath's young active and vigourous soul would continue long to be in his frail, worn out physical frame which was then pining away on account of the death of his beloved wife scarcely a month before he visited Madras. Col. Bhola Nath blunt military exterior betrayed his otherwise soft sweet interior when he cried and cried while narrating to Dr. Kamath the news of the death of his wife, and pointed out to Dr. Kamath his pet dog which was then on Col. Bhola Naths' bed licking Col. Bhola Nath's feet (perhaps trying to console his loving master) and said bitterly sobbing that his residence at Lahore then vacant had no attraction for him and that his pet dog was his only solace. He could not leave his pet at home as there was none to look after him. Long continued ill-health, the cruel separation of a loving life partner, the physical strain of extensive touring as a propogandist of the Indian Medical Association and the exhausting personal interviews he had had day after day, were considered by Dr. Kamath incompatible with a physical body of an Indian, worn out by disease and infirmity and at the time smouldering internally out of sorrow and separation on account of the death of a loving wife. Dr. Kamath was visually moved at the time feeling, within himself that Col. Bhola Nathi's soul was likely to leave his then physical body soon and find another physical body as young as the soul to continue the activities near and dear to the heart of Col. Bhola Nath. So it is we said that we were not surprised that Col. Bhola Nath passed away a month after Dr. Kamath met him at Madras.



Our heart is full of sorrow and we do not wish to say once again what we did say about this noble soul in The Medical Practitioner soon after Dr. Kamath met him at Hotel Bosotto last December. May Col. Bhola Nath's soul rest in peace.

Photo, by kind courtesy of "The Hindu".

Review

Review on the report of the Peddunaickanpet Municipal Ratepayers' Association for the year 1933-35.

The report deals in detail with the origin and growth of the Ratepayers' Association. The Association was brought into existence on 15—9—32 with only 50 members on the roll. It now has 643 members of whom 610 are the ratepayers of the division. As many as 36 paragraphs in the report deal with the activities of the Association and it is seen that the Association has been diligently co-operating with Corporation Executive and helping them in the discharge of their duties. The care of the dust bin was considered by the Association as good a noble duty as the interest they evinced in Corporation Administration. Nothing was left unattempted and everything was done to keep the Corporation Executive alive to their responsibilities in keeping the division clean and healthy and for this purpose the Association utilised the honorary services of Mr. T. A. Ramachandra Sastri whose services the Association rightly eulogises in the body of the report.

We congratulate the Association on the splendid work turned out by them through the agency of their energetic and vigilant Vice-President, Mr. Ramachandra Sastri whom the Association aptly calls its Executive officer. We wish that the report of the Association is broadcasted throughout all the remaining divisions of the city at least. The example of these ratepayers is worthy of emulation by not only the ratepayers of the city of Madras but also by all the local bodies in the Province, if not in India. India is now on the threshold of getting responsible self-government, and crying bitterly for not being trusted by the Government to manage her own affairs. We have been noticing with great regret that majority of local bodies at least in this Province were found wanting in the management of medical departments under them. It cannot be otherwise with regard to other activities of these bodies. It is such Associations conducted on sound and healthy lines that should educate the citizens and enable them to disaharge their duties and responsibilities to themselves and their neighbours. We wish that the noble and the laudible example of the Ratepayers' Association of Peddunaickanpet is followed by other ratepayers not only in the city of Madras but throughout the Province. Before closing, we wish to point out to the Executive Committee of the Association a serious omission in their activities regarding welfare work. Municipalities, local bodies and even the government exist only for one purpose, that is, to enable those under their care to live a healthy and a prosperous life. It is therefore the primary

duty of all organisations to bestow great care and attention about health. This cannot be achieved unless these organisations take keen and abiding interest in the medical institutions. It is very unfortunate that none including the Government have realised the importance of self-governing medical institutions to do health and welfare work. There has been always a tendency to depend upon paid medical service with regard to medical relief. Huge fabulous amounts are now being spent both by the Government and local bodies for paying the medical officers with little or no tangible results on the death rate. If there is any department which should be entirely left to the control of the citizens, it is the medical department. We therefore suggest to this otherwise most useful Association to include in their activities the running of medical institutions for the benefit of the rate payers, started and controlled by themselves with the help of honorary medical service. They will then have the credit of not only preventing death and disease but of saving huge expenditure by the Corporation. They will thus indirectly force this body to reduce top heavy expenditure and thereby check the present tendency of increasing the rates of taxes.

Reg. No. M. 2538.

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

Vol. VII Nos. 6 & 7 MARCH & APRIL 1936

The Medical Practitioner

A Monthly Medical Journal

EDITED BY
Dr. V. Rama Kamath,
Member, Madras Medical Council.

CONTENTS.

Printed at THE .
Managing Editor, .

THE

Medical Practitioner

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

VOL. VII.] MARCH 1936. [NO. 6

Original Articles

THE TREATMENT OF DIABETES MELLITUS

BY

DR. K. C. PAUL, M.D.,

Ppysician-in-charge, Diabetic Clinic, (Outpatient Department) General Hospital Madras.

1. In the latest (1935) edition of his monograph, The Treatment of Diabetes Mellitus, Joslin has stated : "Diabetes in and itself is no longer fatal, and the diabetic has almost ceased to die of his disease." But in 1907 Saundby wrote : "Diabetes is in all cases a grave disease, and the subjects are regarded by all assurance companies as uninsurable lives : life seems to hang by a thread, a thread often out by a very trifling accident." It is apparent, therefore. that the outlook for the diabetic has improved considerably at the present day. This improved outlook is the outcome of the therapeutic advances of recent years.

Modern diabetic therapy is of very recent origin ; but already it has been fruitful of highly favourable results. It has enabled the victims of diabetes to live longer than formerly and to lead healthier and fuller lives. It is, however, in no sense curative therapy, being only corrective and substitution therapy. Its aim is to prevent or annul any and all disability arising as a result of diabetes. This aim it has achieved, and with no scant measure of success.

2. A brief survey of the development of diabetic therapy reveals that it has closely followed the trend of thought that has prevailed from time to time regarding the nature and origin of the disease. It need not surprise us that till recently the treatment was empiric and inadequate ; for, true perception of the nature of the malady occurred only in recent times. An almost indiscriminate use of drugs prevailed till the correct principles of treatment were appreciated nearly two decades ago. But at the present day it is recognized that drugs find no place in the treatment of diabetes.

In ancient times, when the nature of the disease was unknown, drugs were the mainstay of treatment. The physicians of Ancient India, whose therapeutic acumen was of no mean order, imposed dietetic restrictions, but they placed reliance mainly on such medicaments as abhrakabhasmam (a preparation of mica) and vasanthasukumaram (a drug compounded from many mineral and vegetable substances), on decoctions of the seeds of jambul, and on certain herbs. The dietetic regimen they advised was the use of wheat in place of rice without restriction as to quantity. They enjoined physical exercise as a valuable adjunct to the other measures ; and for this they deserve praise as it is really sound therapeutic advice. The gifted Arabian physician, Avicenna, treated the disease with theriak (probably opium), musk, belladonna, and such other substances. There was no dietetic restrictions in his therapeutic scheme or in that of the physicians of Europe.

Glimmerings of the correct principles of treatment became evident only towards the end of the eighteenth century. Rollo in 1798

recorded considerable benefit accruing to diabetic patients from a diet which was almost wholly composed of meat and animal fat; he insisted that rigid exclusion of carbohydrates from the diet was of paramount importance in the successful treatment of the malady. The Rollo regimen was in general vogue for some time, but it was soon found that the addition of green vegetables, poor in carbohydrate, to the dietary made it more acceptable to the patients without materially impairing its usefulness. Credit for the use of green vegetables, boiled in two or three changes of water, to free them of their carbohydrate content, belongs to the eminent French clinician, Bouchardat, who deserves credit also for being the first among Western Physicians to recognize the value of physical exercise in the management of diabetic patients. Bouchardat told his patients who asked for bread, "You shall earn your bread by the sweat of your brow." It is a matter for regret that our physicians do not give this advice to their patients often enough.

Dietary regulation became accepted as a valuable measure for the control of diabetes in the nineteenth century. The use of drugs did not, however, abate, and many new drugs crept into usage. The list of drugs in common use during the second half of the nineteenth century included among others opium, codeine, belladonna, salicylate of soda, iodide of potassium, arsenic, egg-shell powder, strontium bromide, carbonate of soda, carbonate of lithium, preparations of jambul, quinine, salicin, and uranium nitrate. The dietary restrictions advocated by some physicians were such that the patients at times had to be kept behind iron bars to prevent them from obtaining food by stealth. One such physician was Cantani, who was probably the first, the physicians of Ancient India apart, to suggest that diabetes resulted from over-indulgence in food rich in carbohydrates. Be it noted further that the restrictions which were imposed affected only the carbohydrate moiety of the food. This latter criticism applies equally to the dietetic scheme of Kulz, who was the first to plan diets for each patient individually, after careful investigation of the carbohydrate tolerance.

Therapeutic advance of a different order came from Naunyan and his pupils, advocates of carbohydrate-free diets, whose work on acidosis and coma paved the way for the rational treatment of these conditions. They introduced the administration of alkalies in the treatment of diabetic acidosis and coma. But their claim for special recognition rests on the accidental discovery, that total extirpation of the pancreas invariably results in diabetes, which two of them, von Mering and Minkowski, made in 1889. This discovery was the starting point for the investigations which culminated in the isolation of insulin in 1922. It also provoked the many unsuccessful attempts at the treatment of diabetes by extracts of the pancreas.

The opening years of the twentieth century saw the introduction of the famous oat cure by von Noorden. The oat cure was a definite advance on all previous therapeutic measures. The principle underlying it was that of under-nutrition, a fact which von Noorden had not appreciated at the time he introduced it. Attention was sharply drawn to the principle of undernutrition when Guelpa in 1911 started his fasting cure of diabetes The fasting cure was, however, too drastic a measure, and did not find favour in the eyes of most patients Von Noorden had, in his oat cure, employed occasional fast days, which he called metabolic Sundays, and noted beneficial results.

The principle of undernutrition was experimentally worked out and made clinically available by Allen in 1915. He demonstrated clearly that restriction of not only carbohydrates but also of proteins and fats was essential in the therapeutic dieting of diabetes. The clinical results he obtained were far superior to any that had till then been possible. Abolition of glycosuria and ketonuria was obtainable even in severe cases of the disease. Owing to the Great European War, general dissemination of this advance in therapeutic knowledge did not occur till about 1919. In the meantime, Graham had independently established the principle of undernutrition as the basis of diabetic therapy, and introduced the *ladder diets* which are even now in common use.

Experience had taught that withdrawal of all carbohydrate from the dietary was dangerous and caused ketosis. It was known for a long time that "fat burns in the flame of carbohydrate, but without it, it smokes." The recent studies of Shaffer have indicated

in what proportions fat and carbohydrate should be present in the dietary in order that ketosis might not arise. Woodyatt has given a formula which has been employed considerably for working out these proportions in the actual dieting of diabetic patients.

The year 1922 brought with it the long-hoped-for discovery of the pancreatic harmone, insulin. This discovery revolutionized the trend of thought in diabetic therapy. The high hopes entertained in certain circles that insulin would be curative of diabetes did not materialize; but it soon became established that this hormone was the most potent anti-diabetic agent available. At an early stage of the investigations set afoot consequent on the isolation of insulin, it was realized that insulin therapy was substitution therapy and that it would yield the best results in conjunction with dietary regulation. This realization was helpful in preventing the indiscriminate employment of insulin in the treatment of diabetes.

3. Modern therapeutics recognizes that diabetes is a metabolic disorder due to insulin deficiency, that though it is primarily a disorder affecting carbohydrate metabolism, protein and fat metabolism also become involved in the process, and that the deficiency in insulin which is responsible for the disorder becomes aggravated by anything that throws strain on the islets of Langerhans of the pancreas. It recognizes also that the diabetic organism has much the same needs as regards energy expenditure as the normal organism, and that the diabetic organism behaves in practically the same manner as the healthy organism when the insulin deficiency is made good or allowed for. There is also one other fact it takes into account, namely, that the healthy adult ordinarily consumes more food than it is strictly necessary for him. Modern diabetic therapy has been built up with the above as the guiding principles. And it is because of the application of these in practice that the improvement in outlook now claimed for the diabetic has resulted. Though the general rule, "Once a diabetic, always a diabetic", holds good for all practical purposes, the results obtained thus far seem to bear the promise that diabetes may even be recovered from if treatment on modern lines is continued long enough.

*4. It has been pointed out that the aim of treatment in disabetes is to prevent or annul any and all diability arising from the disease. This aim can be met by adhering to certain well-established principles which may be summarized as follows:

(i) Normal values for blood sugar are the best, and in the diabetic an approach to the normal should be insisted upon; that is, the blood sugar when fasting should be within the normal limits of 0.08 per cent. and 0.12 per cent., and should not after meals rise above 0.18 per cent. The normal for urine, that is, absence of sugar, will result when this is achieved (except when the renal threshold for sugar is placed at a very low level).

(ii) Ketosis is abnormal and should be prevented or abolished; at no time should the urine contain any ketone. This can be ensured by keeping the ketogenic-antiketogenic ratio in the diet below 1.5.

(iii) The diabetic has but little reserve to utilize carbohydrate, and this should never be overtaxed: the damaged or defective islets of Langerhans should be spared functional overstrain so that they may not suffer further injury. Allen has shown that the islets of Laugerhans become further damaged if the diet is not strictly limited in carbohydrates, fats, and protein.

(iv) The metabolic functions are best performed when the general health is good; to ensure this the patient should take exercise and regulate his habits. Exercise promotes the utilization of sugar, and should therefore be insisted on wherever possible.

In putting the above principles into practice, the following maxims taken from the Diabetic Creed of Joslin will prove helpful:

"Normal weight or less should be insisted upon in each diabetic.....but therapeutic loss of weight should be extremely gradual.

"Mildness of the diabetes should be assumed, a long life (should) be expected, and the patient (should) be treated accordingly. Hence, the nearer the proportions of carbohydrate, protein, and fat in the diabetic diet conform to those of the normal diet, always seeking to avoid glycosuria and hyperglycaemia, the better it will be for the patient, even at the sacrifice of weight,

*This and subsequent sections of this article originally appeared in the journal of the Stanley Medical School.

though not of strength. A carbohydrate tolerance, unutilized, retrogrades.

"Reversal of the diet, namely high-fat and low-carbohydrate, assumes the contrary, severity of the diabetes, and is dangerous both in principle and in practice and unless accompanied by a minimum protein intake frequently ends in coma.

"Undernutrition (a) prevents diabetes and (b) is the foundation-stone of diabetic treatment, but if hunger can be avoided a smaller number of patients will yield to temptation, break treatment, and in consequence die of coma.

"Extreme inanition with loss of body protein is not worth while simply to render the blood sugar normal.

"Firm persistence in a strict diabetic diet (a) finds ample justification in the patients kept alive by it to profit by insulin; and (b) is essential to safety and success in the use of insulin. Insulin utilizes rather than replaces the advances in diabetic treatment hitherto achieved."

All the principles stated above are embodied in the modern treatment of diabetes, which consists in:—

(1) Dietary Regulation;
(2) Administration of Insulin;
and (3) General Hygienic Management:

It should be mentioned also that a prime requisite for achieving success is the co-operation of the patient, which will be forthcoming only if he is given a proper Diabetic Education.

5. It is generally admitted that in every diabetic the urine should be made sugar-free and the blood sugar normal. As Joslin says, "The urine is to be made sugar-free and the blood sugar normal: (1) because normal values are obviously the best; (2) because a high blood sugar is a stimulus for insulin secretion and the impaired island tissue should be spared overwork; (3) because the removal of the glycosuria proves utilization of the diet." It has been amply demonstrated in recent years that it is a comparatively simple task to render the urine of a diabetic sugar-free and his blood sugar normal. Place him on a sub-basal diet of low carbohydrate content for a few days and glycosuria will usually disappear. If it persists, reduce the diet further, and the desired result will be forthcoming. A preliminary fast will accelerate the disappearance of the sugar from the urine. The same measures will also bring the blood sugar down and keep it within normal limits. It is not, however, freedom from hyperglycaemia and glycosuria on a sub-basal diet that the therapeutist aims at. He seeks to maintain his patient in a state of health and comfort, without loss of strength, and without hyperglycaemia and glycosuria. On a sub-basal diet the patient will lose flesh, his strength will diminish, and he will be unable to do his usual round of duties. The task of the physician is, therefore, to ensure freedom from hyperglycaemia and glycosuria when the patient is on maintenance diet, that is, a diet yielding sufficient energy to maintain him in health and with undiminished strength. Some diabetics remain free from hyperglycaemia and glycosuria when on maintenance diet; they are those suffering from a mild type of the disease. The management of such diabetics is usually an easy matter. The greatest difficulty the physician encounters in dealing with them is to teach them the necessity for not overstepping the limits of the dietary prescribed for them. Many diabetics, however, continue to be hyperglycaemic and glycosuric even on the basal diet. Such diabetics never attain freedom from hyperglycaemia and glycosuria except on a sub-basal diet. Other diabetics there are, in whom hyperglycaemia and glycosuria will be absent when they are on the basal or a sub-maintenance diet, but will be present when on maintenance diet. In dealing with both these groups of patients the physician should employ insulin in order that freedom from hyperglycaemia and glycosuria will be ensured when they are on maintenance diet. It is essential that every diabetic should receive the diet that would, if fully utilized, suffice for his metabolic needs, that is, the maintenance diet, and it is equally essential that in every diabetic full utilization of the diet he receives should occur. It is requisite, therefore, that the diabetic who cannot utilize fully the diet needed for maintenance should be helped by the administration of insulin. But insulin should be made use of only when the maintenance diet is not fully utilized. The maintenance diet is a restricted diet and is so constructed that while it suffices for the energy needs of the individual it taxes the functional activity of the islets of Langerhans as little as possible. Any diet in excess of the maintenance diet will put the islets to greater strain. Therefore, it is imperative that where carbohydrate utilization is limited the diet should never be in excess of the maintenance diet. But this does not mean that diabetics who can fully utilize a diet in excess of the maintenance diet should not take all the diet they can utilize. The contention is that no diabetic should take a diet in excess of the maintenance diet unless he can utilize it fully without the use of insulin; in other words, insulin should not, as a rule, be employed for enabling a diabetic to make use of a diet in excess of the maintenance diet. It may be pointed out also that physical exercise may improve the utilization of the diet to even the full extent in some selected cases, and that recourse should be had to physical exercise as a therapeutic measure, whenever possible, before deciding on the employment of insulin. But insulin should not be denied to any patient, if circumstances permit, in whom for the utilization of the diet required it is necessary. Particular attention should be paid in this connection to juvenile diabetics. In juvenile diabetics, the diet should be such as would permit normal growth to occur; but few juvenile diabetics will be free from hyperglycaemia and glycosuria on such a diet; in them full utilization of the diet proper to them will result only when insulin is given. Insulin will have to be given to diabetics in certain other circumstances. When a diabetic, who ordinarily remains free from hyperglycaemia and glycosuria on the maintenance diet, suffers from an acute infectious disease or is subjected to toxic influences or trauma, he is apt to become hyperglycaemic and glycosuric; in such circumstances, his blood sugar should be kept within normal limits and his urine free from sugar till he recovers from the intercurrent malady, when usually he will continue to be free from hyperglycaemia and glycosuria on the diet he is allowed. Again, when a diabetic shows evidence of dangerous acidosis, or is threatened with coma, or is in actual coma, he should, at the earliest possible moment, be brought under the influence of insulin; to withhold insulin even for a brief while may here determine an untoward termination. But, taken all in all, the cardinal principle remains, that an effort should be made, in every instance, where circumstances permit, to establish freedom from hyperglycaemia and glycosuria without enfeebling the patient by adjustment on the diet; resort should be made to insulin only when dietary regulation fails to secure the results desired.

THE TREATMENT OF BURNS*

BY

DR. B. M. SUNDARAVADANAM, M.B., F.R.C.S. (Eng.)

Hon. Surgeon, Government General Hospital, Madras.

This is a very common condition, sometimes fatal and often necessitating serious incapacity and deformity.

"Damage to the tissues by dry heat constitutes a burn. A similar traumatism caused by a hot liquid or vapour is referred to as a scald." For convenience, both kinds of thermal injuries will be included under the term 'burns'.

CLASSIFICATION

It is usual to follow Dupuytren's classification. In this there are six degrees. Most cases are a combination of several of these degrees.

In the first degree there are no real after-effects. If repeated, pigmentation occurs specially on the front of the legs. In the second degree, blisters are commonly seen, the cuticle being separated from the cutis vera underneath. In the third degree, the entire epithelium is destroyed except localized islands here and there. A soft white scar results, but no contractures are seen. In the fourth degree, complete destruction of the skin and some of the subcutaneous tissues occurs. Destruction of the deeper tissues is included in the 5th degree of burn. In the last two degrees obvious scar with contracture results. In the last degree, carbonization occurs, and there is no recovery.

The considearation of the clinical course and pathology of the condition is essential to a discussion of its treatment.

CONSTITUTIONAL EFFECTS OF BURNS

These give most cause for anxiety and are of the greatest importance in early treatment.

*The Madras University Extension Lectures (1936)

These effects occur in four successive stages:

(1) Stage of shock.
(2) Stage of primary toxaemia
(3) Stage of septic or secondary toxæmia.
(4) Stage of healing.

Before proceeding to it, we shall refer briefly to the nature and causation of shock.

The question has been reviewed by Canon with regard to experimental traumatic shock, and the conclusion that has been arrived at is that shock resulting from severe trauma such as war-wounds, is of 2 kinds, namely

(1) initial or primary shock,
(2) late or secondary shock.

These two are different in causation, severity and consequence.

Initial shock is of nervous origin, similar in nature to fainting or syncopy but not of long duration and is due to a primary disturbance of the nervous vaso-motor mechanism.

Late shock is due to the action of a toxic agent absorbed into the circulation from the site of injury. This toxin is apparently a product of protein disintegration at the site of injury. It will be seen later that the stage of primary toxæmia which follows injury by burning is of similar origin.

First stage or stage of shock.—The main clinical features are prostration, sub-normal temperature, pallor, rapid pulse with low blood pressure and cold skin. This arises immediately after the injury and in the majority of cases is transient and slight in degree, and is rarely of serious significance. In cases of burns, the sources of shock are probably widespread damage to the numerous nerve-endings in the skin.

The stage of primary toxaemia.—This is the danger period in the clinical course and is largely responsible for the high mortality of burns. It commences between 6 and 24 hours after the injury, and in fatal cases terminates within 48 hours of injury. With the onset of toxaemia, the temperature rises often abruptly and more especially in children, may go up to 106°F. The patient becomes restless with an anxious expression the pupils are dilated and the colour is dusk or livid. There is vomiting, often coffee-ground, in nature as a result of hæmorrhagic gastritis. The blood pressure is low, pulse is rapid and small and the respiration rate is increased. Death is preceded by coma.

The researches in connection with this have proved conclusively that a toxin appears in the circulating blood within a few hours of the infliction of the burn. The toxin in the burnt area which is not of bacterial origin is absorbed into the blood stream and gives rise to symptoms of acute toxæmia. The exact nature of the toxin has not yet been determined, but most probably it is a product of protein disintegration occurring under the action of excessive heat and it is said to consist chemically of primary and secondary proteoses. There is some evidence to show that the toxins are carried by the red blood corpuscles themselves and have produced lesions of the liver, kidneys and spleen similar to those seen in typhoid fever and diphtheria.

The third stage, stage of septic or secondary toxaemia.—This arises from ordinary septic infection of the burnt areas. Some degree of infection is present in all cases where the skin is involved. Signs of septic infection appear about the 5th day. The subsequent course depends on the virulence of the infection and on the treatment employed. A few cases of infection with the tetanus bacillus have been recorded.

TREATMENT

The principles of treatment as indicated by the pathological condition in each stage will now be considered.

First stage.—In shock, the main lines of treatment are to avoid undue exposure to cold and restore normal body temperature, to administer fluids and to relieve pain. Pain is frequently severe and drugs of the morphine group should be given to adults. The depressant effects of morphine or heroin in young children must be borne in mind. Treatment of the injury by local measures is begun at the earliest possible opportunity which is frequently during the first stage and involves cleansing and dressing of the affected area. The value of a general anæsthetic cannot be over-estimated.

Second stage.—Here the primary indication of treatment is to prevent the absorption into the circulation of the toxin which is produced in the burnt area. There is no anti-toxin available. The absorption of the

toxin is best prevented by inducing coagulation of the damaged tissue, thus rendering the toxin non-soluble. For this purpose, a local application of tannic acid is the best. To Davidson of Detroit belongs the credit of having introduced the tannic acid treatment in 1925. Tannic acid minimises the acute toxaemia or prevents it entirely.

The *third stage* is that of a septic wound and the fourth is the healing stage.

DETAILS OF MANAGEMENT

The petient is put to bed at once. From the commencement the burnt area is exposed to air. No dressings are applied and the the bed clothes are supported on a suitable cradle fitted with the electric lamp bulbs. If the shock is severe, subcutaneous saline is administered. Morphine or Heroin is given for the relief of pain.

Cleansing.—Under gas and oxygen or ether, the area is cleansed. Blisters are opened up and evacuated and all the epithelium over the blister is removed, so that the tannic acid may come into contact with the damaged tissue underneath. It is here that the toxin is formed and gets absorbed. The whole area is cleansed with ether which exerts a drying and purifying effect and especially if any oily substance has been applied, it helps to dissolve it away, so that the watery solution comes into proper contact with the tissues.

Application of tannic acid.—The solution that is used is a 2½% aqueous solution in warm water. This should be prepared freshly for each application since tannic acid in solution is rapidly changed to gallic acid which has no power to precipitate or coagulate protein. The solution is sprayed with an atomizer and the parts are dried by the bulbs inside the cage. This is carried out at frequent intervals of half an hour as a rule, until all the burnt area is covered by a thin layer of brown coagulated tissue. The coagulation may occur more rapidly in some areas than in others. The areas coagulated are protected from fresh sprayings. In about 8 to 12 hours the coagulum is formed as a rule. If more deeply involved, it requires further sprayings.

Special circumstances.—In burns of the face, the eyes, nostrils and the external auditory meatus are protected during sprayings by pledgets of moist wool. It is not necessary to dry it artificially if the temperature is above 101°. In any case drying of the parts by artificial heat is both unnecessary and inadvisable when the temperature is high. If the front and back of the trunk are involved, the more affected area is sprayed and tannic compresses are applied to the less affected area. The compresses consist of sterile gauze swabs soaked in the tannic acid solution. These are applied at intervals of 8 to 12 hours and the dressings are removed after the coagulum is formed. The areas which are not coagulated are dressed further and the parts that have become coagulated are protected by dry gauze and cotton wool.

Local effects.—The immediate effects of the tannic acid are that after the first one or two applications, the pain is relieved and rapidly disappears. The entire area becomes covered by a thin brown or brownish black leathery coagulum, which is quite insensitive. This also acts as a splint, being rigid in character.

Care of the burnt area.—From the time the coagulum is formed till it comes off completely, no special local treatment is necessary. The bed clothes are supported and the areas exposed directly to air. If blisters are formed they are snipped open and the raw areas left are sprayed again. If fluid collects under the coagulum, it is evacuated through an aperture cut with scissors. If the perineum is involved, the bowels are regulated by enemata and the soiling of area with urine is to be prevented.

Treatment of Sepsis in the third stage is the most difficult problem in the tannic acid method. Signs of a mild degree of infection as evidenced by a discharge of a little purulent fluid from the edges and some reddening of the surrounding skin are occasionally seen at different parts of the area. In this case, no active treatment is necessary. Gross infection is rare and is associated only with the formation of sloughs in the very deeply burnt areas. In such a case the collection of pus may float the coagulum and the coagulum is stripped off or softened by vaseline and then removed. It is very important to note that in no circumstance whatsoever should wet dressings be applied for the coagulum. The presence of moisture is associated with some signs and symptoms of acute toxæmia. The

toxins gain access to the blood stream. Only when all coagulum is removed may wet dressings be employed in the treatment of sepsis.

In uncomplicated cases, healing under cover of the coagulum proceeds. In the second and 3rd degrees, the epithelium covers up the area in from 8 to 16 days. In the deeper ones, the coagulum is adherent till granulations develop. The coagulum is left alone till it can easily be peeled off. Sterile vaseline is applied after the coagulum comes off.

The tannic acid method can be applied even as late as 72 hours, whether or not other methods have been used. After this period the toxaemic danger is passed and in untreated cases frank sepsis generally occurs. At this stage it is to be treated as an infected wound.

General treatment.—As mentioned before, morphia has to be given in these cases. It is most important that the patient should have abundant fluids. If the patient can take the fluids by the mouth, it is sufficient; otherwise, the rectal and intravenous methods will have to be resorted to. If the pulse is rapid and feeble, brandy and glucose can be administered. If vomiting occurs, sodium bicarbonate 15 grains in 2 drams of water every hour has to be given for 5 or 6 hours. If sepsis is found, food of high calorific value should be given. In the severest cases, where a considerable amount of toxin enters the blood stream before coagulation occurs, the method of *exsanguination-transfusion* has to be adopted.

This is a valuable accessory method for dealing with the toxic state. The quantity of toxic blood is removed and is replaced by an equally or slightly greater amount of blood from a suitable donor. The amount of blood varies from, say, 120 c. c. for an infant to 250 to 300 c. c. for a child of 3 years old. In an infant, puncture of the supeiror longitudinal sinus through the fontanelle with a special needle is the best method.

The temperature is carefully watched, especially in Children. If 106 or higher, tepid sponging is indicated. Artificial cooling is very important in these cases. High temperature is very rare after the tannic acid treatment.

Clinical course:—The mortality is very low now after the adoption of the tannic acid treatment. The outlook is not grave even if 40 per cent of the body surface is affected.

Tannic acid should form part of the armamentarium of the village practitioner. In factories and other large estabishments it should find a place in the first-aid equipment, and its application by the compress method included in first-aid training. Where facilities do not exist for proper treatment, patients should be sent at once to the hospital immediately after the burns. Contractures must be prevented by adequate movements if near a joint and by suitable splints. It may be necessary to skin-graft the raw areas left behind.

ALTERNATIVE METHODS OF TREATMENT

Paraffin 7.—The wound is dressed with wool soaked in this mixture which consists of paraffin, vaseline olive oil and B naphthol. The paraffin and the wool cover it in layers. This is a very satisfactory method.

Picric acid method.—This method has been given up now. Another method is to dress the burns with a saturated solution of sodium bicarbonate. This is applicable for the 1st and 2nd degree of burns only.

Abstracts

Prognosis of Gastric and Duodenal Ulcer.

The prognosis with acute ulcers is far more satisfactory than in the case of the chronic variety. Although hæmorrhage may be fatal it is seldom fatal and the ulcer has a natural tendency to heal under the influence of diet and rest. As these ulcers are probably infective in origin if any septic foci are dealt with there may be no recurrences at all. The actual percentage of hæmorrhage from ulcers is probably between 2 to 4%. The prognosis of chronic ulcers has to be considered from two points—morbidity and mortality. The two dangerous and fatal complications are hæmorrhage and perforation. Death from perforation is relatively uncommon so long as adequate surgical aid is available. Nor are the deaths from haemorrhage large; probably not more than 20% of ulcers bleed severely, and of these not more than 5 to 10% die of hæmorrhage. The age of patient is a very important point; death from hæmorrhage is very unusual before the age of 50. On the other hand there is much increased risk with patients whose arteries are atheromatous. Patients rarely die unless they have several haemorrhages within a short time, and if further bleeding takes place it does so within four days. Consequently in cases of severe hæmatemesis it is safe to give a good prognosis if at least as regads immediate risks if four to five days have elapsed without recurrences. Modern methods of treatment, especially transfusion, and the reluctance of surgeons to operate when there is bleeding have considerably improved the prognosis. Pyloric stenosis or hour-glass stomach, both of which result from peptic ulcer, may endanger life by severe malnutrition or alkalosis. In such cases the results of surgical treatment are usually good. About 25% of cases with chronic ulcer are ultimately operated upon. The immediate risks of operation are by no means negligible, and in all probability are far greater than the danger of death from hæmorrhage. The average mortality for all operations is certainly not much less than 5 per cent. Apart from the immediate risks of death from operation there are smaller but very definite dangers due to the development of such serious complications as gastro jejunal or jejunal ulcers and gastro-colic fistulæ. The other risk in these chronic ulcers is that of malignancy. Carcinoma of the duodenum is practically unknown. But carcinoma may supervene on a simple ulcer. Physicians regard this risk as small though pathologists think that malignant change occurs in a high proportion of gastric ulcers. The risk of death from gastric carcinoma is little greater in patient with peptic ulcer than it is among the general population. Prognosis as regards expectation of life is not very unfavourable in patients known to be suffering from peptic ulcer and of 100 patients with proved ulcers not more than five or six were found to die as a direct result of ulcers. As regards the maintenance of good health, the picture is more gloomy as relapses are frequent and often disabling. The outlook as regards the rapid relief of symptoms by medical treatment is very good. Nearly all patients with uncomplicated ulcers whether gastric or duodenal are relieved of their pain within one week of instituting strict medical treatment with rest, diet and alkalis. Unfortunately the improvement is not often maintained for very long when the patient has returned to a normally active life. It has also been found that gastro-jejunal or jejunal ulcers may develop even ten years or more after operation and it is doubtful whether medical treatment alone effects a complete and permanent cure, in over 50% of cases whether gastric or duodenal. Of the factors in prognosis the most important is that the change of permanent cure varies inversely with the chronicity of the ulcers. Thus cases which are diagnosed early, *i. e.*, within six months or a year of the onset of symptoms, are more amenable to medical treatment. Another important factor is the age of the patient. Elderly patients with ulcers whether gastric or duodenal are notoriously unsatisfactory and the ulcer may fail to heal. Recurrences are extremely common even with strict and prolonged treatment. With elderly patient with large gastric ulcers there is always the possibility of malignancy. A fractional testmeal with a high or normal acid curve makes this contingency very unlikely. In patients with duodenal ulcers a very high gastric acidity is an unfavourable sign. Ulcers are more likely to recur if the concentration of acid is very great and if such patients have gastro-jejunostomy performed there is considerable risk of gastro jejunal or jejunal ulceration. On the whole duodenal ulcers tend to occur earlier in life than do jejunal ulcers and

react more satisfactorily to medical treatment. Ulcers which have penetrated deeply often require surgical intervention. Psychology of the individual patient is also important as medical treatment cannot be effective without the co-operation of the patient during treatment. It calls for great attention to detail, perseverance and self-control. The ultimate prognosis must be unfavourable to any patient who is unwilling to mend his ways as regards smoking, alcohol, irregularity of meals, overwork, late nights and the pleasures of the table all of which predispose to the recurrence of the ulcers.

Family history, social status and the occupation of the patient are important. History of peptic ulcers in the family is an unfavourable point. Patients who are financially independent are better than those who are otherwise. Occupation which involves a life with irregular, hasty meals does not induce to permanent cure. This is examplified by the frequency of ulcers in the medical profession.

(The Lancet, Novr 2, 1935).

Sclerocorneal Trephining

Lt. Col. Elliot stresses certain points in connection with sclero-corneal trephining. He still advocates a hand-worked trephine. He makes a long concentric incision, dissects down the sclera and takes up as thick a pad as possible while clearly exposing the limbus area. The splitting of the cornea is an important step in the operation and the further forward one can get the more sure one, is of entering the anterior chamber and so of establishing reliable filtration. Every care should be taken not to drag the uveal tissue into the trephine hole. This can be prevented if the trephine disc is held with the same grip as the bulging iris and the two are cut with one snip of the scissors. When impaction does take place it may be necessary to make a fresh trephine hole. In one of his cases Elliot found the following method suggested by Col. Kirkpatrick very successful.—He ballooned up the conjunctiva with a free injection of novocaine and adrenalin, introduced a Ziegler's knife subconjunctivally and cut right through the base of the iris prolapse. The operation was simple, painless and quick. The result was an astonishing lowering of tension. In his opinion this is a simpler operation and in no way prevents a second trephining at a different place. He also thinks that the operation would be far easier if done early. When detachment of the choroid takes place after the operation, Elliot does not think it necessary to interfere much with the usual habits of the individual barring warning the patient against violent exercise; prolonged recumbency has not had any particular advantage. After the operation it is very important to keep the pupils widely dilated, as otherwise the vision may be lost. For this atropine should be instilled at the time of the operation and for several weeks afterwards. When there is a tendency for the filtration to lessen rapidly in the early weeks after operation, Elliot employs digital massage. The patient can be taught to do it himself and a light touch is better than a heavy one. The movements of the fingers should be directed towards the centre of the globe and the force should not be dissipated in stroking movements which are of little value. When a cataract is to be extracted, it is highly desirable that a large part of the incision—that opposite the filtering scar—should be made in the cornea while a broad bridge is fashioned in one or other side of the incision. This makes for, if it does not ensure, a very early closure of the section and avoids interference with the filtering scar. If the bridge is made right up through the filtering scar there is a grave danger of cicatrisation tying shown the flap, interfering with the filtration and leading to the return of the glaucoma.

(B. M. J. Aug. 24th, 1935)

Notes on Therapeutics, Diagnosis and other Medical Subjects.

DEHYDRATION

By

DR. T. V. MUTHUSWAMI CHETTIAR L.M.P.

Dehydration or deficiency of water and electrolyte is the chief disturbance present in a number of pathological states such as alimentary intoxication, diabetic coma and many such other conditions, accompanied by vomiting, diarrhoea, and diminished intake of fluid. Though dehydration may be brought about by various conditions, the fundamental pathological physiology of these conditions are very much the same.

To understand dehydration requires (1) a knowledge of the amount of water in the body (2) means of maintaining the normal distribution of water and electrolyte within

the body (3) methods by which disturbances in the amount and distribution of water and electrolyte may arise, (4) as the fundamental pathological physiology is the same, treatment on similar lines must be carried out.

CLINICAL TYPES:—The commonest is that following vomiting and diarrhoea i.e. following loss of gastro-intestinal fluid.

2. Due to loss of considerable quantities of sodium, and potassium chlorides as for examble in diabetic coma in which condition dehydration plays a greater role than is usually appreciated. In the diuresis accompanying and preceding diabetic coma, considerable amounts of sodium and potassium chlorides are lost.

3. Due to a deficient intake of water and salt. In chronic nephritis, patients are unable to form a concentrated urine and tend to execrete chlorides when the concentration of these substances is already reduced. This is due to a dificient intake of water and salt.

4. Due to a diminished intake of water over a prolonged period, gives rise to a deficiency in the volume of body water as much water is lost imperceptibly through perspiration and urine.

Symptoms are fever, weakness and loss of strength, loss of appetite, vomiting, diarrhoea and collapse.

TREATMENT:—To combat dehydration, give water and sodium chloride by mouth, by veins, protoclysis or hypodermoclysis. In the case of infants chief reliance is placed on the subcutaneous injection of physiological saline, Ruger's solution, or their alkaline equivalents (as for example Hartmama's solution, Cunningham, and Darrow's solution) the amount given depending upon the estimated loss in weight, it must be sufficient to restore skin turgor and to produce an increase in body weight. A better criterion is the establishment of renal activity, i.e. sufficient saline must be given to produce 800 to 1500 c.cs of urine in twentyfour hours. In infants 500 to 1000 c. c. is enough. Older children seldom suffer from as severe dehydration as babies, and so, the amount required for one is usually inadequate for the other.

Intravenous glucose (10-20 c. c. of 10% solution per Kilogramme body weight) serves the same purpose. This supplies blood volume and is a readily available food.

Vomiting must be treated (accordingly) by gastric lavage with physiological saline and administration of ice. The state of collapse and shock accompanying dehydration is treated by the usual means. Transfusion of blood are among the most useful.

When acute symptoms have subsided give adequate nourishing diet in small and generally increasing amounts.

Ketogenic Diet in Persistent Pyuria.

Summerfieldt treated 14 cases of persistent pyuria by means of ketogenic diet from the spring of 1932. The ages of the children—all girls—were from four to twelve years. There were three children with bilateral hydronephrosis, one with a prolonged pyuria but no anomaly, while the remainder had a unilateral hydronephrosis. All those with an anomaly had an obstruction either at the uretero-vesical orfice, in the ureter or at the pelvo-ureteral junction due to an aberrant artery. Patients were started on a fatty acid to glucose equal to 1.6 : 1 and over a period of a week the ratio was increased to 3 : 1. In a few cases this was increased to 3.3 : 1. Later cases were given 10 grains of ammonium chloride three times a day to hasten the formation of acid urine. Urines were cultured frequently, bacterial counts made and the urinary pH determined by the colorimetric method. Of those children that had previous surgical treatment and still suffered from Bacilluria two of the four did not become bacteria free. One child became bacteria free in six months time and remained so for twelve months; and the other remained free for seven months and had a recurrence eight months later of pyuria with bacilluria. In those that had no surgical treatment in nine out of ten children the urine became sterile. In the one whose urine did not become sterile there was a mixture of bacteria and though B. Coli were killed in 34 days the staphylococci persisted in the urine. The urine did not become bacteria free till the urinary pH became 5.4. It took from one to twelve days to obtain this degree of acidity and as a rule the time required was from 4 to six days.

Sterile urines were obtained in from two to seven days except in those cases where it was found necessary to prolong the diet for a considerable time. One of these patients became bacteria free in 74 days. One in four months and the other in six months. Generally speaking the health of the children has been very good. Most of them have gained weight

and have had a minimum of upper respiratoy tract infections. Three children who did not become bacteria free in the hospital have had a persistent Lacilluria till the present, though one gives consistently negative results for examinations for albumin and pus cells and the third still shows occasional pus cells. In the remaining eleven cases the patients have had sterile urines over a priod of two to eighteen months but in two of these cases there was a pyuria again over a peiod of six months and eight months in which there were numerous pus cells and bacteria again present in the urine. An attempt to treat two infants 14 and 4 months of age was unsuccessful because of their inability to tolerate a high diet.

(*Archives of Disease in Childhood*, Oct. 1935)

Human milk as Hemostatic.

Sole gives a summary report of the hemostatic action of human milk which he discovered in 1931. Human milk surpasses all other hemostatics in vitro as well as in the patient. However, colostrum is ineffective and the hemostatic action develops completely between the fourteenth and the thirtieth day of lactation, but after that it remains practically the same throughout lactation. Only the milk of entirely healthy women (without febrile diseases) should be used. Human milk was found to accelerate the coagulability of animal bloods. The principle in human milk which effects the acceleration of the coagulation adheres to the suspended fat particles and can be separated from milk by centrifugation. The principle is not soluble in alcohol, ether or acetone. The author describes a method for the preparation of a powder, which contains chiefly the coagulating principle and from which aqueous suspensions can be prepared. He discusses the properties, the nature and the purpose of the coagulating principle in human milk. Human milk has a hemostatic effect only when applied locally, whereas enteral or parenteral (intramuscular) administration has no effect on the coagulation of the blood. The author applies the milk by means of iodoform tampons that have been saturated with it. The practical results of the local application of human milk are demonstrated on the basis of the case histories of hemophilic patients (operations and injuries). In such cases and in thrombopenic haemorrhages it produced favourable results.

(*J. A. M. A.* Nov. 16, 1935)

Calcium Deficiency in Children

Nesbit describes a syndrome of increased neuromuscular irritability and functional intolerance occurring in infancy, which is strikingly relieved by measures that improve calcium absorption. 36 cases illustrate the relation of the syndrome to convulsions and functional disturbances occurring in later childhood. These cases portray a symptom complex manifested (1) in early infancy by hypertonia, restlessness, eczema, crying, retraction of the head, irregular respiration, bronchospasm, enterospasm, pyloric spasm, convulsions and spells of cyanosis; (2) in the run about periods by sleeplessness, extreme restlessness, syncope and convulsions; (3) in the school period by hypertonicity, emotional instability; incorrigibility, together with other symptoms of increased neuromuscular irritability and chorea. The frequency of emotional upsets, excessive apprehensiveness, sleeplessness and tremor in the mothers of children having these symptoms have been demonstrated. The prompt relief afforded by calcium therapy in each of the instances cited, encourages one to attribute the underlying cause to some error of mineral metabolism.

(*American J. of Diseases of Children*, June, 1935)

Acid Medication in Treatment of Bacilluria

Crance and Maloney used nitrohydrochloric acid successfully in the treatment of five cases of bacilluria. They administered it four times a day, in doses of 10 minims, using as presciption four drachms of nitrohydrochloric acid (not the dilute) and enough water to make four ounces, one drachm of this mixture being given in two-third's of a glass of water followed by a full glass of water after meals and late at night. Nitrohydrochloric acid reduces the pH to 5 or below in apparently less time than the ketogenic diet and can be administered to the patient without hospitalisation and without change in the ordinary diet. Urine analysis has so far failed to show any damage to the kideney. The authors continue this medication for about one week after the culture has become sterile. They have treated three cases of the B. Aerogenes variety which on acid therapy alone have become symptom free and pus free but have not yilded to sterile culture of the urine.

(*Jl. of Urology*, Baltimore, abv. *J. A. M. A.* Aug. 3, p. 393)

secretion and causes easy and painles expectoration. In cases where the tough secretion is present in the deeper parts of the lungs this Syrup gives excellent results by stimulating physiological secretion and liquifying the sputum. The healing of these affections is thus greatly facilitated by this loosening of expectoration from the inflamed mucous membranes. Syrup Creosal has become therefore the classical treatment for these affections.

In coughs of whatever origin, whether acute or chronic, the response to the excellent sedative and soothening effects of Syrup Creosal A. F. D. is prompt. In dry, hacking and unproductive coughs the action of this Syrup is particularly gratifying. The pain, difficult breathing and restlessness so often attending these coughs are stopped with remarkable promptitude under the influence of this Syrup.

Syrup Creosal may be advantageously employed in both acute and chronic laryngitis. It is not only able to diminish cough and hoarseness, but rapidly lessens the pain which is experienced when swallowing.

Syrup Creosal is specially beneficial in acute and chronic bronchitis. By stimulating the bronchial secretion it helps in the liquefaction and expectoration of phlegm, lessens and soothes irritation and overcomes oppression in the chest. In chronic bronchitis marked improvement follows the exhibition of this Syrup. Emphysematous condition becomes gradually less, dysponea improves, the quantity of sputum diminishes and the expectoration becomes more fluid and mucous. It lessens the spasmodic character and frequency of paroxysms and the exhausting cough is thus much relieved. Syrup Creosal greatly adds to the physical and mental comfort of the patient in chronic bronchitis.

Syrup Creosal A. F. D. is an excellent adjuvant treatment in Pulmonary Tuberculosis. In all stages of this disease this syrup is very valuable, although we never claim to cure the disease with it. It has an extremely favourable influence on expectoration. It promotes expectoration to such an extent that the patient is soon relieved of hacking and exhausting cough and he is able to sleep well at night. Thus he can leave off the use of narcotics. There is diminution in the physical signs in the lungs and the quantity of sputum. Spasmodic coughing disappears, easy cough sets in and the general feeling of well-being is soon perceptible. In conjunction with this an obvious increase in appetite and reduction of temperature takes place and this naturally leads to the improvement in the general condition. Due to its calcium content Syrup Creosal A. F. D. if continued long, brings about in some cases calcification of the tubercular focus in the lungs. This action together with its tonic and stomachic effects raises the value of this preparation in tuberculosis of the lungs. Syrup Creosal A F. D. is of great value in the symptomatic treatment of Pulmonary Tuberculosis.

Syrup Creosal A. F. D is a clear aromatic Syrupy liquid miscible with water in all proportions. It has an invariable potency which enables the physician to give exact amounts. On accout of its great activity, dependability and digestibility, it can be prescribed with confidence in all kinds of coughs. Even after prolonged use this preparations does not disturb the gastro-intestinal tract, nor does it affect the kidneys in any way. No toxic symptoms are ever noticed even after continued use of this Syrup. Due to its pleasant taste and digestibility it can be easily given to children and sensitive adults. As it contains no narcotics Syrup Creosal A. F. D. can be safely given for months in chronic diseases. For the physician who wishes to prescribe a safe, palatable and effective cough syrup, Syrup Creosal A. F. D. can be recommended without the slightest hesitation.

Favus and Tinea Versicolor

Favus, otherwise known as honeycomb ringworm, is caused by a fungus known as genus Achorion. The tissues capable of infection are the skin, the epithelial tissues, the scalp and the nails. The appearance of Favus is most typical when it develops on the head. It is seen here in sharply defined patches which are glossy, red and sometimes moist. In chronic cases the patches may be denuded of hair or may be merely dry or scaly. As the affection develops there may be on the patches white scurfiness which may be soon followed by minute yellow plates. These yellow plates surround a hair follicle and are thinly covered by a layer of epidermis in immediate relation to it. The epidermis round about the hair follicle is firmer than that at the periphery and hence

there is a formation of a depressed cup in which the affected hair is seen in the centre. If the yellow plates are removed by a blunt instrument, a smooth moist and greasy surface is exposed. The fungus usually attacks the hair folicle into which it penetrates and, insinuating itself between the root-sheaths and the soft spongy tissue near the bulb, destroys the hair-root. The result is the hair loses its lustre, becomes friable and is loosened by pressure. Baldness may sometimes result due to the tension of the skin caused by the crusts or to the inflammatory irritation set up in the skin and the follicles.

The patient complains of considerable itching which becomes very much accentuated as the disease progresses. Scratching in order to relieve itching may give rise to secondary lesions such as pustulation and haemorrhage. If the infection is very extensive, mousy odour is present. Favus may spread from the scalp to the trunk, where it appears as dry red scaly rings smaller than those of the ringworm. The fungus of this disease may insinuate itself under the finger nails due to scratching and here the disease is very obstinate. It may be seen here as a yellow spot lying under the nail substance or it may protrude from its free margin in front.

Another skin disease caused by vegetable parasites is Tinea Versicolor or Pityriasis. The causative organism is Microsporon Furfur. It usually grows in the superficial layers of the epidermis but the hairs remain particularly free from infection. The covered parts of the body are generally affected by the disease. The eruption is characterised by large patches or spots which are either pale yellow or dark brown, and in rare cases black in colour. These patches are slightly elevated and are composed of branny scales which become easily loosened and which can be removed by friction with finger nails. In the beginning the patches may be small and round but they soon tend to coalesce, forming irregular large patches with remarkable symmetrical outline. The disease is found on the chest, abdomen and on the back. It may also be seen on the arms, thighs etc., but it is never found on the exposed parts of the body presumably due to the spores being completely removed by washing. The disease is not so contagious, but intimate association with the patient suffering from it may spread it. Persons perspiring freely are likely to get it but the dry-skinned ones are never affected by it.

For both these skin affections Sarcoptol containing active colloidal sulphur is the best remedy available. It ranks very high as a fungicide and penetrates into the skin better than any other drug of this class. Further, its antiseptic action is very useful chiefly in preventing the spread of the infection. Sarcoptol is a reliable parasiticide, specially in Favus and Tinea Versicolor as it readily permeates the tissues of the scalp and exerts its influence on the spores of the fungus embedded in the deeper layers of the integument. Thus the growth and virulence of the organisms is effectively inhibited. In these affections Sarcoptol is remarkably efficacious on account of the ease with which it is absorbed, its marked parasiticidal action, its sedative effects and the permanence of its results.

Constitutional remedies such as Fer-Ma-Pho, Hypercytol injections are of considerable value in these affections. The main treatment, however, is local, which should be carried out with persevering and continuous efforts.

In Favus the crusts must be thoroughly softened with oil and removed by washing it with soft soap and water. In severe types starch and Boric acid poultice, when properly applied is very useful. After washing, the affected portions should be rubbed with Sarcoptol lotion, commencing with one part of the solution to two of water. The strength should be gradually increased until pure Sarcoptol is applied. This application should be carried out at least twice a day. Epilation should be done, if necessary, systematically commencing at one end and gradually cleaning the affected area by regular progression. Persistent treatment on these lines is quite sufficient for a complete and speedy cure and if care is taken to preserve the follicles, permanent baldness will never occur.

The treatment of Tinea Versicolor is also quite simple. If the patient appreciates the need of exterminating all sources of propagtion, the fungi will be eradicated and the trouble will never recur in his life time. In this condition also, the affected parts are completely washed with soft soap and warm water and all greasiness of the surface should be removed. The skin is then dried and Sarcoptol lotion, one part of the solution to

two of water, should be applied. Here also, the strength should be increased according to the requirements of the case. Application should be done twice daily for a week at the end of which period almost all the trace of the disease will disappear. The lotion should be thoroughly rubbed in the affected parts morning and evening. The results are simply satisfactory. The only trouble about the condition is that it is likely to recur. It may persist off and on for the whole of the patient's life. Care should therefore be taken to root out all the foci of infection by means of this preparation. The underclothing of the patient should be boiled every day to destroy all the spores and thus fresh outbreaks of the disease may by prevented.

Interesting Case Reports.

1. I was called one night to see a Hindu patient about 60 years old. He presented such a grave anæmic syndrome and such intense cachexia that I thought of some malignant growth somewhere probably in its last stages. He was extremely weak, apathetic and he never cared to answer questions. No history either of alcoholism or any specific disease could be elicited. This illness, according to his relatives, was of two years' duration. For the last three months the disease had developed rapidly and progressively and there was severe anæmia, loss of strength, emaciation and anorexia. The patient had no proper digestion. In fact he presented all symptoms and typical signs of pernicious anæmia which was in a fairly advanced stage. There was waxy pallor, the skin was lemon yellow and the mucous membrane lacked colour. The patient had considerable asthenia. His pulse was very weak and the blood-pressure low, 96 systolic and 52 diastolic. Blood examination showed nearly 860,600 of red blood cells and hæmoglobin percentage was 30. There was almost complete achlorhydria. The patient was exclusively treated on Injectable Hepatrol and Hæmopanbiline, the former parenterally and the latter by mouth. He received one ampoule of 2 c. c. of Hepatrol intramuscularly every day and two teaspoonfuls of Hemopanbiline in fresh lime juice thrice daily before meals. He followed the usual light diet and no other antianæmic therapy was resorted to. A month of this treatment produced remarkable results. The patient who had hardly any appetite longed for his food every day. He was eating and digesting well. After a break of one week during which Hepatrol injections were stopped but Hemopanbiline continued, the treatment was again started. After nearly three months of this regime his strength returned, the colour of the skin became normal and blood examination revealed progress towards recovery. Red blood cells were 30,65,000 and hæmoglobin percentage was 65. Gastric analysis showed that there was sufficient hydrochloric acid. The same treatment was continued for nearly six months at the end of which period the blood cell count was nearly 45,40,000 and 100 percent of hæmoglobin. The patient was in almost the last stage of pernicious anæmia with low blood cell count. His complete recovery clearly demonstrates the remarkable efficacy of combined treatment of Hepatrol parenterally and Hemopanbiline by mouth.

2. This was a case of a woman of nearly 50, who sought my advice for nervous disturbances, palpitations and attacks of suffocation which coincided with the first menopause. For the last one year she used to get such attacks off and on. She got very much exasperated by these attacks and when she came to me she was in a typical state of neuropathy. Nothing abnormal was found anywhere and I believed these to be climacteric disturbances. Opocrin Ovaro-Pituitary (A. F. D.) was prescribed and both the ampoules as well as the opocrins were given. She was having 6 opocrins per day and the injections every other day. After a series of 12 injections was completed a very notable improvement was established. The palpitations and the attacks of suffocation very rarely disturbed her, but the nervous disturbances did not improve much, though they had lost their former severity. Another course of 12 injections was given and at the end of this there was complete disappearance of all the symptoms. She was all this time taking opocrins by mouth. She felt very much better after two months of this treatment and her general condition also improved.

THE
Medical Practitioner

VOL. VII.] MARCH & APRIL 1936. [NO. 6 & 7

DECISIONS OF THE ALL INDIA MEDICAL CONFERENCE.

In the last issue of "The Medical Practitioner" we discussed about the views expressed by the Chairman Reception Committee and the President of the conference held under the auspices of the Indian Medical Association at Nagpur. The resolutions passed by the conference were published in The Medical Practitioner in January. Any topic that comes for consideration before an all-India gathering and finally takes a form of a resolution, being of vital importance to the profession, we have been every year discussing in these columns about the decisions arrived at by the conference. Out of twenty resolutions that were discussed, nineteen were passed by the conference. Barring one which was termed as a "resolution of courtesy" concerning about thanks giving and three more resolutions moved by the President, the rest fifteen resolutions received the earnest attention of the conference. Out of these fifteen, the followings resolution was rejected by a narrow majority of two.

The resolution ran thus :—"In the opinion of this conference a registered medical practitioner should not have any connection with an open druggist's shop where prescriptions other than those of his own are dispensed". Of all the professions, the only one that has or at least professes to maintain the highest code of ethics is the medical. Yet the only one that is capable of setting at naught not only ethics but even crime is the medical. We did mention in these columns once or twice that the medical profession is so pliable that the worst perpetraters of crime could escape undetected while a saint in the profession apart from not being recognised as such, will not even be appreciated. We trust the members of the profession which is as sacred as it is noble will bear with us when we frankly express that because of the above fact it is desirable that this noble and sacred profession should maintain or at least have before them the highest ideals even at the risk and cost of personal gains monetary or otherwise. No member of any other profession can deal with the body or even with the soul of those entrusted to his care to the extent a medical practitioner does. The trust imposed in him by virtue of his being a medical man, has no parallel or even an approach. So it is incumbent on the members of the medical profession to keep in view the highest imaginable code of ethics. The fact that even a saint amongst the medical practitioners is at times ignorantly or maliciously connected with worst possible crime should not be forgotten. Treating a patient and supplying him medicines, materials and appliances etc. are correlative duties which cannot be separated. A medical practitioner is justified to charge a fee for a consultation and supply his patient whatever he needs to carry out the advice given. This is usually done in all civilised countries. To our knowledge this practice is followed on a large scale in Bombay and Calcutta where a practitioner charges a fee ranging from annas eight to rupee one for advice given to a patient at a time and this includes the supply of medicine. In Madras the principle of the above practice is followed but the patient is not charged an uniform sum but is made to pay a sum ranging from annas two upwards depending upon the items of supply in the form of medicine, appliances etc., and the patient is made to understand that he is paying the

price of medicine and not for consultation. There are a large number of general practitioners who call the place of their business by suitable names to indicate it as a chemist's shop. There are a few who do not style the place of their business as chemists and druggists but actually cater in the way the chemists and druggists do; while a few others particularly in service get themselves attached to a chemists and druggists shop on commission basis. Practitioners in service especially in the mofussil have such commission accounts with important firms in the towns and cities. As expressed above the best of intentions of the practitioners regarding their patients are at times misconstrued. It is usual with some patients or their relation to suspect that a particular practitioner is intentionally prolonging the treatment to gain money either by the sale of medicines or by visits. So inspite of the highest ideals inculcated in the recognised Code of Medical Eithics, medical practitioners are at times treated most uncharitably. The more so the practitioners should strive to maintain the Code of Ethics as scrupulously as possible. "Deriving pecuniary profit from the sale of any secret remedy; entering into any compact with Pharmist to receive a share in the profits arising from the sale of medicines prescribed or medical or surgical appliances; keeping an open shop that is, one for the sale of medicines, medical or surgical appliances etc., other than those prescribed by himself or by another registered practitioner (this definition to hold good for ten years after the proposed Pharmacy Act for India shall have come into force)", are some of the practices considered by the existing code of Medical Ethics, to tend to lower the dignity of the medical profession. The main object of the code of Medical Ethics is to give the patients the best benefit of treatment by medical practitioners and certain practices on the part of the practitioners, have been condemned so that they may be above suspicion. The code does not condemn the manufacture of remedies whose ingredients are published nor does it prohibit the sale of medicines by practitioners to their own patients. To suit the existing conditions in India the code is relaxed and

...who maintain a pharmacy are
...ll medicines etc., on the pres-
... other registered practitioner.

Under the circumstances the resolution tabled at the open conference was in con, formity with the existing Code of Medical Ethics and ought to have been passed without a division though the resolution contemplated breach of ethics in case of practitioners maintaining a pharmacy and selling goods on the prescription of fellow registered practitioners which is to be allowed for ten years after the proposed Pharmacy Act for India comes into force. In view of the resolution passed later by the conference regarding the urgent necessity of enacting legislation, in the shape of Pure Drugs Act and a Pharmacy Act and the establishing a college of Pharmacy prohibiting a practitioner from selling medicines etc. on the prescription of a fellow registered practitioner, was not only consistent but imperative. The fact that the resolution fell through after prolonged and heated discussion with a narrow majority of two votes indicates that the general sense of the profession on the subject was in favour of the resolution. We are rather surprised why the President ruled the demand for poll out of order especially when the subject under consideration was discussed thread bar by eminent members of the profession and the difference of votes against the resolution was only two. Many a time it so happens even in statutory gatherings that the show of hands cannot always be relied upon especially in contentious subjects when the show of hands shows a very narrow majority.

We are glad that important topics, concerning the life and prosperity of the medical profession engaged the attention of the conference and resolutions concerning these subjects were passed unanimously. Amongst these subjects the most important now requiring the attention of the profession is with regard to Medical Education and the conference decided that all existing medical institutions in India should conform to the minimum standard of qualification prescribed by the Indian Medical Council. This is a move in the right direction and will eventually put an end to the caste distinctions now prevailing in the profession and will help the profession to have more harmony and establish in this country a well-organised and united medical fraternity. The conference ought to have also reiterated their attempts to harmonise the profession in the

near future. Time has been very propitious at least for the last one year for the fruition of such attempts. The Legislative Assembly as it is now constituted ought to have been requested by the conference to amend the Indian Medical Council Act so as to bring the Medical Licentiates within the purview of the Act. As has been discussed by us repeatedly in these columns, the objection to have them within the purview of the Act on the imaginary difficulty of securing reciprocity from the General Medical Council, is a myth so long the Medical Licentiates are permitted to associate themselves professionally with practitioners registered in the Medical Register published by the General Medical Council. This omission is certainly regrettable.

The amending of the Lunacy Act with the purpose of removing the invidious distinctions shown to those in the British Register and to the State paid practitioners, which subject was the matter of discussion at the conference demands the earnest attention of the practitioners in India. The Provincial Medical Councils should be made to take up this question and bring pressure on the India Government to effect the amending of the Lunacy Act at an early date.

The establishing of a separate teaching cadre for Medical Schools and Colleges under the Government is a reform which is long over due. This reform is not at all difficult of accomplishment and may be given effect to with much less financial commitment on the part of the Government if it is made possible for the independant practitioners to join this cadre as part time or honorary teachers. There is no dearth of highly qualified practitioners who are capable of handling any subject in medical science.

Abuse of hospital facilities attracted the attention of the conference. This subject has been discussed in these columns in various aspects and we cannot afford to loose yet another opportunity available to reiterate our views on this subject which is literally as knotty as it is intricate. Vested interests have been entirely responsible for the gross negligence on the part of the Government in not giving their earnest attention to this most important subject which if carefully handled will afford greater facilities for the hospital going population amongst the rich, the middle class and the poor and bring more money for hospital administration. This subject is very important deserving to be discussed elaborately. We therefore reserve our comments on this subject at present.

We trust the Government in all the provinces will note the unanimous opinion of the conference that it is dangerous to entrust vaccination and food inspection to non-medical men. The Government of Madras have gone many steps further in encouraging quackery and on the recommendation of the Director of Public Health, has been permitting anti-cholera inoculations to be done by non-medical sanitary inspectors on the plea of economy. It is certainly less risky to allow non-medical men to do the work of the Director of Public Health than allow them to do the legitimate work of the medical practitioners for which purpose techinical knowledge is highly essential. The village folk are credulous to any imaginable degree. They are at present in the clutches of the quacks and qualified practitioners find it hard to make a bare living on account of the menace of the quacks in rural areas. The unscrupulous sanitory inspectors and other non-medical men who are entrusted with the work expected of qualified practitioners are likely to trade on the credulity of the villagers on the authority of the Government. We wish the provincial medical councils take up this question and urge on the respective Governments not to encourage quackery with the false ideas of economy.

We regret to note that the independent medical profession in C. P. failed in their duty in not availing themselves of the support of the conference for condemning the Government of C. P. in showing invidious distinction between the different sections of the profession in service and in private practice with regard to the issuing of the medical certificates while they passed the other two pious resolutions concerning this province one for establishing a medical college and the other to bring into existence a medical council for the province.

Correspondence Reports Etc.

The Tinnevelly District Medical Association, Palamcottah.

(AFFILIATED TO THE INDIAN MEDICAL ASSOCIATION).

The Tinnevelly District Medical Association held its monthly meeting on Saturday the 25th April 1936 at Tiruchendur. A Health Exhibition was arranged at the Board High School. Tiruchendur, at 9-30 A M. Lieut. Col. T. S. Shastry, I.M.S., welcomed the guests and requested Mr. Bryant, I.C.S., Sub-Collector of Tuticorin, to open the Exhibition. Mr. Bryant, I.C.S., expressed in a short speech that such Exhibitions were very useful, instructive and beneficial to the masses and expressed his high appreciation of the activities of the Tinnevelly District Medical Association under the guidance of Lieut. Col. T. S. Shastry, Temple Superintendent Mr. Muthiah Pillai, B A., B L., explained in Tamil the gist of Col. Shastry's address on the need and use of this monthly Health Exhibition. Dr. K. Govinda Ayyar, L.M.P., gave an interesting lecture in Tamil on the prevention and causation of Tuberculosis, Flies and Mosquitoes and Cholera, explaining in Tamil for the benefit of little boys and girls of the local schools, who were present at the exhibition. The exhibition was very much appreciated by the public and the Deputy Inspector of Schools Mr. Sankara Iyer offered hearty thanks to the Tinnevelly District Medical Association on behalf of the Educational Authorities.

After tea and music with Jalatarangam between 5 and 6 P. M., the meeting of the Association commenced under the Presidentship of Lieut. Col. T. S. Shastry, I.M.S., the President of the Association who presided over the Business Meeting of the Association—the Medical Meeting having been presided over by Dr. K.Srinivasaraghava Ayyangar, L.M. & S, Civil Surgeon, Tuticorin and president of the Tuticorin Medical Union.

After the passing of the condolence resolution on the demise of Dr. C. Appavoo Pillai, a senior member of the profession and reading of the minutes of previous meetings a comprehensive resolution pointing the necessity of attaching cancer-clinics to all District Hospitals and requesting the Governor to utilise the King George Memorial Fund entirely for the relief of cancer was passed. The resolution requested the medical profession and the public to subscribe liberally for the relief of cancer.

Then the Medical Meeting was held under the Presidentship of Dr. K. Srinivasaraghava Ayyangar, L. M. & S.

Dr. T. K. Nilakanta Ayyar, read Clinical Notes on the following cases, which were operated on by Lieut. Col. T. S. Shastry, at the Headquarters Hospital, Palamcottah :—

1. Gastric Ulcer, for which Disconnection, Eiselsber's Operation with Gastro-jejunostomy was done.

2. Gastric Ulcer with stenosis of Pyloric Ring, for which Partial Gastrectomy and Gastro-jejunostomy (Moyinhan's) was done.

3. Duodenal Ulcer with gall stones and extreme stenosis of the Pyloric Ring—for which partial Gastrectomy and Gastro-jejunostomy (Polya's) was done.

Dr. (Mrs) Amirtharaj, of Tuticorin read notes of a case of Cancer Breast (Female) which was operated on by the Civil Surgeon at the Government Hospital, Tuticorin.

Then Dr. Subramania Ayyar, of Karaikudi, demonstrated to the audience the full apparatus for testing Blood-sugar made by Carl Zeiss. Dr. P. Ramalinga Nayanar, of Srivaikuntam, read a most interesting and learned paper on "Revolution in Surgery".

Lieut. Col. T. S. Shastry offered thanks to Dr. J. T. Moses. Sub Assistant Surgeon of the Local Fund Dispensary. Tiruchendur. and to his fellow-members for the splendid arrangements for the meeting.

Thereafter Lieut. Col. T. S. Shastry, summed up the salient and important features of all the cases and addresses and clearly explained the Modern Operative treatment of Gastric and Duodenal Ulcer. He also appealed to the Medical Profession to do their best for Cancer-Relief in the District, and proposed a hearty vote of thanks to Dr. K. Srinivasaraghava Ayyangar, Dr. Subramania Ayyar and Dr. Amirtharaj.

Thereafter an excellent Dinner brought the happy gathering to a close at 11 P. M.

Piece of Metal in Baby's Heart

Stated to have been found embedded in the heart, a small piece of metal was produced at the inquest at Canvey Island, Essex, on the newly-born child of Evelyn Margery Bromley a 17-year-old girl, living with her parents in Toronto-road, Canvey Island.

The minute piece of metal was discovered at a post-mortem examination of the body of the baby, which died a few hours after birth.

Dr. T. W. Eaton expressed the opinion that it was part of a trinket or piece of jewellery that might have entered the mother's body pre-natally, and the baby grew round it. It was a most unusual case, the doctor declared, and one he had never heard of before. The presence of the metal was likely to cause death by interference with the valves of the heart. Dr. Eaton added that after the post-mortem examination he checked over all his instruments, thinking that probably the piece of metal may have become detached from one of them. They were all intact.

Recording a verdict of "Death from heart failure," the coroner, Mr. H. J. Jefferies, remarked, "It is a mystery". The coroner further observed that there was no evidence to show how the metal came into the position in which it was found.

Commenting on the inquest disclosures, a well known London obstetrician stated that he had not heard of such a case, but it was well within the realms of possibility. "We have all heard of extraordinary things," the obstetrician continued. "The mother may have swallowed the piece of metal, but it would be very difficult to determine how it finally got into the blood circulation. There are many instances of people who said they had run pieces of fishbone or metal into their feet, and these foreign bodies have appeared years later in other parts of their bodies. One of the strangest cases I have heard of concerns a man who was operated on some years ago for a suspected tumour, and the doctors took away two crude forms of infant life. The explanation was that Nature intended him to be one of triplets, and he was born with the origins of two other lives within him. He grew to manhood, when some condition of the body made the organisms develop."

(Times of India 4-4-1936)

Girl Brought Back to Life

"DEAD" FOR FIFTEEN MINUTES

A girl who had been "dead" for fifteen minutes was brought back to life by medical skill and two of the luckiest of chances. She is Daisy Allen, aged 23. Recovering from a long illness, she was still visited weekly by a doctor. Feeling tired after an outing the previous day, which had been her first for some time, Daisy decided to rest, although, otherwise, she was perfectly well.

She then had a heart attack, just at the moment when Dr. Justin Bailey had arrived at the front door—by a coincidence, one day earlier than usual. He hurried to her bedside, and pronounced her "gone." Breathing had ceased, and the heart was no longer beating.

Also, by a most extraordinary coincidence, the doctor had with him a new drug called "coramine." which was injected into Daisy's heart less than a minute after the seizure. He then applied artificial respiration. A quarter of an hour later he called in Daisy's mother, after performing what she described as a "miracle."

The girl's heart had begun to flutter and, after fifteen minutes was beating almost normally. Daisy was taken to hospital, where she regained consciousness after twelve hours. She was able to sit up the next day and the doctors are hoping that she will soon be better than she has ever been.

The girl's mother said in an interview, "Daisy's mind is completely blank regarding what happened to her." Of the incidents before her heart stopped beating the first thing she remembered when she regained consciousness at the infirmary after twelve hours, was a motor trip the previous day.

(Times of India 25-4-1936)

Triumph of Science

DEAD GIVE SIGHT TO THE BLIND

Science's triumph over blindness by the grafting of corneas of eyes from the dead to the living is revealed by Professor V. P. Filatov, director of the eye clinic of Odessa, who is visiting Moscow.

This process will be one of the most important tasks of a new ophthalmic institute of Odessa.

Last year 250 such grafting operations were performed, and in 100 of these cases the eyes from dead bodies were used.

Many of the patients in these cases are now able to read and work without handicap

By means of a "thought rap" scientists of Illinois University have been able to witness in the brain of an animal the ebb and flow of consciousness, that force as mysterious as life itself, wires the "News Chronicle" New York Correspondent.

When the animal was conscious an electrical current two to three millionths of an ampere was observed in a galvanometer to flow from the nerve to the brain.

When the animal was under anæsthetics the current flowed in the reverse direction.

The tests were conducted by placing one electrode on the cerebral cortex and the other on the exposed sciatic nerve.

(Times of India 22-4-1936)

News and Comments

A Social Function. To meet, the President and the Vice-President of the Madras Medical Council Dr. V. Rama Kamath arranged a special function at the Gokhale Hall, Madras on 20-4-36. At the special suggestion of the one of the chief guests, the President, the gathering could not be a big one and it was the desire of the President to give as little publicity to this social gathering as was possible. As the publication of medical matters in a medical journal is not considered unethical and as the purpose of the gathering was entirely for the benefit of the medical profession, a member of the Madras Medical Council being the host, we could not supress the news concerning this function. The Medical Practitioner being the only medium in this province specially started to give publicity to the activities of the Madras Medical Council and other topics concerning the life and prosperity of the medical profession it could not afford to supress the news of an important social function. The gathering was a choice and a distinguished one. Invitations were sent to all the members of the Medical Council and officers of the hospitals in the city not excluding the honoraries. There was a good response from all the hospitals excepting one institution in North Madras. Almost all the Europeans who were invited were present and a few that could not attend on account of previous engagements expressed their regrets to the host. After the partaking of light refreshments catered by the Modern Cafe, the host introduced the chief guests, Major-General Sir Frank Connor, the President and Dr. R. J. Dyson, Chief medical officer M.S.M. Ry, the Vice-President of the Madras MedicalCouncil He said that the President of the Medical Council who was always the Surgeon-General with the Government of Madras needed no introduction especially to a gathering consisting of the pith of the medical profession in the city who come in contact with him in his official capacity, but Dr. Dyson had to be introduced especially to the Indian members of the profession that were present. Dr. Kamath added that apart from personal and individual introduction of Dr. Dyson to the other guests, which he did soon after Dr. Dyson entered the Gokhale Hall, he wanted to say a few words about Dr. Dyson by way of congratulating him on behalf of the profession on his being elected unanimously as theVice-President of the Madras Medical Council, at its March session. Dr. Kamath did not keep it a secret that he was mainly responsible in honouring Dr. Dyson as the Vice-President of the Medical Council, it being the only gift the medical council could confer on one of its members for approved service to the profession. The Madras Medical Council said Dr. Kamath, was as undemocratic as it is defective yet he thought that the Government should be made to learn a lesson from the Medical Council that inspite of serious defects in its constitution and working, the Madras Medical Council was at present imbibed with the highest ideals of democracy inspite of the inherent spirit of autocracy displayed in the Madras Medical Registration Act. So he deliberately broke the old convention that the Vice-President of the Madras Medical Council ought to be one from amongst the representatives in the council either from the group II (graduates) or group III (Medical Licientiates of India and all the rest that could not be registered in the first two groups of the medical register). It was even pointed out to Dr. Kamath that the President of the council was always from group I of the Register and that therefore the Vice-Presidentship should be reserved to a representative of either the II or III group in the Register. Dr. Kamath

did not yield to this argument and told his colleagues in the council that even conventions should not loose the prevailing sense of democracy and that a new convention must be brought about which enjoined on the council to select a Vice-President by turn every year from one of the three groups and that this year the honour should go to one from group I as ever since the Medical Council came into existence a practitioner in group I in the register was not elected as Vice-President. Having said so much by way of introducing the chief guests Dr. Kamath narrated briefly the qualities of the head and the heart of Sir Frank Connor who though a surgeon and had a garb of a bureaucratic officialbody of one belonging to the Indian Medical service, was every inch of him a democrat. Dr. Kamath humourously expressed his fears in approaching Major-General Sir Frank Connor for the first time soon after he came to this province. A strong impression had been printed in his mind ever since his school days where he saw for the first time as a medical student, the late Col. F. C. Reeves the then Superintendent of the Royapuram Medical School functioning also as a surgeon and it was not possible for him to forget the awe inspiring look of the Surgeon Superintendant of the Royapuram Medical School and the other surgeons he came across in his professional capacity such as the late Col. Giffard and the late Col. Niblock all of whom had a rough military outlook inspite of a kind heart. But it was a very pleasant surprise to him that the very look of Major-General Sir Frank Connor was quite the opposite of his past impressions of surgeons. Dr. Kamath saw an amiable smiling face responsing to his greetings. Dr. Kamath then narrated some incidents which impressed him that Sir Frank Connor was an ideal Chief not only of the Medical Department but also of the entire medical profession, by virtue of his being the exofficio President of the Madras Medical Council. Dr. Kamath casually mentioned that a personal contact of Sir Frank Connor did materially change his (Dr. Kamath's) body and mind for the better. Regarding the other chief guest, Dr. Kamath said that though he was an European occupying the idential position of a Suregeon General being the chief medical officer of M.S.M. Ry. on a smaller scale he carried with him lofty ideals of democracy which he practically demonstrated in his capacity as one of the elected members of the Madras Medical Council. Dr. Kamath had at first his own misgivings about this guest being also a surgeon but Dr. Kamath's close association with Dr. Dyson while both of them served in the disciplinary committee of the Madras Medical Council, impressed him without a shadow of doubt that though registered in group I of the Medical Register and a chief medical officer having under him a large number of practitioners in the I, II and III groups of the Medical Register, as a member of the medical council Dr. Dyson treated all registered practitioners alike to whichever group they belonged. Dr. Kamath told those assembled that Mr. Dyson was a real acquisition to the Madras Medical Council and thought it was his duty to appeal to the medical profession to take advantage of the positions, temperament and inclinations of the chief guests of the evening during their regime as the President and Vice-President of the Madras Medical Council and make this council an ideal body to guard the rights and privileges of the profession without any idvidious distictions of grades and castes now prevailing in the noble profession.

Both the guests made suitable replies to the references made to them by the host and expressed their appreciation of the purpose and usefulness of such social functions. Sir Frank Connor invited the practitioners to speak about any matter concerning the profession requiring the attention of such a gathering. Dr. U. Krishna Rao, Member Medical Council brought to the notice of those present the glaring injustice done to the profession by the heads of some departments of the Government in not approving the medical certificates granted by registered medical practitioners and calling upon the subordinates under them to get a second opinion from Government medical officers. He mentioned about a certificate granted by himself and which was sent to a Government medical officer for a second opinion and said that it was most insulting that a certificate issued by a member of the Madras Medical Council in his capacity as a Registered Medical practitioner, should be censured by another registered practitioner in service in spite of the fact that he being a member of the medical council, was one of the

judges to try registered medical practitioners for disciplinary conduct. Sir Frank Connor could not evidently meet Dr. Krishna Rao's arguments and mentioned about his experience as one of the Presidency Surgeons in Calcutta, that a registered medical practitioner was found sitting at the door of one of the public offices for the only purpose of issuing medical certificates to the employees attending that public office which he did for a pittance of a few annas. He also referred to his experience as one of the chief medical officers for an Insurance Company about the medical certificates issued by practitioners at random. Dr. Krishana Rao, not being satisfied with the reply, said there were instances of corrupt practices amongst the members of the medical profession even in service and it was therefore necessary that the practice of obtaining a second opinion on medical certificates issued by private practitioners should be abandoned.

Though we cannot approve of the claim put forth by Dr. Krishna Rao for a member of the Medical Council to be exempted from the operation of a procedure applicable to all registered practitioners, we cannot but take yet another opportunity of protesting against this most unethical procedure condemned by us repeatedly in these columns.

Dr. Kamath while expressing his gratitude to the guests of the evening said that in all matters concerning the medical profession in this country the members of the medical profession in service should take a lead which they can easily afford to do being in a much more advantageous position in every way than his brethren in private practice. Dr. Kamath referred to a speech made by Major Mc. Robert, Professor of medicine Medical college and Physician General Hospital Madras to the medical students at the annual gathering in a private hostel in the city which he said proved that the State paid medical practitioners were capable of comprehending most lofty ideals not only in medical ethics but in the exercise of the medical profession whether it be as a practitioner, a teacher, an examiner and a social worker. The words of wisdom expressed by Major Mc. Robert and published in the columns of The Medical Practitioner were worthy of being written in bold types on the walls of every medical institution public or private including the consulting rooms of the medical practitioners. Dr. Kamath wished to see many more medical officers coming to the rescue of the profession and establish in this country a contented and harmonious medical fraternity. He also mentioned to the members of the profession that the salvation of India whether it be in politics or anything else and especially regarding the medical profession depended entirely on the united co-operation of the British and the Indian races on equal footing.

Omissions: Dr. Kamath, the host of the Social Function, desires to make mention that due to overfulness of his mind and the limited time before him he failed to express his gratitude to Dr. Venkataswami Chetti, nominated member, Madras Council and its Vice-President last year for making it possible for the council to elect Dr. Dyson unanimously as its Vice-President this official year. Dr. Kamath's statement suggesting to the Council to bring about a convention that the Vice-President should be unanimously elected every year from amongst the elected representatives belonging to group I, II, or III by turn, was objected to by Dr. U. Krishna Rao who was of opinion that the convention ought to have been settled at a previous meeting of the Council and not on the day of the election of the Vice-President. Dr. Venkataswami Chetti who occupied the Chair that day being the Vice-President till then, ruled my suggestion out of order. Dr. Kamath bowed down to the decision of the Chair though inwardly he must have thought that he was in order. Immediately after the ruling, Lt. Col. Mahadevan proposed that Dr. Venkataswami Chetti be re elected as the Vice-President. Dr. Satakopan seconded the proposal. To be consistent with his views and to gauge the views of the majority in the Council Dr. Kamath rose up quickly and proposed the name of Dr. Dyson. This proposal was seconded by Col. Hingston. Then Dr. Venkataswami Chetti gracefully came to the rescue and magnanimously withdrew his candidature with the result that Dr. Dyson was unanimously elected as the Vice-President. It is hoped that the Madras Medical Council will note what he is going on around them, in other democratic institutions and see to it that the only gift of honour they have by virtue of a very defective and undemocratic Council, is awarded by them by turns as suggested above and will not follow the old undesirable custom to bestow this honour on one and the same person and keep him on as the Vice-President year after year till he ceases to be a member of the Council, as was the case in the past history of the Council.

Another omission was about specialisation. This subject was commented upon in these columns last month. On occasions when the officials and non-officials mix freely as friends, a discussion on a subject of importance to the profession ought not to have been omitted. Dr. Kamath sincerely regrets this omission especially so, when Sir Frank Connor was so kind as to invite discussion on any of the subjects concerning the profession. We hope the profession both official and non-official will rise to the occasion and respect the principles underlying specialisation in the interests of the profession as a whole and not in individual interest. The Surgeon-General with the Government of Madras is the right person to take any initiative in matters like this and we trust Col. Newcomb, who is now acting for Major-General Sir Frank Connor, as Surgeon-General with the Government of Madras, will pave the way before the latter returns, by advising the Government to insist that medical officers in charge of Special Departments should not practise any other branch of medicine excepting that for which they are appointed as specialists.

A third omission was about the Co-operation of the practitioners in service and in independent practice with their brethren in service belonging to the Preventive Department. Dr. Kamath who was till a few years ago, the elected member of the Madras Corporation sent invitations for the 'Social Function' to the Health-Officer, Corporation of Madras and two Senior Assistant Directors of Public Health personally known to him. Lt. Col. Ganapathi was not invited as he was out of Madras. The absence of Public Health friends at the social gathering and not overfulness of Dr. Kamath's mind, was the cause of this omission. As was expressed by Dr. Kamath and endorsed by Sir Frank Connor, advantage will be taken in future of such gatherings in discussing vital problems concerning the profession and the public. Conclusions arrived at by mutual and heart to heart talks will have a lasting effect; such discussions will be more conducive for the growth and prosperity of the profession than the orders of the Government which keep changing with the persons in charge of the Department concerned.

Prevention is better than cure: In the Correspondence Columns of this issue an extract from the Code of Medical Ethics as approved by the Madras Medical Council is published at the request of the Registrar. The purpose of publishing this extract seems to be to apprise the Registered Medical Practitioners that what is mentioned in the extract constitutes 'infamous conduct in a professional respect.' We wonder if the Madras Medical Council has ever decided as to what constitutes 'Professional misconduct' for the purpose of bringing Registered Medical Practitioners within the desciplinary control, the only punishment that could be awarded by the Council being the erasure of the name of the practitioners from the Register either temporarily or for good. Information published by the Madras Medical Council for the guidance of Registered Practitioners consists of Part I and Part II. Under Part I appears a Warning Notice from the Madras Medical Council which says, that "the resolutions and decisions of the General Medical Council of the United Kingdom upon forms of professional misconduct" should be adopted by the Madras Medical Council, with the proviso added "subject to the laws in force in India." This is followed by the Warning Notice published by the General Medical Council, Great Britain and under seven different heads information has been published to indicate clearly 'what is infamous conduct in a professional respect.' Under the first heading, it is said that a Registered Practitioner will be liable to have his name erased from the Register in case he was shown to have signed or given under his name and authority any certificate report or document which is untrue, misleading and improper. In the second heading employing unqualified assistants and covering unregistered practitioners have been mentioned as infamous conduct. Under the headings number three and four, the responsibilities of the Registered Medical Practitioners, in the sale of poisons and dangerous drugs are mentioned, the breach of which is punishable with the erasure of name in the Register. The fifth

prohibits the Registered Medical Practitioners from associating themselves with unqualified practitioners or with practitioners who are not registered. In the sixth heading advertising and canvassing are mentioned as offences. The seventh and last prohibits Registered Practitioners from associating with unqualified midwives.

Under Part II of information 'A code of Medical Ethics' is published. In the first para of this code seven items almost identical with the seven items of information appearing in Part I are repeated briefly. The rest 29 paras deal with general advice which ordinarily cannot come under any of the headings mentioned in Part I. The notification by the Registrar, Madras Medical Council referred to above is the copy of para 22 appearing in the Code of Medical Ethics. It explains what constitutes breach of professional propriety. No where either in this para or other paras appearing in the code it is mentioned that a breach of professional propriety or violation of advice given to practitioners in this code as a guide to maintain the dignity of the profession, constitutes an act punishable with the erasure of the name from the Register. Sale of secret remedy is quite different from taking any part in the manufacture or sale of proprietary food or medicine if the ingredients of the food or the medicine are not kept secret. In all civilized countries Registered Medical Practitioners who invent new drugs, chemicals and even patent foods, take part in their sale though indirectly. Ehrlic in Germany, Ross and Brahmachari in India were not punished for inventing and supplying products of their invention to the public or the profession. A combination of drugs in a scientific way to suit a particular indication for the treatment of diseases is as good an invention as the finding out of new chemicals as medicine. A large number of eminent Registered Practitioners especially in Bengal and in other provinces of India are either partners or sole owners of firms manufacturing and selling proprietory medicines, foods and other requisites for the sick. Patent medicines and proprietary foods are now being prescribed largely by eminent Registered Practitioners throughout the world to the extent of even a fault and all of them are still in the Medical Registers. This aspect apart, the legislature in this province had decided that covering and association with unregistered persons was not an offence though it is definitely an offence in Great Britain. 'An advice regarding professional propriety' should not be made much of and construed as an offence punishable with erasure of the name in the Register.

We learn that the resolution which is the subject of these comments was passed by the Madras Medical Council on a complaint from a Registered Practitioner who pointed out to the Council that Registered Practitioners should not be permitted to be canvassing agents. The complainant saw a medical graduate engaging himself as a canvasser for a proprietary food. It is certainly against the dignity of the medical profession if a qualified practitioner registered himself in the Medical Register to be recognised as such and took to a profession which does not require the skill of a medical practitioner. Medical Councils in India should bear in mind not only existing laws of this country but also existing conditions. Laws are amended or even repealed to suit existing conditions as was recently done by the Madras Legislative Council without any objection from the executive Government with regard to covering and association of Registered Practitioners with persons who were not registered. Registered Practitioners find it hard to make a bare living by the exercise of the profession for which they got themselves trained and take up some work or other to maintain themselves. Unequal and unwholesome competition between state paid practitioners and private practitioners has been one of the chief causes for the existing state of affairs. In addition to the competition with their own fortunate brethren in service, the private practitioners have to stand the menace from quacks and charlatans not to mention the competition from another class of practitioners who are the products of the Government from the Indian Medical School. If the Medical Councils are not cautious and discriminate and choose to punish the Registered Practitioners violating the advice mentioned in the Code of Medical Ethics without taking into consideration the conditions in this country it is just probable that more amendments will be passed by the Legislative Councils of the nature passed in Madras and referred to above. Consequently the Medical Councils

will have no work and will naturally disappear.

The remedy to prevent these ills lies in the hands of the Medical Councils who should do all that is possible for them to induce the Government to put an end to the difficulties in the way of the Registered Practitioners which prevent them from earning their bread honourably by the exercise of the profession for which they got themselves trained spending large amounts of money. It is want of work as qualified practitioners that has been forcing Registered Practitioners to take to canvassing and other methods of eking a livelihood. In almost all the streets of the big cities and even in nooks and corners of villages are now seen Registered Practitioners canvassing for proprietary medicines or foods. So far the Bombay Medical Council only had taken notice of these unfortunate medical men and thought it fit to remove their names from the Register. The Madras Medical Council is likely to follow suit. The best method we will suggest to the Medical Councils in the interest of the profession, is to adopt preventive remedies for these ills in the way suggested by us above and in the meanwhile we would suggest as good a preventive remedy to the practitioners who have registered in the Madras Medical Register to apply to its Registrar to remove their names from the Register writing to him briefly in one sentence, "Please remove my name from the Register" as this brief request would suffice to enable the Registrar to remove a name from the Register. Such a procedure has been sanctioned by the Madras Legislative Council. Soon after these practitioners feel bold to practise the profession for which they are trained, they may apply to the Registrar to put them on the Register once again. This is permissible in Madras and should be made permissible in other provinces especially in Bombay. The most important point of Ethics in any profession is to keep the pot boiling by all honourable ways and all concerned should view this problem seriously and sympathetically too. Prevention is always commended to be better than cure. It cannot be otherwise to Medical Councils and the unfortunate members of the Medical Profession as well.

Is it Insult or Contempt? The Madras Medical Council had appointed a Special Committee consisting of Major. Ebden, Drs. (Miss) Findlay, Rama Kamath, Guruswami Mudaliar and Dr. Dyson, the last named being the Convener of the Committee, to go into the question of Medical Education for the Licentiates. One of the duties of the Committee was to inspect the L. M. P. examinations from the first to the final year. Through the Surgeon-General with the Governmment of Madras, the convener made very elaborate and satisfactory arrangements with the President Board of Examiners who at present happens to be the Superintendent of the Stanley Medical School. Basing on the time-table received from the President Board of Examiners, the convener drew a time-table with the authority and sanction of the Committee apportioning days when a member of the Committee should act as Inspector for a special subject and made the inspection so convenient that without any disturbance to the examiners, or the examinees each Inspector might have exceptional opportunities of inspecting every examination.The Inspection was at the practical examinations and the first day of inspection fell on 18-4-36 at 2 P. M. when the examinations in Physics, Organic Chemistry and Biology ought to have taken place. The Inspector on duty that day went round all the halls of the Madras Medical College where the examinations were being conducted, he could not get any information where these examinations were going on till at last the Civil Surgeon in charge of Research at the Medical College, was kind enough to accompany the Inspector to a tiffin room where the Inspector was introduced to one Mr. T. R. Subramanya Iyer, one of the examiners that day. The Inspector was surprised to know from this examiner that all the examinations were over before 1 P. M. having commenced at 8 or 10 A.M. He also informed the Inspector that the time-table was changed and he had information about the change in a communication dated 7-4-1936 from the President Board of Examiners. The Inspector had to go home with feelings which could be imagined than described. There was a repetition of the same scene on 29-4-36 when the same unfortunate Inspector was the victim. The examination in Anatomy which ought to have taken place at 2 P. M. was over before 1 P. M. Something of a serious nature was in store for this Inspector that day. Having learnt that examination in

Anatomy was over, the Inspector proceeded to the hall where examination in Organic Chemistry was conducted. At the very entrance to the laboratory where the examinations were going on the Inspector introduced himself to the chief examiner of the day in Organic Chemistry. We publish here below the conversation between the Inspector and the two examiners Drs. Rajagopala Naidu and Mannady Nayar, as sent to us by the Inspector who reproduced it immediately after the scene in a letter addressed to the convener of the Special Committee, Madras Medical Council:—

Dr. Naidu, "You cannot inspect, You may just see. I can permit only one as I did the other day regarding Inorganic Chemistry Examination."

Inspector, "nobody is accompanying me."

Dr. Naidu, "Where is your permit?. The person who saw the practical examination in Inorganic Chemistry brought with him a permit."

Inspector, "Are you not aware that the Madras Medical Council had appointed a Committee to go into the matter of Medical Education for the L. M. P. course and that this committee have been inspecting the practical examinations for the L. M. P. this year? May I also know who you are, and what is your position regarding to-days examination?"

Dr. Naidu, "I am the Professor of Chemistry Madras Medical College and the Chief Examiner for L. M. P. in Organic and Inorganic chemistry."

Dr. Naidu then sent for Dr. Mannady Nayar who was at the other end of the Laboratory.

Dr. Naidu to Dr. Mannday Nair, "He (i.e., Inspector) says he is an Inspector come to inspect the examination conducted by us. He has no permit. What shall we do?"

Dr. Nayar addressing the Inspector, "We cannot allow you to be here, will you leave the hall?"

The Inspector informs us that he curbed his temper and did not wish to create any unpleasant scene and left the hall saying "I am standing outside the Laboratory why do you insult me by asking me to leave the hall."

Dr. Nayar, "Will you leave the hall immediately?"

Feeling nervous and diffident on account of what happened on 29-4-'36, the Inspector took previous permission from both the examiners Drs. Naidu and Nayar when his turn came to inspect the examination in Organic Chemistry on 6-5-'36 and the Inspector wrote the following conjoined letter to these examiners sending each a copy as the examiners were very particular that the Inspector should possess a 'permit' before he entered the examination hall and as such a 'permit' was not made available to him by the Convener even after he received the report wherein mention was made about the 'permit.'

6th May 1936.

To

Drs. S. Rajagopala Naidu, B.A., M.B.B.S, and A. S. Mannady Nayar, M.B.B.S., Ph.D. (Edn,)

Gentlemen,

Having had most unpleasant experience at the practical examination hall on 29—4—36, when both of you were examiners for Organic Chemistry for L.M.P. students and when one of you, Dr. Mannady Nayar asked me to 'go out of the hall', I wish to give you previous intimation, that it is my turn to-day to inspect examination in Organic Chemistry. I have not been supplied with any 'permit', which both of you demanded from me that day though you knew that the Medical Council desired to inspect the L.M.P. examinations through its inspectors and knew me well as one of the members of the Madras Medical Council. Kindly let me know per bearer, if you will permit me to enter the hall to-day. Unless you intimate to me immediately in writing, I feel nervous and diffident to do the duty assigned to me as an Inspector. Though I have addressed to you conjointly, I have sent you each a separate letter to avoid any inconvenience or delay.

Enclosed I have sent you each a slip to note your approval, which your may kindly return per bearer putting your signatures therein.

Yours faithfully,
INSPECTOR.

Permission was granted and the Inspector did his work on 6-5-'36.

As it is reported to us that the unfortunate incident in the Organic Chemistry Laboratory has been the subject matter of talks and comments amongst the staff of the Madras Medical College and elsewhere and all sorts of versions are given for want of first hand information, we thought it was desirable to publish the conversation as narrated to the Convener of the Special Committee by the Inspector and wrote to both the Examiners requesting them to send us their version by 10 A.M. on Sunday the 17th May. But both of them were silent. It should therefore be inferred that they do not question the veracity of the statement made by the Inspector soon after the event.

The Madras Medical Council is a statutory body. The Inspectors were asked to do a statutory duty under instructions from a Special Committee appointed by the Madras Medical Council and the Convener of the Committee did take all precautions to avoid any inconvenience to the examiners or to the examinees. The Madras Government is to conduct the L.M P. Examinations with the help of a Board of Examiners all of whom including the President are the servants of the Government belonging to the Medical Department of which the Surgeon-General is the Head. Why the President Board of Examiners did not communicate the change in the time-table for the examinations to the Convener of the Special Committee while sending a communication regarding the changes in the time-table to the examiners concerned, is beyond our comprehension. We learn that the Convener had sent a report of all the scenes narrated above to the Surgeon-General with the Government of Madras. Though the Inspector is the direct victim of the annoyance due to want of information regarding change in the time-table and later a victim of a deliberate insult, the contemptous behaviour displayed at the examination hall cannot but reflect on the Madras Medical Council and also on the Madras Government. The fact that the permanent Surgeon—General who is the ex-officio President of the Madras Medical College just left Madras on long leave, has set many musing, a few of whom have been saying already, "Is it come to this?"

The City Municipal League and Dr. Cochrane:—The Madras City Municipal League organised the Civic Exposition on 18-4-'36 at the Progressive Union School Hall, George Town, Madras, where interesting charts, posters, and pictures were exhibited explaining the diseases prevalent in the City, their causes and treatment. There were charts to demonstrate the special activities of the League in preventing street nuisance, traffic dangers, etc. The Civic Exposition was opened by Major-General Sir Frank Connor, the Surgeon-General with the Government of Madras. R. G. Cochrane M.D., M.R.C.P., D.T.M., & H. Medical officer Lady Wellingdon Leper Settlement, Chingleput spoke on "Campaign against Leprosy". On the following day Dr. Govinda Pillay, Health Officer read a paper on "Health problems" in the City of Madras and Dr. K. C. Paul read a paper on "Diabetes". Extracts of the extempore speeches of Sir Frank Connor and Dr. Cochrane have been published elsewhere. Dr. Govinda Pillai made a survey of health conditions in the City during recent years and said there had been improvement in every direction and closed his paper by appealing to the public for co-operation with the Health Department. Dr. Paul in his paper said that diabetes was not as dreadful as it was considered once and people did not die so much on account of the disease itself but fell a prey to the complications and sequelae of diabetes. With proper care about diet and regimen a diabetic patient, said Dr. Paul could live the usual span of life. He warned the public against the dangers to diabetic patients on account of ever so many preparations advertised profusely as cures for diabetes. Sir. Mohamed Usman who presided on the second day of the Civic Exposition, expressed his joy that the public were having valuable advice from eminent medical men through the agency of the Madras City Municipal League and suggested to the League to continue organising such lectures on common diseases. The most important and urgent propaganda which every citizen should take upon himself in City said Mohamed Usman, was the stopping of the street nuisance of people answering the calls of nature. Sir Mohamed Usman opined that stringent measures should be adopted to make the Madras streets cleaner, even approaching the Government with a request that the Magistrates should be advised to inflict exemplary punishment on the offenders committing nuisance in the streets. We congratulate the Madras City Municipal League on their having conceived the idea of associating with the activities of the League persons of eminence in the Medical Profession who could talk with authority on vital health problems confronting the public. Dr. Govinda Pillai being the Health Officer of the Madras Corporation is a popular figure known to the profession and the public and needs no introduction to our readers so also Dr. Paul Hon. Physician Government Rayapuram Hospital Madras, and Hon. Physician in charge of Diabetes Clinic, out patients department of the Government General Hospital. But Dr. R. G. Cochrane should be made known both to the public and the profession not at all in his interest but in the interests of the humanity.

Dr. Cochrane is a doctor of medicine, Member of the Royal College of Physicians (Lond) and a Diplomate in Tropical Medicine and Hygiene. From 1924 to 1929 he worked in the Leprosy Settlements in Bihar (Purulia) and Bengal (Bankura). He then returned to London and took up the appointment of Medical Secretary of British Empire Leprosy Relief Association and continued in that office till last year. He is now in our midst.

Dr. Cochrane is one of the highest authorities in Leprosy and is attached as the Medical officer of Thirumani Leper Settlement about 40 miles from Madras. Members of the Medical Profession from distant foreign countries attend this institution for study and research. The members of the profession in this province if not in India should take advantage of the knowledge of one of their brethren who is a specialist and an authority in Leprosy, a disease which is curse to our country yet preventable, relievable and to certain extent curable. Dr. Cochrane is a medical missionary in the true sense of the term and unless India has many more missionaries of the type of Dr. Cochrane scattered all over, the problem of irradiacating leprosy in this poor country will continue to be so inspite of many well meaning at times fussy lay brethren and sisters of the medical profession who have been devoting their lives as social workers. The profession is thankful to the City Municipal League in giving them an opportunity of knowing Dr. Cochrane through the columns of The Medical Practitioner. The dieals of the League seem to be lofty and we trust they will be visualised.

Madras Government Encourages quackery !: The Sanitary Inspectors belonging to the Madras Provincial cadre have organised themselves into an Association which holds annual conferences in the office of the Director of Public Health presided over either by this officer or his neighbour in office, the Surgeon-General with the Government of Madras. At the last conference, the Director of Public Health mentioned amongst other things regarding the activities of his department that the experiment introduced a few years ago of permitting Sanitary Inspectors to do inoculations for cholera, had proved very useful. Such a statement had naturally irritated qualified members of the medical profession especially those practising in rural areas and we have received written and oral protests. One of the prominent rural practitioners has been repeatedly reminding us to publish his communication to us on this subject which he sent soon after the Sanitary Inspectors' Conference met. We have refrained from publishing this letter which contains allegations which though not unfounded, would loose their import and seriousness, in case the author making these allegations wishes to publish his letter under different feathers. This practitioner alleges that the village folk submit themselves to be inoculated by the Sanitary Inspectors under pressure and fright and that there had been untoward happenings to those inoculated. Inflammation, cellulitis and even the grave infection tetanus, have been not uncommon in minor or major surgical operations in the hands of even expert surgeons. It is quite possible that all conceivable and serious complications may set in, in an apparently simple minor operation of inoculation. In any other civilised country the Government would have been hooted most indignantly for encouraging quackery in a progressive and scientific era when qualified professional service is available and can be made available. We will ask most seriously the member or members of the Government who sanctioned this procedure if he or they would submit to be inoculated by a Sanitary Inspector who is authorised to do the same on a poor dumb villager? Lt. Col. Webb, the Dircetor of Public Health who was the author of this cheap scheme having gone on leave at the time, we saw his successor in office, Major Histerlow soon after we read a report about this new scheme in news papers from the latter, who was the then officiating Director of Public Health. He held his lips tight when he whispered into our ears that the Government sanctioned the scheme a year befor he took charge of office. The present Director of Public Health Lt. Col. Ganapathi could not disown the legacy bequeathed to him by his predecessor. We have referred to this subject in the Editorial of the current issue of The Medical Practitioner and suggested that the Medical Councils should take up this matter and see not only inoculation but vaccination etc., which require the skill of qualified practitioners should not be entrusted to lay persons. In the meanwhile we would advise members of the medical profession in rural areas to be vigilant and bring to the notice of the Director of Public Health any thing untoward that might have happened and may happen on account of vaccination and inoculation being performed by lay persons in his department.

Bogus degrees: It is most deplorable that neither the Central nor the Provincial Governments in this country have as yet realised their responsibilities to the public and the scientific medical profession in preventing persons assuming bogus titles to indicate that the posssessor thereof is one who could treat human diseases and even perform operations. There is at present an Act, called the Indian Medical Degrees Act No. VII of 1916 passed by the then Indian Legislative Council now the Legislative Assembly which is intended to regulate the grant of titles implying qualifications in Western Medical Science, and the assumption and use by unqualified persons of such titles. This Act prohibits anybody from assuming any title or adding anything more to his name implying that he holds a diploma or degree recognised by General Medical council or recognised by the Government for the purpose of this act. The Medical degrees conferred by the existing Indian Universities and the Diplomas granted by the examining bodies appointed by the Government in different provinces are the qualifications contemplated in this Act. Homoeopathic, Ayurvedic and Unani systems do not come within the purview of this Act. The Act is so lax and vague that if a person assumes the title of M. D. or any such degrees conferred by any University or F.R.C.S. Diploma and adds the word Hom to indicate that he practises Homoeopathy or similarly adds any letter to indicate that he practises Ayurvedic or Unani system he cannot be punished. Inspite of the defects in the existing Act, there have been cases in Madras, reported to the Madras Medical Council which could have been taken cognizance of by the Government and offenders punished but the Government even after repeated requests from the Medical Council would not themselves take any action. Nay it was possible in Madras for a compounder once employed in a quasi Government Hospital to assume a medical degree conferred by Calcutta University and practise as a Registered Medical Practitioner within a radius of even not a mile from the very institution where till recently he was a compounder competing with the very Government Medical Officers under whom he once served. These medical officers were either callous or nervous to report about this practitioner to the authorities concerned, as this practitioner was also Hon. Presidency Magistrate by the Government of Madras. The vigilant eye of The Medical Practitioner exposed this glaring fraud and about a year ago the name of this Hon. Presidency Magistrate cum Registered Medical Practitioner was removed from the Madras Medical Register. The callousness on the part of other Provincial Governments to save the public from the clutches of the quacks has not been less though perhaps not so glaring as that of the Madras Government. There is now a stir in all the provinces from the Members of the Medical Profession who are hard bit on account of the ever increasing number of quacks who have been not only assuming the titles of qualified practitioners but now starting institutions for the purpose of conferring bogus titles. The Punjab Medical Council has been more active than her sister councils in other provinces in booking the offenders of the Indian Medical Degrees Act. But the Act being very defective as pointed out by us a little while ago much could not be done to prevent quackery. Dr. Gianchand Blaganna, member the Punjab Medical Council is reported to have moved a resolution at the April session of the Punjab Medical Council, requesting the Government of India to amend the Indian Medical Degrees Act in such a way that the courtesy title 'Doctor' is not used by any person not authorised legally to do so and no body excepting those qualified to practise Western Scientific System of Medicine could prescribe drugs and preparations published in the British Pharmacopeia. Though we are in sympathy with the object and purpose conveyed in the resolution, we regret to mention that the wording of the resolution is defective. We have no idea if the Punjab Medical Council approved the resolution as it is or in a modified form. In Bombay the Bombay Medical Union, is arranging to introduce a Bill in the local Legislative Council to prevent the conferring of Bogus Degrees. In Madras an attempt was made

recently by Dr. V. Rama Kamath to move a few resolutions on the floor of the Madras Medical Council requesting the Government to stop quack practice or even to check the same but the consensus of opinion prevailing in the council was such that he found no useful purpose would serve by moving the resolutions and withdrew them after some informal discussion. This subject being of all-India importance should be dealt with by the Central Government and we suggest to all concerned that instead of piece meal work, the Indian Medical Profession as a whole should bestir themselves and bring pressure on the India Government to take drastic action to prevent quackery by amending the Indian Medical Degrees Act suitably. Time seems to be very propitious for an all-India agitation on this subject. We find that the Madras Mail had drawn the attention of the Government to the urgent need of effective control over quacks and charlatans in the interest of public safety. The Times of India in Bombay has been also interesting itself on this subject. We trust other Indian dailies will follow suit. The profession should not only thank the Madras Mail and the Times of India but supply them with materials to keep up the agitation. We will be as vigilant as we ever have been before.

War Supersession or a Ruse ? We learn that one or two Civil Assistant Surgeons are promoted as officiating Civil Surgeons and in the near future a few more are likely to be transformed as such superseding a large number of their senior brethren in service. The supersession seems to have been effected to serve as a recognition of services rendered by these Assistant-Surgeons during the War. This move has set several thinking if this is a ruse to bring up a favourite of somebody somewhere, who ingeniously wishes to sling mud into the eyes of the public and make it appear that supersession was justifiable so as to enable him to pull up his favourite and for this propose War Service has been made an excuse. The appointments as professors of the Vizagapatam Medical College, as Medical Officers of Special Departments were considered till recently as justification by those interested in their favourites to transform very junior Civil Assistant-Surgeons as Civil Surgeons. One such Assistant-Surgeons was at the time of transformation in temporary service. During the Great War, a few Civil Assistant-Surgeons were made to act as Civil Surgeons on the same principle. Such reckless, unjustifiable, inhuman supersessions were repeatedly brought to the notice of the Government through the columns of The Medical Practitioner till at last the Government were forced to realise after the Retrenchment officer submitted his report to them a few years ago during the period of depression, apprising the Government that apart from injustice done to the seniors in service by such supersessions, the policy till then followed by the Medical Department was financially unsound. Since then the Assistant-Surgeons posted for teaching in the Vizagapatam Medical College were not trasformed as Civil Surgeons and it was also found possible to post them to Special Departments as such without superseding their seniors in service, though the teachers and specialists possessed higher qualifications which were earned by them at public cost. On the same principle War Service alone should not be taken into account for superseding seniors by juniors. Service, good record, and merit should be the only guiding factors while promoting Assistant Surgeons to the grade of Civil Surgeons. It is of course justifiable to prefer one with War Service other requirements being equal. If the Government wishes to reward Assistant-Surgeons for War Service they may do so by other ways. They may be given Government lands as gifts as is done in the case of regular military service men. There cannot be any objection to give these Assistant-Surgeons special remuneration in the shape of a lump sum or as special pay as they now do for some Assistant Surgeons holding special appointments. They may be also permitted to retire earlier on full pension. Perhaps Fundamental Rules do not permit all this and that is why Peter should be robbed to pay Paul. We wonder if those who are the stage actors to effect these transformations remember that the existing Statutory Rules do not permit the promotion of a junior superseding a senior unless the latter is informed in writing the reasons justifying the Supersession. We are yet to know if War Service has been mentioned in Fundamental Rules or in Statutory Rules as one of the qualifications to justify Supersession.

This belated reward for War Service at the cost of deserving seniors should not be encouraged by the Government, in the interest of justice and fair play. They should devise other less objectionable ways and means to remunerate Assistant-Surgeons for having rendered War Service.

A Dawn of Hopeful Expectations: We congraulate the Madras Government on their having posted an Europeon civilian as the Secretary for the Medical and Public Health Departments both of which are made independent of the Local Self Government Department. The proper thing to do would have been to establish a Public Health Ministry with a qualified medical man as the Secretary. We hope this will be the next immediate step after the transitional period of reforms. The pivot of good Government should rest on a strong Secretariat uninfluenced and unshakable by the parties in power or in opposition. Whatever might be the defects in the steel frame of a Civilian Bureaucrat if there be any remnant of justice left at present in the Secretariat in this province, it is certainly due to the existence of the European I.C.S. officers in that building. The affairs of the Medical and Public Health Departments are not satisfactory as yet. A fabulously large and disproportinate amount of nearly a crore is being spent by the Medical Department with little or no cheque whereas the Public Health Department is getting only 24 lacs or very near this amount for its expenditure. Attempts should be made by the Government to entrust Hospital Administration to the public encouraging every way Voluntary Medical Relief and Medical Service as in Great Britain. We trust Mr. C. H. Masterman the newly appointed Secretary to Government, in charge of Education and Medical and Public Health Departments will acquaint himself with conditions of the Departments now under his personal control as compared with such conditions in the country of his birth and pave the way for the inauguration of an ideal Health Ministry in days to come. Mr. Masterman belongs to a group of European Bureaucrats who have been democratic at heart and did not disguise their sympathies for progress and reform. We trust he will continue as such in the new atmosphere he is placed at present and earn the gratitude of the Public, not excluding the members of the Medical Profession whether they be in the Service of the Government or in the Service of the Public.

A correction: In the last issue of The Medical Practitioner while commenting on the Medical and Public Health Budget of this province, we said that "no other Department of the Government spends such a huge amount" of nearly a crore of rupees as was spent by the Medical Department. We are informed that there are three other Departments, the General Administration—Secretariat and Head Quarters Establishments, the Educational and the Police which spend much more than the Medical Department. Inspite of this correction our comments that the supervision and control over an expenditure of nearly a crore of rupees in the Medical Department is insufficient, cannot loose its seriousness and force when it is known that the three Departments now mentioned have much better and more efficient control over the expenditure in those Departments both in quality and much more in quantity.

Lt. Col. Mahadevan Honoured: We congratulate Lt. Col. Mahadevan, Superintendent Stanley Medical School on his having been elected as the Fellow of the Royal College of Physicians Edinburgh. He is the second Indian in this province to get this honour. Lt. Col. Mahadevan is an old student of the Madras Medical College. After qualifying himself as L. M. S. in 1910, he entered the Provincial Medical Service as an Assistant-Surgeon. It is said that he was not pulling on well with an I.M.S. officer under whom he was working as an Assistant-Surgeon in the General Hospital Madras, and young Mahadevan seems to have then determined not to serve as a subordinate under this I.M.S. officer and went to Edinburghq ualified for the Diplomas L. R. C. P., & L.R.C.S. and L. F. P. S. (Glas.) in 1913. Luck favoured the youthful ambition of Mahadevan and he got temporary commission and served in the army during the Great War. Soon after he was made permanent member of the Indian Medical Service. In 1922 he became F. R. C. S. (Edin.) and was transferred to Civil Department in, 1923. After serving as D. M. O. in three districts he was posted as the Superintendent of the Government Royapettah Hospital Madras from where he was transferred as the Superintendent Royapuram now Stanley Medical School where he has

been serving for the last six years. Lt. Col. Mahadevan's regime as the Superintendent of the Medical School has been one of progress. He was mainly responsible to introduce five years course for the Medical Licentiates in this province having cooperated whole-heartedly with his then Chief, Major-General Sprawson to both of whom the students of the Stanley and other medical schools in this province are under a deep debt of gratitude. Lt. Col. Mahadevan has a rare gift in him of keeping himself popular in this surroundings. The students of the Stanley Medical School love him and admire him and we join them in our admiration for Lt. Col. Mahadevan who, though at present in high rank in the I. M. S. has not lost his love for study and research in recognition of which he was elected as the Fellow of the Royal College of Physicians Edinburgh of which college he has been a Surgeon from 1922.

A Pride of Medical Profession: Rao Bahadur Dr. A. Lakshmanaswami Mudaliar, Honorary Assistant Surgeon to His Excellency the Viceroy, Second Obstetric Physician and Gynaecologist Government Hospital for women and children Madras has been unanimously elected by the Senate of the Madras University to act as its Vice-Chancellor. This is the first time to our knowledge in the history of the Madras University that an eminent and distinguished member of the medical profession has been honoured by the University as its Vice-Chancellor. Dr. Lakshmanaswami Mudaliar is a well known member of the medical profession and equally well known to the public in his various capacities. He is a prominent member of the University Senate and also its Fellow. He has been taking keen interest not only in medical education but in all matters concerning education in general. This is not an occasion for us and we feel it unnecessary to bring to the notice of our readers the distinguished career of Dr. Lakshmanaswami Mudaliar in the profession as well as in the service to which he belongs. Suffice it to say that he has been shining well in whatever capacity he has had occasions to serve. We hope time will not be far when the Madras University confers on Dr. Lakshmanaswami Mudaliar the permanent appointment as Vice-Chancellor [illegible] confirm their recognition of his service [illegible] cause of education. We congratulate Dr. Lakshmanaswami Mudaliar who is really a pride of the medical Profession.

Ourselves:—Under the caption "Apology again" we narrated the circumstances which have been compelling us to publish The Medical Practitioner late these few months. In addition to the worries due to the affairs of a Co-operative Bank of which our Managing Editor is the President, he had to attend as an Inspector on behalf of the Medical Council at all the practical examinations for L.M.P. diploma from about the middle of March till the first of May, 1936. Exactly the same day when he fell ill last year in the third week of April he had an attack of Influenza which though passed off without any untoward complications, did materially affect his activities. He is still on bed leaving it only to attend to urgent work. He has almost retired from active professional life and it is his intention to spend more time in future in the service of the profession. Soon after he gets rid of his present worries it is his desire to concentrate his attention on The Medical Practitioner to pull it up to better speed of usefulness. Till then we beg of our readers to excuse us for all our omissions. Inspite of our troubles we have been keeping alive to the needs of the members of the profession whether they be in service or in private practice. Though it may look to a few an Utopian task, we are now seriously finding ways and means to bring together the two wings of the Medical Profession, Service and Non-service under one banner of service to humanity adopting the "give and take policy". The social function adverted to in these columns is the first attempt in this direction. It did augur well and in the right direction. Though the journal appears this months as a combined issue we did attempt to give our readers enough matter to think over and digest. The journal is a month or two old; but the contents especially the News and Comments are as fresh. We once again repeat our appeal to our subsrcibers to treat the journal as their own though Dr. Kamath owns its formal proprietorship. We cannot feel delicate to place before you our handicaps, disabilities and difficulties many of which being outside our control, we crave once again the sympathetic indulgence and goodwishes of our subscribers.

Correspondence Reports Etc.

(Continued from page 144)

Notice

The Registrar, Madras Medical Council has sent us the following matter for publication: –

The Madras Medical Council at its meeting held on the 3rd March 1936 resolved that the following notice be published in all possible Medical Journals.

"It is a grave breach of professional propriety for a Medical Practitioner to take any part in the manufacture, or sale, of a proprietary food or medicine or to have his name in any way associated with it. Medical men should also be cautious how they lend themselves to the puffing of these articles."

(Extract from the Code of Medical Ethics, para 22).

Civic Exposition Madras

Major-General Sir F. P. Connor, Surgeon-General with the Government of Madras, opened on 18-4-36 the Civic Exposition organised by the Madras City Municipal League at the Progressive Union School Hall, George Town. Dr. R. G. Cochrane delivered a lecture on 'Leprosy' on the occasion. There was a large gathering.

The Surgeon-General said at the outset that he regretted much that there were not many ladies present at the function. The activities of the League should interest the womenfolk. The function of a Municipal League was to point out defects in the Municipal administration. Such organisations would do great good if, in addition to pointing out defects, they also made constructive suggestions for the improvement of the city. The Surgeon-General then requested Dr. R. G. Cochrane to deliver his address on Leprosy.

Dr. Cochrane said that for the ultimate eradication of the disease the co-operation of the general public was absolutely essential. People in India, as well as in other countries, used to look at leprosy as a visitation from God. It was wrong to think that it was incurable or dreadful. From his short experience in this Presidency, he found that the greatest danger to public

health was not the street beggar suffering from leprosy, but the large number of persons suffering from the disease, who were living in houses and coming in contact with children. The problem, continued the speaker, could not be solved in a short time. The general public should be taught everything about the disease. The public should be sufficiently educated to help the authorities. Isolation could not be resorted to in all cases. In the very early stages of the disease, the persons affected could be isolated in their own homes and treated. During the past decade the speaker said, the general public had done an admirable amount of propaganda work, but the time had come now to alter their plan of work to some extent. They should try to treat active cases and not merely isolate them. Leprosy, being one of the ordinary endemic diseases, should be treated as other diseases in the hospitals in the Presidency. The speaker visualised the time when the Tirumani settlement would be a settlement only for bad cases. He also hoped that they would be able to build up a children's section in the settlement where children could be treated. In conclusion, Dr. Cochrane said that he was glad to see that the public were interesting themselves in the problem.

The Surgeon-General, in bringing the proceedings to a close, said that Dr. Cochrane was one of the leading authorities in the world on the disease and Madras should congratulate itself on having secured his services. The Surgeon-General said that he was in entire agreement with Dr. Cochrane in views expressed by him, although the methods suggested by Dr. Cochrane were not in full accord with the procedure they were adopting now in the Presidency. He hoped that in future more intensive work would be done and more clinics started.

The Surgeon-General congratulated the Madras City Municipal League on organising the interesting exhibition. It was only by persistent effort that the League would be able to do something tangible. The field was unending and the League must give their attention to all problems. He was in New Delhi for some time. He found the city clean, well-planned and beautiful. A lot of money was spent to make it so. They could make Madras cleaner, healthier and more beautiful by persistent work. He wished the League God-speed.

NOTICE

Readers of The Medical Practitioner are requested to quote the Registered numbers appearing on post wrapper against their names while communicating with the Managing Editor. He finds it at times very difficult to identify the authors of the letters from amongst 3000 names, especially when names and initials appear to be identical.